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Philadelphia College of Osteopathic Medicine

Department of Psychology

A CULTURAL COMPETENCY PROGRAM FOR PSYCHOLOGISTS:  
CLINICAL AND SUPERVISORY PRACTICES WITH  
LATINO CULTURE AND LANGUAGE

By Marie C. Weil

Submitted in Partial Fulfillment of the Requirements of the Degree of

Doctor of Psychology

August 2010

**PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE**  
**DEPARTMENT OF PSYCHOLOGY**

Dissertation Approval

This is to certify that the thesis presented to us by Marie C. Weil on the 18th day of August, 2010, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

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## Abstract

This study was designed to develop and evaluate an online cultural competence training program for psychologists ( $N = 6$ ). Psychologists who supervise clinical psychology graduate students were recruited via their affiliations with the Philadelphia College of Osteopathic Medicine (PCOM), the National Council of Schools and Programs of Professional Psychology (NCSP), the Association of Psychology Training Clinics (APTC), the Association of Psychology Postdoctoral and Internship Centers (APPIC), and the Pennsylvania Psychological Association (PPA). The purpose of the study was to address multicultural training gaps between supervisors and doctoral students in psychology and to meet the psychological needs of Latinos, the largest ethnic minority group in the United States. The program was expected to develop and increase psychologists' sensitivity to Latino culture and language and enhance their multicultural competence in supervision. The study examined cultural competence as measured by the Cultural Competence Assessment (CCA), supervisory multicultural competence as measured by the Multicultural Supervision Inventory – Brief (MSI – B), and supervisory styles of psychologists as measured by the Supervisory Styles Inventory (SSI). The results revealed that psychologists gained knowledge in Latino culture and language and in multicultural supervision following completion of the cultural competence program. The major implication of this study supports the idea that cultural competence training is an effective, promising tool with which to educate psychologists in cultural and supervisory practices as they relate to the treatment of Latinos. Recommendations for future training and research on cultural competency include the development of cultural

competency curriculum models for psychology and continuing education mandates in multiculturalism for psychologists.



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## Epigraph

You can't go to your oppressor for affirmation...that is a contradiction in terms. So we decided to do it ourselves. Then the Asians followed, the Chicanos, and even White women got their own theories. Everyone jumped on the band wagon! I mean we aren't at the promise land but we are a lot further than we were 50 years ago when I left graduate school.

Dr. Joseph L. White, on developing a Black psychology, (American Psychological Association Office of Ethnic Minority Affairs, 2010, p. v).

## **Chapter One: Statement of the Problem**

Psychologists' unique preparation facilitates their ability to engage in effective treatment with diverse people in an increasingly multicultural world. Because of this, they have an opportunity to incorporate relevant aspects of culture and strengthen the therapeutic alliance when providing interventions.

Culture, like therapy, is dynamic. Culture is defined as, "the distinctive customs, values, beliefs, knowledge, art, and language of a society or a community" (VandenBos, 2007, p.250). Culture can also be defined as its integration with a person's life, "Culture is both a product of group values, norms, and experiences and of individual innovations and life histories" (Guarnaccia & Rodriguez, 1996, p. 421). These cultural and linguistic issues impact all persons. Psychologists and countless others benefit when they seek to become competent practitioners in multicultural psychology. In particular, this study focused on promoting greater awareness and knowledge of Latino culture and language to inform clinical and supervisory practices simultaneously, as the field of clinical psychology advances in multicultural competence.

### **Statement of the Problem**

This study addressed three fundamental topics in multicultural psychology. The first relates to supervision and training needs in programs. Psychology's advancement toward multicultural awareness and competence is evidenced by requirements for programs in professional psychology to meet accreditation standards for students to have knowledge in individual and cultural diversity in psychological science and practice (American Psychological Association (APA), 2009). The ethical code for psychologists (APA, 2002) outlines principles of beneficence and nonmaleficence (Principle A), social

justice (Principle D), and people's rights and dignity (Principle E) that are inherent in the APA Multicultural Guidelines for Education, Training, Research, Practice, and Organizational Change for Psychologists (APA, 2003). Psychology trainees depend upon the training and supervision they receive to achieve this ethical standard of competence. The supervising psychologist is also bound to the same ethical standard of competence. Likewise, trainees develop cultural competence in supervision. Inman (2006) stated this succinctly, "Trainees look to supervisors in developing the cultural competence needed in providing culturally responsive treatment" (p. 73).

The second area addressed the growth of the Latino population in the United States. Latinos are the fastest growing ethnic minority group in the United States, accounting for 45.5 million people as of July 1, 2007 and 15% of the total population (U.S. Census, 2008a). Trainees in psychology are being prepared to provide psychological services to multicultural populations. However, although more psychology trainees are receiving multicultural training in their programs today, the same supervisees are likely to be at practicum or internship sites where their supervisors have had less diversity training as part of their own preparation (Constantine, 2003). This implies a need for supervisors to have cultural competence training before or simultaneously with their supervisees.

In 2004, 20.1% of the recipients of doctoral degrees (Ed.D. and Ph.D.) in psychology were ethnic minorities, with 6.3% representing Latinos. Ethnic minorities composed 19.9 % of new enrollees in Psy.D. Programs in psychology; 6.1% of these were represented by Latinos (APA, Office of Ethnic Minority Affairs, 2008). This means

that the majority of psychological service providers continue to be White<sup>1</sup> despite the growing need to accommodate a culturally diverse population in the United States. The growth of the Latino population and of new Latino psychologists means that there is an increasing need to address issues of culture and language in training programs and in supervision (Fuertes, 2004; Munsey, 2009).

The third area is related to the health and mental health disparities for Latinos. Effective interventions are needed to address and reduce these disparities for non-White ethnic groups in mental health services. The *Surgeon General's Report on Mental Health: Race, Culture, and Ethnicity* (United States Department of Health and Human Services (USDHHS), 2001) indicated that racial and ethnic minorities have less access to mental health services than do non-Hispanic Whites. Furthermore, racial and ethnic minorities are less likely to receive needed care, and when they do, the care is more likely to be poorer in quality as compared with non-Hispanic Whites. This inequality means that minority communities have a higher proportion of individuals with unmet mental health needs and lower utilization of mental health services. At the same time, ethnic minorities do seek treatment when symptoms are severe, often at primary care providers or at non-formal traditional health providers in their own communities (USDHHS, 2001). The Surgeon General's Report revealed that persons in the lowest socioeconomic status (SES) in society are 2-3 times more likely than those in the highest SES to have a mental health problem. Cultural and linguistic issues impact the needs of those who require

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<sup>1</sup> The term "White" as used in this program follows terminology and census categories in the United States with recognition that racial and ethnic categorizations that fall in "White" and "non-White" change over time. Specifically, the use of the term "White" distinguishes membership from other ethnic minority groups (e.g., Latino, African American, Asian American, American Indian, Alaska Native, and Native Hawaiian, and multiracial groups). Finally, "White" is very heterogeneous and would benefit from greater specification to include cultural groups not currently identified in the US Census (e.g., Arab Americans, Eastern Europeans, and other recent immigrants from Latin America, Africa, Asia, and Europe).



psychological treatment. Psychologists who are trained to be culturally competent in working with Latinos can better understand and effectively treat “the help-seeking person [who] interprets his or her troubling experiences through a culturally influenced prism...” (Snowden & Yamada, 2005, p. 145).

### **Purpose of the Study**

Psychologists with specialized skills in language and culture are in great demand to help reduce the health and mental health disparities evident across multicultural populations in the United States. Arredondo and Perez (2006) highlighted the six multicultural guidelines published by the American Psychological Association (APA, 2003) and identified resources available to psychologists in order to enhance their culturally responsive awareness, knowledge, and skills. The online cultural competence program for psychologists in this study sought to improve clinical and supervisory practices with increased sensitivity to Latino culture and language in those settings that train doctoral level externs or practicum students in psychology. Implementation of the study occurred under the supervision of The Philadelphia College of Osteopathic Medicine’s (PCOM) Department of Clinical Psychology in Pennsylvania. Content of the program included learning about various Latino cultural characteristics, language, and supervisory issues.

### **Relevance to Cognitive Behavioral Therapy**

Andrés-Hyman, Ortiz, Añez, Paris, and Davidson (2006) reviewed six Latino cultural constructs and values that were covered in the cultural competence program: (a) dignity and respect, (b) family values and the value of family, (c) personalism, (d) machismo, (e) marianismo, and (f) religion and spirituality. The program in this study

incorporated these cultural values and integrated adaptations of cognitive-behavioral therapy (CBT) with Latinos (Organista, 2006). CBT treatment orientation among psychologists (Hays, 2006) lends itself for use with multicultural populations (Hays, 1995). The application of CBT with Latinos is pertinent for bilingual psychologists working with this ethnic group; reference to CBT examples highlighted its advantages (Organista, 2006). In PA for example, Puerto Ricans make up the largest Latino group (Escobar-Haskins, 2008). Furthermore, limited research from large epidemiological studies has determined that Puerto Ricans in the U.S. mainland experience the worst mental health status of all Latinos (Guarnaccia, Martinez, & Acosta, 2002). Latinos are expected to benefit from treatment by multiculturally competent psychologists and their supervision offered to psychology trainees.

## **Chapter Two: Literature Review**

Approximately 50 million Latinos composed the population of the United States in 2009 (U.S. Census, 2009). With nearly one of every three U.S. residents expected to be Latino in 2050, (U.S. Census, 2008a), the largest worldwide association of psychologists recommended implementation of its own study to examine the translation of research into other languages and examine ways to encourage members to learn second languages, including Spanish (APA, 2005).

This study considered prominent issues in multicultural psychology within a cultural competency training for psychologists. The cultural competence program focused on increasing psychologists' sensitivity to issues that impact Latinos to reduce the mental health disparities. Moreover, the program concentrated on enhancing psychologists' knowledge to provide multicultural supervision.

### **Latino Demographics in PA**

Latinos are the largest ethnic minority group in the United States and make up 15% of the total population (U.S. Census, 2008a). Of these (U.S. Census, 2006), Mexicans compose the largest subgroup (64%), followed by Puerto Ricans (9%), Cubans (3.4%), Dominicans (2.8%), Central Americans (7.6%), South Americans (5.5%), and other Hispanics (7.7%). Of great importance is the fact that 78% of U.S. Latinos, ages 5 and older speak Spanish at home. Pennsylvania (PA) is home to 4.2% of Latinos (Escobar-Haskins, 2006; U.S. Census, 2008b) and many areas such as Luzerne County, Pennsylvania had a significant growth rate (175.9%) of Hispanics in 2006 (U.S. Census, 2006). Two-thirds of Latinos in PA are English fluent, but 31% have limited English fluency that needs to be considered in the provision of mental health treatment needs.

Notably, eight counties in PA have Latino populations greater than 5% (U.S. Census, 2008b).

### **Latino Mental Health**

Increasingly, greater attention and more research are taking place to inform the mental health community of the variables that are important when working with Latinos: immigration, language, and social contexts (Alegría et al., 2007). Data from the National Latino and Asian American Study (NLAAS) were analyzed to determine prevalence rates of depressive, anxiety, and substance use disorders among Latinos in the United States. The study sampled 2,554 Latinos during 2002 – 2003 in English or Spanish with a representation of 868 Mexicans, 495 Puerto Ricans, 577 Cubans, and 614 Latinos of other national origins. Alegría et al. indicated that the NLAAS was the “first nationally representative study of English and Spanish-speaking Latinos” (p.68). Lifetime psychiatric disorder prevalence estimates were 28.14% for Latinos and 30.23% for Latinas. Puerto Ricans had the highest overall lifetime prevalence rates, and in the previous year, had higher psychiatric disorder prevalence rates (38.98% and 22.88% respectively) compared with Cubans (28.38% and 15.91%), Mexicans (28.42% and 14.48%) and other Latinos (27.29% and 14.42%). Immigration status data, stating specifically whether one was born in the U.S. or was foreign-born, indicated that U.S.-born Latinos were significantly more likely than foreign-born Latinos to fulfill lifetime psychiatric disorder criteria. Puerto Ricans were at highest risk for rates of previous-year psychiatric disorders than were Cubans, Mexicans, and other Latinos. These estimates were considered conservative because of the lack of representation of incarcerated and homeless populations as well as the inability of the diagnostic instrument to represent

culture-bound syndromes. The pervasiveness of mental health problems among Latinos in the United States begs the need for adequate treatment.

### **Mental Health Disparities**

Disparities in health and mental health access and utilization are well documented (Rios-Ellis, 2005; USDHHS, 2001, Viccora, 2001). Mental health disparities are defined by Aguilar-Gaxiola in Viccora (2001) as, “the difference in the incidence, prevalence, morbidity, mortality and burden of diseases and other adverse conditions that exist among specific population groups” (p. 24). Based upon studies available at the time, the USDHHS (2001) reported mental health utilization for Latinos born in the United States was less than 1 in 11 and for Latino immigrants born outside of the U.S., it was less than 1 in 20.

Snowden and Yamada (2005) reviewed research that investigated cultural factors related to disparities in mental health treatment. Compared with Whites, ethnic and cultural groups have less access or ability to obtain mental health treatment. In 2001, a main barrier to access was the lack of health insurance (USDHHS). When cultural groups do obtain access, quality of treatment is not certain. Cultural factors related to access include the cognitions, attitudes, and preferences of ethnic and cultural patient populations that may differ from the providers’ ability to respond to these needs. For example, ethnic groups and non-ethnic groups with mental health needs obtain more services for mental health problems with their general medical providers than with providers specialized to treat mental health. Access problems are understood by reviewing utilization rates, or rates of use, in relation to the reference group’s need for services (USDHHS, 1999).

According to the USDHHS (2001), fewer than 1 in 11 Latinos with mental health problems utilized mental health providers and fewer than 1 in 5 Latinos utilized general health care providers, with even lower utilization rates reported for Latino immigrants, to fewer than 1 in 20 for specialized mental health providers and 1 in 10 for general health care providers. Several issues likely contribute to low utilization. First, Latinos also use alternative treatments in conjunction with conventional treatment. Second, Snowden and Yamada (2005) indicated a need for more research to determine how cultural groups' mistrust of mental health providers and the stigma which is related to mental health impacts acquisition of treatment. Third, acculturation remains an important factor in the treatment disparities and greater understanding is warranted regarding the fit between the cultural group and the mental health provider. Therefore, the lack of culturally sensitive therapy may contribute to access problems and discontinuity of treatment (Snowden and Yamada, 2005). Last, although ethnic and cultural populations are overrepresented in public sector mental health care, providers do not meet federal regulations of Title VI of the Civil Rights Act of 1964 equally. Despite federal requirements that recipients of federal funds provide equal access services to limited-English proficient persons, providers differ in their assessment of language needs of patients, staff training and monitoring, interpreter use, translation of written documents, and how or whether they inform patients of their right to this type of free assistance (USDHHS, 2009).

In a secondary data analysis of mental health care recipients in the California public mental health system, Snowden (2007) hypothesized that minority family involvement mediated disparities. A total sample of 4,038 clients were identified and assessed, followed by interviews of 2,531 clients who were randomly selected. The

random sample consisted of 8% Asian, 16% Latino, 9% African American, and 67% White clients. The majority of Asians (72%) lived with their family compared with 62% of Latinos, 35% of African Americans, and 32% of Whites. Regression data showed that compared with Whites, Latinos had 2.6 fewer contacts with outpatient treatment and 0.36 fewer contacts with inpatient treatment. However, after controlling for information about whether or not clients lived with and were supported by family members, no significant difference was found. Snowden (2007) offered two explanations for the finding that clients who lived with families received lower levels of mental health care. The first explanation suggested that the family engages constructively with the client, thereby reducing mental health symptoms and promotes adjustment that results in less need for treatment. The second explanation suggested that minority families might avoid mental health treatment due to stigma, fear, or past failure. In sum, Snowden (2007) provided initial cultural explanations for disparities in mental health treatment.

More recently, professionals have called for research that goes beyond documenting Latinos underutilization of mental health services to focus on how to get quality mental health services to Latinos (López, 2002; Vega & López, 2001). One specific recommendation called for intervention studies to determine those things that are effective or those that are not effective. In addition, López (2002) encouraged research to examine how organizational factors contribute to the development and evaluation of cultural competence models. Outcome data on cultural competence models can support their usefulness in addressing the provision of culturally competent mental health treatment (Vega & López, 2001). A 2005 report by the National Council of La Raza on disparities in Latino mental health suggested that greater numbers of Latino mental health

providers and those who can understand Latino cultures and who speak Spanish are needed to address the provision of quality mental health services for this population (Rios-Ellis, 2005).

One particular study surveyed Latinos in southern California communities about their perceived mental health needs and explored possibilities to effect quality mental health treatment (Kanel, 2002). Kanel compared low-skilled, working poor Hispanics, born primarily in Mexico, with college students, born primarily in the United States, about their perceived mental health needs and factors related to expectations about mental health treatment. Data suggested that most Hispanics in the community and in college (67%) would seek an appointment with a family therapist if they had family problems. Most Hispanic participants (59%) believed that medicine would not help with mental health problems and 77% preferred to speak to a therapist. In terms of level of comfort, the participants indicated a preference for a professional therapist who gives a lot of advice and asks a lot of questions rather than a very talkative and very quiet provider. Although this was a descriptive study, it provided insight into the factors that may relate to the provision of quality mental health treatment for a Latino population, specifically recognizing that Latinos have a desire to obtain mental health treatment. The inclusion of ethnic members in research and the study of cultural variables continue to evolve with greater knowledge of how Latino cultural values and language influence treatment.

### **Cultural Competency and Treatment**

Although there are numerous definitions of culture, a common element involves values and behaviors (Atkinson, 2004) that are learned via various systems including family, community, and the larger society. We are all cultural beings who subscribe to



“distinctive customs, values, beliefs, knowledge, art, and language of a society or a community” (VandenBos, 2007, p. 250). However, in addition to group culture, it is integrated at an individual level with experiences and life histories (Guarnaccia & Rodriguez, 1996). Cultural psychologists include values in all understandings of human behavior in psychology relative to the local cultural context (Segall, Lonner, & Berry, 1998).

Guideline 1 of the American Psychological Association (APA) Guidelines for Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists (APA, 2003) encourages psychologists to recognize themselves as cultural beings influenced by attitudes and beliefs about others who are racially and ethnically different. Cultural competence models encourage the practice of self-reflection as an initial stage in the process of becoming multiculturally competent (Sue, Zane, Hall, & Berger, 2009; Sue, Arredondo, & McDavis, 1992). Roysircar (2004) made this explicit: “Therapists’ cultural self-awareness is a precursor for effective and culturally relevant therapy” (p.658).

Cultural competence may exist at three levels: a provider and treatment level, institutional level (operations of an agency), and a systems level (community system) (Sue, et al., 2009). This study examined the cultural competence of a provider and how this impacted supervision practices pertaining to clinical treatment. Specifically, it was based upon defining the therapeutic encounter process as culturally competent (Sue, 2003). Although definitions of cultural competency are broad, Sue, et al. (2009) provides three conceptual categories of definitions: “(a) the kind of person one is, (b) skills or intervention tactics that one uses, or (c) processes involved” (p. 529). All three of these

conceptualizations were integrated in this study to help elucidate what is meant by being a culturally competent psychologist *and* supervisor. The first and most prominent model lists characteristics of a culturally competent provider. According to Sue et al. (2009) and Sue, Arredondo, and McDavis (1992), the culturally competent counselor [psychologist] has:

**Cultural awareness and beliefs:** The provider is sensitive to her or his personal values and biases and how these may influence perceptions of the client, the client's problem, and the counseling relationship.

**Cultural knowledge:** The counselor has knowledge of the client's culture, worldview, and expectations for the counseling relationship.

**Cultural skills:** The counselor has the ability to intervene in a manner that is culturally sensitive and relevant. (Sue et al., 2009, p.529)

Cultural awareness, beliefs, and knowledge may also be thought of as cultural empathy. Roysircar (2004) defined cultural empathy as "therapists' awareness of clients' worldviews, which is acknowledged in relation to therapists' awareness of their own personal biases" (p. 660).

The second model views cultural competency as a skill to be learned, and involved the use of cultural adaptations such as modifying CBT for Latinos (Hays, 1995; Organista, 2006). According to Sue et al. (2009), the provider learns to be competent following training and supervision experience in the skills model.

The third model describes the development of cultural competence during the dynamic process of movement between culture-specific (emic) and culture-general (etic) systems (López, 1997). Emic systems are those that pertain to a specific culture and etic

systems are those that pertain to most or all cultural systems. The process approach to cultural competence emphasizes understanding how the provider assigns meaning within the sociocultural context and recognizing that individual members of a cultural group may not subscribe to that cultural group's norms (López, 1997). According to López, a cultural assessment involves looking at culture-specific (emic) and culture-general (etic) perspectives. During the assessment, the psychologist continuously guards against applying culture-general information to a client by considering that the unique individual may not subscribe to specific values of his or her culture. The model emphasizes addressing cultural issues by having the psychologist consult with others to test biases, assumptions, and overlooked cultural information. The goal of cultural assessment is to carefully balance the culture-specific and culture-general perspectives without overpathologizing (judging normal behavior in a specific culture as pathological and failing to account for culture) or minimizing (making an error and not pathologizing actual symptomatology because cultural factors were assumed) (López, 1997). All three of these models have resulted in applicable cultural competence targets in mental health work.

### **History of organizational cultural competency.**

In 2000, Siegal et al. developed six domains of cultural competence performance measures in mental health treatment to target administrative, provider network, and individual caregiver levels of organization cultural competency that followed from the national working group of the Substance Abuse and Mental Health Services Administration. In particular, Siegal et al. (2000) reported that the history of cultural competence evolved from the Civil Rights Act of 1964 that barred discrimination in

federal programs and assisted in the measure of consumer satisfaction through complaints and incidents received.

### **Ethics.**

An important aspect of cultural competence is the history that culture has played in the development of ethical principles of the psychology profession, especially with regard to ethnic issues. Hall, Iwamasa, and Smith (2003) reviewed the history of ethical standards with ethnic people established 30 years ago. The discussion directly addressed the ethical principles of psychologists (APA, 2002): beneficence and nonmaleficence (Principle A), social justice (Principle D), and people's rights and dignity. The authors themselves are culturally competent ethnic psychologists. Ethical standards, according to Hall, Iwamasa, and Smith (2003), came into being because of the inhumane and unjust outcome of the Tuskegee study in Alabama during which 600 African American men participated in a study of untreated syphilis conducted by the United States Public Health Service from 1932 to 1972. Investigations in 1972 by the health department found that the African American men did not volunteer but were told that they would receive medical treatment for "bad blood." Institutional Review Boards (IRBs) were established to monitor and regulate research following this outcome in order to protect participants in research. At the time, the Tuskegee study was legitimized by the all African American Tuskegee Institute teaching hospital. It was not until 1997 that President Clinton apologized and acknowledged the federal government's responsibility for the atrocity. The science of psychology is value-laden and therefore, psychologists must be ever vigilant and aware of the positive and negative implications of their research and work. It behooves psychologists to be culturally competent when understanding human behavior

and ethical decisions. Psychologists make frequent ethical decisions and perhaps do this more so when providing treatment to ethnically and linguistically diverse clients.

#### **Vail Conference history.**

In 1974, the APA sponsored the Vail Conference and recommended that “clinical psychologists should become knowledgeable about culture” (Hall, Iwamasa, & Smith, 2003, p. 303). Among others, the conference addressed social issues and multiculturalism in psychology training programs. The themes evolved from prior conferences and unresolved problems. The Civil Rights movement of the 1960s charged the Black Student Psychological Association to demand several actions from the APA, and a Task Force on the Status of Women in Psychology was convened to enfranchise women in psychology (Korman, 1974). The steering committee of the conference included many minority group members. Korman’s report on the Vail Conference acknowledged the need for cultural diversity training in psychology and the inclusion of students from diverse backgrounds to insure that “psychologists have an obligation to provide services on a genuinely broad and nondiscriminatory basis” (p. 445). The recommendation directly addressed psychologists’ ethical code of competence (APA, 2002).

#### **APA Multicultural Guidelines.**

In the same year as the Vail Conference took place, a report on cross-cultural ethics to the APA Committee on International Relations in Psychology encouraged researchers to collaborate at the local level and culture with a local researcher. In 2002, the APA Council of Representatives approved as policy the Guidelines on Multicultural Education, Training, Research, Practice and Organization Change for Psychologists (APA, 2003). Guidelines, however, are not mandatory and cannot be enforced upon

psychologists (Hall, Iwamasa, & Smith). As psychology advances, cultural competency among practitioners grows and concentrates on understanding the ethical implications.

### **Psychopathology and culture.**

The American Psychiatric Association's involvement with the incorporation of culture in psychopathology has also been important to the field of psychology and multiculturalism. The *Diagnostic and Statistical Manual (DSM)* prior to the fourth edition (American Psychiatric Association [APA], 1994a) reviewed cultural principles only briefly in the reference and introductory sections. However, culture was carefully considered in the *DSM-IV*. This inclusion was accomplished in a number of ways. It began with the introduction of the manual that alerted clinicians to the challenges of a multicultural society and emphasized the need to be aware of assessment issues. Cultural considerations are presented throughout the text to stimulate culturally sensitive use of the manual. Specifically, cultural variations in diagnoses are discussed from the childhood-onset disorders to the personality disorders.

Attention to cultural influences also impacted the multiaxial system of assessment and diagnosis as presented in the *DSM-IV* (APA, 1994b). Guidelines for formulating assessments and diagnoses were included for the clinician. Finally, a glossary of culture-bound syndromes that helps to define specific folk categories of illness and distress was supplied. The glossary illustrated the need for an understanding of cultures from an anthropological perspective.

In terms of the upcoming edition of the *DSM (DSM-V)*, discussion occurred regarding infusing the entire manual with sociocultural aspects of mental illness (Alarcón et al., 2009). In addition, elaboration of the cultural formulation assessment along with its

relocation to the section on diagnostic assessment has been proposed. A number of the cultural and international experts who are members of the Gender and Culture Study Work Group advocated for inclusion of universal and cultural dimensions of mental illness to increase the sociocultural validity of the *DSM* (Alarcón et al., 2009).

The way that researchers and clinicians conceptualize culture directly informs how treatment programs demonstrate cultural competency. In culturally competent treatment for Latinos, Guarnaccia and Rodriguez (1996) emphasized the fact that hiring staff who speak Spanish to work with Spanish speaking clients is not enough. Language facilitates much more than communication. It allows a person to express his or her emotions as well as cultural and social status (Guarnaccia & Rodriguez, 1996). Nor is it just, according to Guarnaccia and Rodriguez, to focus on general values of Latinos that tend to emphasize stereotypes and mislead providers into thinking that all Latinos and specific individuals share these general values and perceptions of health. Guarnaccia and Rodriguez (1996) found six components of culture that are implemented in programs to demonstrate culturally competent mental health services: (a) ethnic identity, (b), language, (c) cultural material features, (d) traditional events and celebrations, (e) shared values, and (f) views of mental illness. According to Rogler, Malgady, Costantino, and Blumenthal (1987), culturally sensitive treatment for Latinos must be accessible, incorporate Latino cultural characteristics, and be adapted in treatment.

### **Cultural and Language Issues**

Several Latino cultural values need to be understood when providing psychological services to Latino clients (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). The following interpersonal Latino values are presented, keeping in mind

the importance of individual differences because some may not subscribe to these cultural values: *personalismo*, *familismo*, *respeto*, *dignidad*, *orgullo*, *confianza*, and *simpatía*.

- *Personalismo* is indicative of the value placed upon the interpersonal relationship versus other factors. Santiago-Rivera et al. (2002) suggested that *personalismo* means that the person is more important than the task; for example, when a patient, as perceived by a physician, is more important than is his or her short time allotted for a medical visit.
- *Familismo* represents the importance of the close family connection stressing “interdependence, cohesiveness, and cooperation among family members” (Santiago-Rivera et al., p. 43). Relatedly, Falicov (1998) emphasized that terms such as *enmeshed* and *codependent* may erroneously pathologize Latino families instead of exploring their strengths. The importance of family for Latinos is within a collectivistic framework (Falicov, 1998) and is the center of life. Latinos are impacted by the proximity of family members; the support provided by family members beyond the nuclear family; time spent visiting family, supporting children, and their role in immigration or emigration. Family rituals and traditions are often celebrated around events like cooking, eating, or during holidays.
- *Respeto* denotes respect and places importance on the person’s role and position while guarding communication and rules to follow to avoid conflict (Santiago-Rivera et al., 2002).
- *Dignidad* denotes dignity and includes values of *personalismo* and *respeto* that result in feeling pride and worth from one’s actions (Santiago-Rivera et al., 2002).



- *Orgullo* means pride and may be reflected in strong emotional feelings, especially about one's personal history and ethnic heritage (Santiago-Rivera et al., 2002).
- *Confianza* signifies the development of trust and an intimate bond of interpersonal comfort between people, prevalent in allowing "Latinos to be more direct in conversations and to help establish a therapeutic alliance." (Santiago-Rivera et al., 2002, p. 114). Successful therapeutic social interactions likely contribute to effective therapy with Latinos.
- *Simpatía* is defined by Triandis, Marín, Lisansky, and Betancourt (1984) as "a permanent personal quality where an individual is perceived as likeable, attractive, fun to be with and easy-going" (p. 1363). This pattern of social interaction among Latinos is called a cultural script (Triandis et al., 1984). In relationships, the emphasis of someone who is *simpático* of one who is in harmony and avoids conflict, and such a person is often referred to as *buena gente* (nice person) (Santiago-Rivera et al., 2002).

Finally, religious beliefs and spirituality are part of Latino culture that psychologists may need to incorporate during assessment and treatment. The context of religion and spirituality traces historically to the conquest of the New World and indigenous peoples (Santiago-Rivera et al., 2002). Meaning, illness, and unfortunate circumstances are often explained through religious and spiritual contexts as are family and lifestyle practices (Falicov, 1998). All of these cultural values were demonstrated in case examples in the cultural competence program.

Language is the vehicle in which communication occurs. More importantly language facilitates the expression of emotions and carries a cultural status (Guarnaccia

& Rodriguez, 1996). Indeed, an individual's experience is most accurately portrayed in the individual's language (Lu, Lim, & Mezzich, 1995). The Spanish language is a common, uniting element among Latinos, despite differences found from country to country (Chong, 2002). It is perceived as a way to maintain cultural and ethnic heritage (Altarriba & Santiago-Rivera, 1994).

Language has been a barrier for Latinos' access to treatment services because of the lack of bilingual providers. Santiago-Rivera et al. (2002) suggested that matching a Latino client with a provider who speaks Spanish may be more important than matching by ethnic background. Chong (2002) asserted that providers can more readily develop cultural sensitivity than they can learn to be proficient in Spanish. Latino cultural values may positively impact the therapeutic situation in which a Spanish-speaking client may appreciate an English-speaking psychologist's use of some words in Spanish (Santiago-Rivera et al., 2002). Even though communication with a provider fluent in Spanish may facilitate communication and therapy, the consequence of this alone does not guarantee cultural sensitivity or competence. Recent research indicated a need for psychological training for bilingual providers to provide services in Spanish (Biever, et al., 2002).

Language contributes to one's identity and pride (Altarriba & Santiago-Rivera, 1994). In therapy with a bilingual client, speaking in the second language (language switching) can serve to distance the client from issues when emotional associations are lessened by having different meanings of words in two languages (Altarriba & Santiago-Rivera, 1994). According to, Altarriba and Santiago-Rivera (1994), the technique of letting the client switch languages from non-dominant to dominant allows the client to express emotions with more spontaneity and less inhibition. Thus, it has the potential to

accelerate the therapeutic progress. However, bilingual therapists need to be alert for use of language switching as resistance and avoidance of painful experiences related to one's dominant language. Finally, Santiago-Rivera and Altarriba (2002) also encourage providers to recognize that clients' bilingualism is a strength.

Effective assessment and treatment of the Latino client stresses a need for a conceptual framework. Santiago-Rivera (1995) proposed an integrative framework with five dimensions to incorporate culture and language in treatment. The first considers the level of acculturation of the client and recommends a formal assessment. The second level considers the language and traditional culture by assessing the language which is dominant, and also the preference of culture by assessing the extent to which the client adheres to traditional cultural values. The way that a Latino client may express himself or herself in treatment may be misunderstood by a psychologist who has different cultural values and beliefs. Language is highly important in the provision of psychological services because "language is the method by which knowledge, beliefs, and traditions are transmitted and is closely related to an individual's history and culture" (Santiago-Rivera, 1995, p. 12). The third level considers the client's psychological and physical health by assessing the pathology, cultural basis of health issues, somaticism, and psychosocial stressors. The fourth level considers the therapeutic approach by the psychological provider and the fifth level considers specific cultural interventions and cultural resources. Culture and language factors can be incorporated into the psychologist's treatment conceptualization to employ culturally appropriate treatment. This begins with the development of providers' cultural competency.

### **Cultural Competency Training for Providers**

Several efforts have been undertaken to assess and train healthcare providers to become culturally competent. Schim, Doorenbos, Miller, and Benkert (2003) developed a Cultural Competence Assessment (CCA) tool for a diverse group of healthcare staff. The original instrument was modeled on cultural diversity, cultural awareness, cultural sensitivity, and cultural competence behaviors. The pilot group consisted of a 125 hospice employees and volunteers, with the largest representation (40%) coming from the nursing discipline. Internal consistency reported was 0.92 and construct validity by factor analysis of the 25 items was above 0.42. A later study (Doorenbos, Schim, Benkert, & Borse, 2005) demonstrated the use of the CCA among healthcare providers from hospitals, community health and home health agencies in nonhospice settings with internal reliability of 0.89 and construct validity that explained 56% of the variance.

In 2006, Schim, Doorenbos, and Borse tested a cultural competence education program for interdisciplinary hospice workers using a pre-post crossover design. The 25-item CCA was administered to 130 hospice workers at pretest, after a 1-hour cultural competence educational intervention about end-of-life care or after a 1-hour control educational session on ethical and legal issues about end-of-life care, and at posttest. Hospice workers were randomly assigned to receive the cultural competence or control education session first, followed by the crossover session they had not received. Content of the cultural competence educational intervention included: (a) definitions of culture, diversity, race, and ethnicity; (b) discussion of awareness, sensitivity, and competence in hospice care; (c) suggestions on expanding cultural knowledge, attitudes, and skills; (d) approaches to client-centered cultural assessment, and (e) dialogue about barriers to

service including language, fear and mistrust of providers, sociocultural issues, and providers' cultures. Cultural competence scores were derived from the CCA. Results of the study indicated that the cultural competence scores were significantly greater after the cultural competence education intervention for both groups (Schim et al., 2006). The study represented a successful attempt to provide cultural competence training and measure the outcome of the program with diverse healthcare workers.

A similar cultural competency training program and assessment were developed for physicians. Thom and Tirado (2006) developed a measure of physicians' culturally competent communication behaviors called the Patient-Reported Provider Culturally Competency Scale (PRPCC). A total of 320 patients with diabetes or hypertension completed the 13-item PRPCC regarding culturally competent history taking and culturally competent explanations by physicians on a 5-point scale, at four locations in California. Reliability of the PRPCC was .89 and validity of the construct correlated moderately with trust and satisfaction. Thom, Tirado, Woon, and McBride (2006) used the PRPCC as an outcome measure in a pretest-posttest control group design at four other physician practice sites in California. Two sites received a culturally competent training intervention and feedback (aggregated PRPCC scores from patients) and two other sites received feedback only. The culturally competent program consisted of three modules of approximately 5 hours: (a) expanding knowledge of ethnic patients, (b) enhancing communication skills for cultural competency, and (c) use of interpreters and cultural brokering. Thom et al. (2006) found no significant difference in PRPCC scores by intervention in either group. The lack of a significant effect of the cultural competence training was explained by the brevity of the intervention without reinforcement of

behaviors and need both for interactive training and for practice time for the physicians to implement the knowledge (Thom et al., 2006). Although healthcare has begun to address the cultural competence training of physicians (Beach et al., 2005; Fernandez et al., 2004; Wilson-Stronks, Lee, Cordero, Kopp, & Galvez, 2008), much less empirical research with psychologists and trainees has occurred.

There is a dearth of literature on outcome research related to multicultural competency training for psychologists (Sue et al., 2009). A limitation of cultural competency research has included the lack of measurements evaluation about the impact of cultural competency on treatment. Sue et al. (2009) argued that “research is needed to gain knowledge about what works in cultural competency and how it works” (p. 533). The profession would benefit from studies that show how providing multicultural training for psychologists and trainees impacts the delivery of psychological services and the satisfaction of clients. The limited information is surprising, given the professional standards of conduct for psychologists.

### **Ethical Standards for Psychologists**

The standards of professional conduct for psychologists are specified in the Ethics Code of the American Psychological Association (2002). Ethical standard 2.01 indicates that psychologists have or obtain **cultural competence** through education, training, consultation or supervision to practice effectively:

Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective

implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies. (APA, 2002, p. 5)

The ethical code for psychologists (APA, 2002) outlines principles of beneficence and nonmaleficence (Principle A), social justice (Principle D), and people's rights and dignity (Principle E) that are inherent in the APA Multicultural Guidelines for Education, Training, Research, Practice, and Organizational Change for Psychologists (APA, 2003). Psychology trainees are dependent upon the training and supervision that they receive to achieve the ethical standard of competence in the field. The psychologist supervisor is also bound to the same ethical standard of competence. Similarly, cultural competence is developed as part of the training and supervision that trainees receive. The Multicultural Guidelines facilitate understanding of this process.

### **Multicultural Guidelines for Psychologists**

All six of the Guidelines for Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (APA, 2003) are applied in this study and are implicit in the cultural competence program. Guideline 1 encourages psychologists to recognize themselves as cultural beings influenced by attitudes and beliefs about others who are racially and ethnically different. Guideline 2 encourages psychologists to recognize the importance of multicultural sensitivity and responsiveness to racially and ethnically diverse individuals. Guideline 3 encourages psychologists to use multiculturalism and diversity constructs in education and as Arredondo and Perez (2006) stated, "...to link knowledge to research, assessment, and clinical practice" (p.3).

Guideline 4 (APA, 2003) encourages psychologists to conduct culture-centered and ethical psychological research among ethnically, racially, and linguistically diverse populations. Guideline 5 applies one's awareness and knowledge of culture and worldviews to clinical practice, utilizing cultural adaptations (APA, 2003) as part of the skill or intervention model described by Sue et al. (2009). Guideline 6 promotes a social justice and organizational change process toward multiculturalism whereby psychologists facilitate organizational transformation and culturally competent policies and practices (APA, 2003). However, the process of becoming multiculturally competent certainly transcends these guidelines.

The Multicultural Guidelines have existed since 2002. It is important to keep in mind that cultural competency be understood as a lifelong journey, instead of steps taken only when following guidelines. As a discipline, psychology is making strides.

### **Culturally Competent Evidence-Based Treatment**

In 1999, Sue pointed out that the United States was the largest producer of psychological research. The theories and principles in the research, according to Sue (1999), were all too often assumed to be universal and generalized to all human beings. At that time, the United States comprised only 5% of the world population but its sample of psychological research was assumed to be universal. Sue criticized the psychological research at that time as lacking in multicultural awareness because members of minority groups were not included. However, as recently as 2005, Miranda et al. noted that ethnic minorities are still largely missing from the research. In a review of treatment efficacy, Miranda et al. (2005) posed the question of whether or not it is appropriate to advocate for empirically based treatments for minority populations, and whether or not current



treatment efficacy (randomized control trials) and effectiveness (outcome) studies can generalize to minority populations. Of importance to this study's question is that Miranda et al. (2005) suggested that evidence-based care for depression for adult African Americans and Latinos improves outcomes and can be generalized to these populations.

Most recently, multiculturalism and evidence-based practice (EBP) are discussed as being interdependent upon one another (Morales & Norcross, 2010). The APA Task Force on Evidence-Based Practice defined EBP as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, 2005, p. 1). Rightly so, Morales and Norcross (2010) argued that culture must be part of clinical practice in order to be considered EBP. Furthermore, including culture in clinical practice and research reinforces the relevancy to the target population. Cognitive-behavioral therapy (CBT), a leading EBP, and multiculturalism are addressed together in several writings focused on Latinos.

### **Cognitive-Behavioral Therapy (CBT) and Latinos**

Although CBT is pervasive (Hays, 2006), it is not surprising to learn that culture is neglected in CBT. In 1995, Hays discussed the need for attention to cultural influences in the field of cognitive behavioral therapy and outlined several useful applications of CBT with multicultural populations and likely ways that CBT may be modified to become culturally appropriate. Adaptations to an EBP such as CBT are defined as:

Modifying, supplementing, or sequencing the treatment, in ways not studied in the research trials, to accommodate the needs of the patient. Adaption assumes that the practitioner is competent in the cultural and linguistic aspects of the client and

has experience in integrating these variables in a culturally competent and congruent manner. (Morales & Norcross, 2010, p. 826)

First, CBT emphasizes the needs of the individual, and if the individual is of a diverse culture, then his or her needs would include attention to cultural factors in treatment (Hays, 1995). Second, CBT focuses on empowerment of the individual. Individuals are afforded the respect and understanding of her or his situation and given the tools to implement new skills in the future. Given that ethnic minorities may experience oppression, Hays (1995) underscored the importance of empowerment in therapy. Third, CBT's attention on symptom alleviation and specific behaviors, thoughts, and emotions keeps focus on the here-and-now and may reduce emotional distancing and language switching interventions when working with clients who speak multiple languages. Last, CBT emphasizes assessment and client progress throughout the course of therapy with a potential for treatment to be completed in a shorter time period, compared with other treatments (Hays, 1995). The CBT therapist who recognizes one's own biases and the biases of the treatment orientation applies APA's Multicultural Guidelines 1 and 2 in an effort to make CBT a culturally responsive approach (Hays, 2006). Overall, CBT represents a theoretical orientation adapted for providing culturally competent services to Latinos.

Organista (2006) reviewed the advantages of using cognitive behavioral therapy with Latinos. First, the stigma of seeking mental health services may be reduced for Latinos in CBT because of the didactic emphasis of the approach, the use of therapy manuals, and homework sessions. Second, the short-term orientation of CBT with a focus on problem solving and the *here-and-now* may be a good fit with low-income Latinos

who have limited resources and a need for flexibility. Last, the educational approach of CBT and ability to orient Latino clients to therapy may be helpful for Latinos who may be less likely participate in treatment.

In terms of limitations (Organista, 2006), the lack of CBT outcome research with Latinos is most notable, but existing research is promising. Other limitations of CBT may be modified to become culturally sensitive and relevant. The author also pointed out that CBT has traditionally focused on individual-level variables to modify thoughts, behaviors, and skills in order to effect change, but the reality for many Latinos is that environmental, social, and cultural contexts may influence their problems. For example, laws, policies, and norms affect Latino health and mental health and are beyond the client's control. Finally, mainstream U.S. values may have the potential to conflict with traditional Latino values and negatively affect the clients in CBT treatment. For example, Organista (2006) noted that the individualistic orientation of U.S. values and CBT may conflict with a collective or familial orientation of Latinos; a scientific and intellectual reasoning of U.S. values and CBT may also conflict with a religious faith or importance of emotions of Latinos (p.79). Therefore, Organista (2006) offered suggestions for modifying CBT to Latino clients.

CBT can be adapted when treating Latinos (Organista, 2006). First, therapists need to be sensitive to the importance of developing trust and emphasize the personal dimensions of relationships. It is suggested that therapists engage clients in sufficient small-talk (*plática*), including sensible self-disclosure to promote the need to balance the professional relationship and personalized attention to the client, thereby delaying immediate focus on the presenting problem. Second, clients can be oriented to therapy

and motivated to engage with the use of bilingual videos depicting the therapeutic process or a mock therapy group. Finally, modifications to traditional CBT interventions are explored and outlined in case studies (Organista, 2006). The online cultural competence program in this study included several of Organista's examples.

The interventions involve cultural adaptations to CBT (Organista, 2006). Family activities can be emphasized with an importance of family as it corresponds to the client's taking better care of himself or herself to reinforce the collectivist value of family. Low-income or free activities in the community can be incorporated when designing behavioral plans (such as free admissions to museums, visiting friends, etc.) for clients with limited resources. In order to avoid labeling a client's thinking as irrational or distorted (and possibly offend values that are part of a person's core cultural beliefs), cognitive restructuring techniques can be adapted with use of the "Yes, but..." technique (Organista, 2006, p.82). For example, "Yes, my pain does make it very difficult to do many things, but...", "...but I guess I can do some things." (Organista, 2006, p.87). Because CBT may involve assertiveness training, these skills can also be modified in culturally sensitive ways (Comas-Díaz & Duncan, 1985) that are less confrontational, and promote friendliness (*simpatía*) and respect (*respeto*) for the other's social status (e.g., between older and younger; men and women; etc.). Role-plays and modeling can incorporate the use of prefacing phrases that demonstrate respect for adherence to cultural norms of appropriateness while modeling assertiveness at the same time such as "With all due respect" and "Would you permit me to express how I feel about that?" (Comas-Díaz & Duncan, 1985).

These adaptations to CBT for Latinos are promising and pertinent for bilingual psychologists working with Latinos. The use of culturally-adapted CBT improves access to culturally competent psychological treatment. Moreover, it addresses the President's New Freedom Commission on Mental Health's goals to eliminate mental health disparities and implement evidence-based treatment (USDHHS, 2003).

Limited research from large epidemiological studies tells us that Puerto Ricans in the U.S. mainland experience a mental health status that is worse than that of all other all Latinos (Guarnaccia et al., 2002). The poor mental health status of Puerto Ricans is attributed to numerous social, historical, and political factors. According to Christensen (1975) and Ghali (1982), Puerto Ricans experience an identity crisis because of their questioning, "Are we Puerto Ricans or U.S. Americans?" (Ghali, 1982, p. 99). Puerto Ricans have two languages, two flags, two citizenships, and two very different worldviews (Falicov, 1998; Ghali, 1982). Therefore, conflicting values may occur between two different countries and possibly include disagreements about the political status of the island of Puerto Rico. Ghali (1982) explained that powerlessness of colonized persons may lead to economic stress. Among Latinos, Puerto Ricans have the highest level of unemployment and the highest percentage of people below the poverty level (Falicov, 1998). In Pennsylvania, Puerto Ricans make up the largest Latino group and can benefit from culturally-adapted CBT.

### **Cognitive-Behavioral Therapy Outcome Studies with Latinos**

There are approximately six outcome studies with Latinos that assessed the effectiveness of CBT and four of these are included for review (Organista, 2006); the other two addressed CBT applied to youths in school-based programs. The research

addressed issues of language and culture in treatment and assessed the effectiveness of CBT applied to Latinos.

In a retrospective study of 175 low-income and minority medical outpatients diagnosed with depression, Organista, Muñoz, and González (1994), explored the reduction of patients' depressive symptoms following 12 weeks of primarily group cognitive behavioral therapy (some received individual CBT). The majority of patients was female (75%); many were Latina, Spanish-speaking (44.4%); others were White (34.6%), and African American (18%). Most of the ethnic minorities in the sample had not completed high school and on average were in their late 40s. All participants were referred by their primary care provider at the university hospital clinic in California to the free depression clinic at the hospital.

Group treatment in Spanish and English followed the CBT modules developed from *Control Your Depression* book and those who participated in individual treatment (2 hours weekly for 12 weeks) also followed the treatment manual (Organista, Muñoz, & González, 1994). The participants were assessed for diagnosis using the Structured Clinical Interview for DSM-III-R Outpatient Version (SCID-OP) and staff verbally translated the SCID-OP questions in Spanish to those who required it during the evaluation. The patients completed the Beck Depression (BDI) self-report about the severity of depressive symptoms (or the Spanish language version that staff had back-translated) at pretreatment and at the beginning of each treatment session. The dropout rate for the sample was high (58%) and analyses indicated that younger, minority group therapy patients were more likely to drop out than were others. Organista et al. (1994) concluded that treatment was effective because BDI scores went from severely depressed

to moderately depressed from pretreatment to posttreatment. The authors suggested that treatment could be enhanced by increasing the duration from 12 to 16 weeks but that this may conflict with the expectation of briefer treatments by low SES and minority groups. Organista et al. (1994) also discussed the need to augment the outcome measures (which they have done at the clinic since the exploratory study was conducted) and consider that over 50% of the sample was diagnosed with severe medical conditions.

Dropout rate was specifically addressed in another exploratory study at the same university hospital depression clinic in California where the addition of clinical case management with group cognitive behavioral therapy (CGBT) was expected to afford a greater benefit to patients (especially those who spoke Spanish) in reducing their depression and in increasing retention rates than to those patients who had received CGBT alone (Miranda, Azocar, Organista, Dwyer, & Areane, 2003). During a 4-year period of the study, over 1,163 low-income clients were referred to the clinic but only 199 of those eligible participated in the intervention and were randomly assigned to the CGBT or the CGBT plus case management condition. A total of 39% of the sample spoke Spanish as the primary language; 23% were African American; 29% were White, and 9% were Asian American.

Patients in the Miranda et al. (2003) study were provided with 12 weeks of group cognitive behavioral therapy adapted from the *Control Your Depression* book and from manuals prepared in Spanish (with cultural adaptations) and English, targeting low-income and ethnic minority primary care patients. Those who completed 8 of 12 sessions ( $N = 132$ ) were considered to have received adequate treatment. Case management interventions occurred over a six-month period with regular home visits, advocacy and

referrals, on average a total of 10 hours of care per patient. The SCID and Spanish language version were used to establish a diagnosis of major depression and the BDI (and BDI-Spanish) and Social Adjustment Scale (and Spanish version) were used to assess depressive scores and social adjustment and family relations at baseline and again at months 4 and 6 following the initial group session. The authors found that both Spanish speaking and English speaking patients who received the case management plus GCBT were less likely to drop out of therapy before completing 8 sessions; they also attended more sessions than those who received GCBT alone. An interaction was found for the case management plus GCBT group, whereby the Spanish speaking patients had fewer depressive symptoms at posttreatment than did the English speaking patients and the Spanish speaking patients had not had the GCBT. Both English speaking and Spanish speaking patients responded equally well to GCBT alone. The authors cautioned that the findings of case management and culture were not predicted and furthermore, that Latinos received more home visits for case management than did non-Latinos. Miranda et al. (2003) also explored the need to understand medical patients who have depression but had no prior psychiatric treatment. Finally, more recent GCBT in Spanish at the university hospital (Aguilera, Garza, & Muñoz, 2010) incorporated the use of “technological adjuncts” including audio coaching files and mobile-phone based text message to address literacy concerns and enhance homework adherence.

One of the first studies to compare the effects of CBT on women with depression was conducted by Comas-Díaz (1981). A total of 26 depressed, low SES women were referred to the experimenter by local social service agencies to participate in a study comparing CBT, Behavioral Therapy (BT), and a Wait List group. All women were



Puerto Rican, spoke Spanish only, and had been in the U.S. an average of 5 years.

Participants were matched by age and severity of their depression and randomly assigned to one of the three conditions. The BDI Spanish translation and Hamilton Rating Scale for Depression, Spanish translation, were given at pretest, one week after the last treatment group, and at 5 weeks follow-up. In addition, the author developed a depression behavior rating scale that was completed by the participant's significant other at pretest and posttest.

The women in Comas-Díaz's study (1981) participated in five 1.5 hour group sessions with the experimenter either in the CBT or in the BT group. A manipulation check was included to control therapist's characteristics and bias across groups. The participants also completed a questionnaire regarding their experiences in therapy, which revealed no difference between the CBT and BT groups. The author concluded that although both the CBT and BT groups were effective in reducing depression from pretreatment to posttreatment, only the BT group members maintained their improvement from posttreatment to follow-up. Comas-Díaz (1981) highlighted the importance of short-term behavioral and cognitive oriented group therapy and discussed the limitations as the brevity of follow-up and specific sample utilized in the study. Finally, Comas-Díaz (1981) explored the reasons that group therapy may be particularly salient for these Puerto Rican women within a cultural context.

In another outcome study, CBT and Interpersonal Therapy (IPT) for depressed Puerto Rican youth were compared with a wait-list control (Rosselló & Bernal, 1999). A total of 161 youth were referred for depression from school principals and social workers to a university psychology clinic in Puerto Rico. Of those referred, 71 adolescents, ages

13-18 were randomly assigned to one of the three conditions. The majority were female (54%) and 46% were male and all were in 5th to 12th grade in school. The Diagnostic Interview Schedule for Children was utilized to diagnosis clients with depression.

The youth in the Rosselló and Bernal (1999) study participated in 12 one-hour individual therapy sessions weekly in either the CBT or IPT treatment. The CBT model was based upon the model developed by Miranda et al. (2003) at the California depression hospital clinic and adapted for use with adolescents in an individual therapy format. The IPT model utilized a treatment manual originally developed for adults and was adapted for youth in the study. Treatment integrity was ensured with use of the manuals, and a manipulation check was incorporated with videotaped sessions coded by an independent reviewer. Adolescents' symptoms of depression were assessed by self-report on the Children's Depression Inventory (CDI), Spanish translation; self-esteem was assessed with the Piers-Harris Children's Self-Concept Scale (PHCSCS), Spanish translation; social adjustment was assessed by the Spanish adaptation and translation of the Social Adjustment Scale for Children and Adolescents (SASCA); family functioning was assessed with the Family Emotional Involvement and Criticism Scale (FEICS); and behavioral problems were assessed by parents on the Child Behavior Checklist (CBCL-P) and by the adolescents themselves on the CBCL-adolescent. Attrition was high (53% IPT, 44% CBT). The authors found that both IPT and CBT are effective for depressed Puerto Rican adolescents in reducing depressive symptoms and in increasing self-esteem, in comparison with the control group from pretest to posttest. Rosselló and Bernal (1999) discussed the limitations related to the small sample size but also emphasized the need for cultural considerations and adaptations of treatment manuals that were piloted prior to the

study. The authors recommended further investigation into the use of IPT because it alone had positive outcomes on self-concept and social adaptation, as compared with the control.

### **Culturally Competent Treatment for Latinos**

D'Andrea and Heckman (2008) reviewed multicultural counseling outcome studies completed over 40 years, from 1967 to 2007, to assess the application of multicultural counseling theory in therapy with culturally diverse clients. A total of 53 studies were reviewed; these included African, Latino, Asian/Pacific Islander, Native Americans, and multiple ethnicity clients. According to D'Andrea and Heckman (2008), more frequent, multicultural outcome research has occurred recently as compared with previous years, with an increase in studies that examine clients' psychological and behavioral functioning. However according to D'Andrea and Heckman (2008), most of the research was beset with problems of internal and external validity and contained small sample sizes, including nonrandom assignment. D'Andrea and Heckman asserted that multicultural counseling theory development extends beyond the empirical evidence that supports it. Several research recommendations were offered to "include multicultural counseling competence as an independent variable" of study and "acknowledge the multidimensionality of multicultural counseling" (D'Andrea & Heckman, 2008, p. 361). Selected outcome studies that are not CBT oriented but which incorporate cultural and linguistic modifications for serious mental illness have focused on the important role of family in Latino mental health.

Cultural interventions for mental health treatment for Latinos contain specific modifications of language and cultural components to existing practice. Weisman (2005)

developed a treatment manual in Spanish for families called a culturally informed therapy for schizophrenia. The manual was piloted in a 15-session family treatment program (Weisman, Duarte, Koneru, & Wasserman, 2006) including modules on collectivism, education, spirituality, communication, and problem-solving. Specific cultural values of Latinos such as low expressed emotion, external attributions of illness, spirituality and religion, and family cohesion were expected to contribute to reduction in relapse rates. Similar Latino cultural values were investigated in other research on serious mental illness.

Kopelowicz (1997) reviewed previous treatments for individuals with schizophrenia who received social skills and independent living skills training and asked how cultural factors could be integrated into similar interventions for Latinos with serious mental problems. A modification of the University of California at Los Angeles (UCLA) Social and Independent Living Skills modules was undertaken. The treatment modules for medication management and symptom management were translated into Spanish with the introduction of cultural factors such as the importance of family involvement in skills training groups and education about physical origins of mental health to reduce blaming of the patient. Clients and treatment providers were also matched according to ethnicity and language. The results of the pilot study indicated that the patients learned skills and retained those skills six months post training and had higher levels of functioning as rated by staff and physicians, compared with their skills and functioning before the training. Kopelowicz (1997) recommended that materials be translated into Spanish at an elementary grade level and suggested that the emphasis on independent living may not be

a culturally appropriate strategy for Latinos in treatment, who in fact, may return to live with family. These components were included in a later outcome study.

Kopelowicz, Zarate, Gonzalez, Smith, Mintz, and Liberman (2003) conducted an outcome study comparing Latinos with schizophrenia who had received a culturally informed Spanish adaptation of a family-assisted skills training module with those who had received customary outpatient care over 3 months. A total of 92 outpatient Latinos in Los Angeles County, diagnosed with schizophrenia, were randomly assigned to the treatment or control condition. Most Latinos were of Mexican-American and Central-American origin.

The skills training involved family members of patients in treatment who served as coaches to offer their relatives the opportunities, the encouragement, and the reinforcement in applying skills. Kopelowicz et al. (2003) expected that the treatment group would show greater self-management of symptoms, lower relapse and lower rehospitalization rates, greater medication adherence and higher psychosocial functioning, and attitudes of acceptance toward illness than the control group. Trainers in the treatment group were bilingual and bicultural and participated in the translation of materials into Spanish at an elementary reading level. In addition, trainers in the treatment group adapted an informal personal style and included food and small talk in their sessions. Results indicated support for some hypotheses because Latinos in the family-assisted skills training group showed significant decreases in symptoms, increased skill acquisition and use and increased level of functioning, compared with the Latinos in the customary care group. Additionally, a greater number of control group participants were rehospitalized than were participants in the treatment group. Kopelowicz et al.

(2003) concluded that this type of culturally informed skills training in Spanish was effective because gains were maintained at six months post treatment. Other research has also shown that ethnically focused treatment can have a positive impact on mental health outcomes.

Mathews, Glidden, Murray, Forster, and Hargreaves (2002) completed a retrospective study that investigated the relationship of matching mental health patients to ethnically focused inpatient psychiatric units to outcomes such as time to rehospitalization, referral destination on discharge, and length of stay at San Francisco General Hospital. The ethnic unit staff was of the same cultural background, bilingual or multilingual, and included teams that focused on diagnosing and treating patients in a culturally competent manner. A total of 447 Latinos were matched to an ethnically focused unit and were compared with Whites, with Asians who were matched to an ethnic unit, and Blacks who were matched to an ethnic unit. A time of discharge, Latinos and Asian patients, matched to their respective ethnic unit were more frequently referred to outpatient or residential treatment on discharge than were unmatched patients, Black patients, and White patients. No relationship was found between matching and time to rehospitalization or to length of stay (Mathews et al., 2002). Although the study appeared promising, it did not describe the ethnic or culturally sensitive treatment that was provided. A prominent aspect of multicultural training in psychology incorporates an understanding and a fostering of the development in a student's competency to provide culturally sensitive treatment. Therefore psychologists with knowledge and skills in multicultural supervision are also needed.

## Supervision

Supervision is defined as a “distinct professional activity in which education and training aimed at developing science-informed practice are facilitated through a collaborative interpersonal process” (Falender & Shafranske, 2004, p. 3). Supervision serves two purposes according to Bernard and Goodyear (2009, p. 12): “*to foster the supervisee’s professional development* (a supportive and educational function) and *to ensure client welfare* (the supervisor’s gate keeping function is a variant of the monitoring of client welfare).” Numerous approaches to supervision exist including psychotherapy-based, developmental, process-based, and competency-based (Falender & Shafranske, 2004). Although the different models are not discussed in this review, the collaborative interpersonal process is particularly salient.

Bordin (1983) discussed the supervisory working alliance as a process that includes change during which supervisor and supervisee mutually agree on the goals and tasks of supervision. They share a bond that demonstrates liking, caring and trusting of each other. Specifically, Bordin (1983, p.37) listed the goals of supervision as: (a) mastery of specific skills, (b) enlarging one’s understanding of clients, (c) enlarging one’s awareness of process issues, (d) increasing awareness of self and impact on process, (e) overcoming personal and intellectual obstacles toward learning and mastery, (f) deepening one’s understanding of concepts and theory, (g) providing a stimulus to research, and (h) maintaining standards of service.

In a multicultural supervisory framework, supervisory style or manner of approach and response to supervisee’s needs (Friedlander & Ward, 1984) appeared to be important to the collaborative interpersonal process of supervision. Friedlander and Ward

(1984) developed the Supervisory Styles Inventory (SSI) to identify dimensions of supervisory style. General aspects of all supervisory styles were conceptualized in Friedlander and Ward's model to account for the supervisor's assumptive world (past training and experience), theoretical orientation to counseling, style or role (task-oriented or teacher), strategy or focus, format, and technique, with all six levels being interdependent. A series of studies was conducted that resulted in a 33-item self-report inventory available both for supervisees' and for supervisors' reports of the supervisors' style of psychotherapy. The SSI is composed of one word adjective descriptors obtained from analyses of interviews with professional supervisors and a subsequent card sort to develop clusters of supervisory styles. The unipolar items on the inventory are rated on a 7-point scale from 1 (*not very*) to 7 (*very*), indicating the supervisor's perception of his or her own style as a supervisor. Three possible styles are obtained: attractive, interpersonally sensitive, and task oriented. The *attractive* style reflects a collegial style (e.g., "warm," "supportive," "friendly," "open," "flexible"), *interpersonally sensitive* reflects a relationship-oriented style (e.g., "invested," "committed," "therapeutic," "perceptive") and *task oriented* reflects a content-focused style (e.g., "goal-oriented," "thorough," "focused," "practical," "structured"). Internal reliability of the SSI is reported to range from .76 to .93 and convergent validity has been obtained with a measure of supervisory role behavior and supervisory working alliance (Friedlander & Ward, 1984; Ladany, Walker, & Melincoff, 2001). High intercorrelation was found between the attractive and interpersonally sensitive subscales, indicating that these two styles may be more alike than different (Ladany et al., 2001).



Supervisors develop the competence of their trainees and monitor the therapeutic process (Koocher, Shafranske, & Falender, 2008). Supervisors function in multiple roles with their trainees: teacher, mentor, facilitator of self-awareness and personal exploration, evaluator, gatekeeper, administrator, and model of ethical legal and professional practice standards (Koocher et al., 2008, p. 163). Within the supervisory process and multiple roles, diversity is a core clinical and supervisory value that guides the practice of culturally competent supervision (Falender & Shafranske, 2004).

### **Multicultural Supervision**

Multicultural supervision encompasses the supervisor and supervisee exploring various aspects of culture (e.g., age, gender, race, ethnicity, social class, religion, sexual orientation) that pertain to providing psychological services with culturally diverse clients (Constantine, 2003). Indeed, the supervisory relationship is affected by the client's culture (Norton & Coleman, 2003). The term cross-cultural supervision is often used to refer to a supervisor-supervisee dyad when each member of the team is from different a racial or ethnic group. Multicultural supervision competence is a dynamic process characterized by "supervisors' awareness, knowledge, and skills in addressing multicultural issues both within the context of supervision relationship and with regard to supervisees' relationships with their clients" (Constantine, 2003, p. 384). A number of key premises underscore the culturally responsive supervisory process:

- Culture and ethnicity are active, ongoing, ever-changing processes essential to be addressed in supervision;
- Clients, therapists, and supervisors are influenced by multiple cultures – local, regional, national, and global;

- Supervisors must understand, appreciate, and respond to local and wide-ranging cultures that provide the context for, and influence the expression of, a client's (whether an individual's or a family's) behavior and mental and emotional processes; and
- All therapies and their supervisions are predicated on epistemologies (ways of understanding our world) – epistemologies are culturally based, and this must be addressed and integrated into supervision (Vargas, Porter, & Falender, 2008, p. 123).

Although three broad issues are often investigated relative to multicultural supervision (Norton & Coleman, 2003) including institutional issues, ethnic and racially diverse supervisors, and supervisor multicultural competence, this study focused on the latter. Other research on racial identity models and multicultural supervision exists in the literature (Constantine, Warren, & Miville, 2005; Ladany, Inman, Constantine, & Hofheinz, 1997).

Supervisors' lack of multicultural competence is attributed to the relatively recent emergence of multiculturalism in training programs (Norton & Coleman, 2003). Supervisors may have received graduate training prior to the recognition of the importance of multicultural issues (Wong & Wong, 1998). This competence deficit is considered problematic because there is a power differential in the supervisory relationship in which the supervisor is expected to have an "expert" role and evaluates the work performed by the supervisee. Supervisees, however, have been exposed to multicultural training in their graduate programs and may expect the supervisor to initiate discussion of the cultural issues in supervision, and therefore be reluctant to raise these

issues themselves. According to Norton and Coleman (2003), supervisees of color may be in a double bind with supervisors who fail to raise race and cultural issues in supervision because this risks their professional and personal development and also risks repercussions for bringing these issues to their supervisors' attention. The supervisors' lack of multicultural knowledge and awareness of power differentials functions to "silence and, quite possibly, demoralize supervisees of color" (Norton & Coleman, 2003, p. 122). In order to prevent this, Norton and Coleman (2003) recommended that supervisors need to be aware of their own multicultural competence limits and initiate discussions about race and culture in their supervisory relationships.

A number of assessment tools for measuring supervisor multicultural competence were found in the literature (Inman, 2006; Ortega-Villalobos & Pope-Davis, 2007; Pope-Davis, Toporek, & Ortega-Villalobos, 2003; Wong & Wong, 1998). More research has been completed on assessing counselors' or trainees' multicultural competencies but will not be reviewed here (e.g., Cross-Cultural Counseling Inventory – Revised (LaFromboise, Coleman, & Hernandez, 1991); Multicultural Awareness Knowledge and Skills Survey (MAKSS) (D'Andrea, Daniels, & Heck, 1991); Multicultural Counseling Inventory (MCI) (Sodowsky, Taffe, Gutkin, & Wise, 1994); and Multicultural Counseling Knowledge and Awareness Scale (MCKAS) (Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002).

Inman (2006) tested a model to determine the effects of trainees' perceived supervisor multicultural competence and supervisory working alliance on the trainees' own multicultural case conceptualization abilities and trainees' perceived supervision satisfaction. A randomly selected sample of student members of the American

Association for Marriage and Family Therapy were contacted and 147 of these provided responses on mailed questionnaires. Results from the study indicated support for the model because supervisor multicultural competence was positively associated with supervisory working alliance and supervision satisfaction. However, contrary to expected findings, supervisor multicultural competence had a negative relationship with trainees' multicultural case conceptualization. Inman reported that supervisory working alliance is essential in multicultural competence. Inman (2006) suggested that the unexpected results could have stemmed from other influencing variables such as the beginning level of students who participated, limited time in the supervisory relationship, and inadequacy of the expert rating methodology used.

Pope-Davis, Toporek, and Ortega-Villalobos (2003) designed an instrument to assess supervisors' and supervisees' perceptions of multicultural supervision competencies called the Multicultural Supervision Inventory (MSI). There is a triadic relationship at the foundation of multicultural supervision (Wong & Wong, 1998). The supervisor and supervisee interact to enhance their relationship to impact the training for the supervisee directly. In addition, the supervisee has a relationship with the client that benefits from the supervision that the supervisee receives. Ultimately, services provided to the client improve, based upon the supervision received by the supervisee (Pope-Davis et al., 2003; Wong & Wong).

The most recent version of the Pope-Davis et al. (2003) instrument is the Multicultural Supervision Inventory – Brief Scales (MSI – B) (Ortega-Villalobos, & Pope-Davis, 2007). The MSI – B is an 18-item inventory consisting of two subscales (fostering multicultural competence in supervisees and culturally sensitive collaboration)

in versions available for supervisor and supervisee to evaluate their most recent multicultural supervision experiences. Supervisors and supervisees at APA-approved internship sites participated in the original Pope-Davis et al. (2003) study. A follow-up validation study found high reliability between .88 and .92 and validity that accounted for 25% of the variance (Ortega-Villalobos, Pope-Davis, & Merluzzi (2007) as cited in Ortega-Villalobos & Pope-Davis, 2007).

Wong and Wong (1998) developed the Multicultural Supervision Competencies Questionnaire (MSCQ) based upon Sue et al.'s (1992) multicultural competencies of attitudes, knowledge and skills and an additional relationship factor (Sodowsky et al., 1994). Wong and Wong (1998) undertook the task to address the growing need for supervisors to be culturally competent because more graduate students represent ethnically diverse groups and also to provide the ability for nonethnically diverse graduate students to acquire multicultural competencies from a culturally competent clinical supervisor. The MSCQ is a 60-item questionnaire that was completed by graduate students in a counseling psychology program. Students evaluated recent practicum or internship supervisors from a different ethnic or racial background on statements from four subscales (attitudes and beliefs; knowledge and understanding; skills and practices; and relationship). Although internal reliability was high (.90s), no validity was reported. The select sample of 20 completed questionnaires from counseling psychology students in British Columbia, Canada indicated that trainees rated their supervisors as low in multicultural supervision competencies. The study set the stage for future research to address the growing need to improve multicultural training needs in

graduate programs and to make supervisors aware of their own multicultural supervision issues.

In a different approach to target successful multicultural supervisory behaviors, Dressel, Consoli, Kim, and Atkinson (2007) described 35 behavioral statements generated by a consensus panel of knowledgeable university counseling center supervisors (counseling and clinical psychologists). Multicultural supervision was defined as situations in which the supervisor and supervisee were ethnically different. Successful multicultural supervision was defined as:

Things you said or did (as the supervisor) that led to successfully facilitating the supervisee's growth and development as a person and a professional or that led to a successful bridging of ethnic/cultural barriers between the supervisor and the supervisee. It does not refer to things you said or did that provided insight into the client's issues. (Consoli, Kim, & Atkinson, 2007, p. 53)

Dressel et al. (2007) underscored the premise that successful multicultural supervision behaviors reflect both "core supervisory behaviors" and "specific multicultural issues" (p. 61). The top ten behavioral statements of successful multicultural supervisory behaviors identified were:

1. Creating a safe (nonjudgmental, supportive) environment for discussion of multicultural issues, values and ideas.
2. Developing one's own self-awareness about cultural/ethnic identity, biases, and limitations.
3. Communicating acceptance of and respect for supervisees' culture and perspectives.

4. Listening [to] and demonstrating genuine respect [for] supervisee's ideas about how culture influences the clinical interaction.
5. Providing openness, genuineness, empathy, warmth, and nonjudgmental stance.
6. Validating integration of supervisees' professional and racial/ethnic identities and helping to explore potential blocks to this process.
7. Discussing and supporting multicultural perspectives as they relate to the supervisees' clinical work.
8. Tending to feelings of discomfort experienced by trainees concerning multicultural issues.
9. Supporting supervisees' own racial/ethnic identity development.
10. Presenting oneself nondefensively by tolerating anger, rage, and fear around multicultural issues. (Dressel et al., 2007, p. 57)

### **Multicultural Supervisory Interventions**

Miville, Rosa, and Constantine (2005) provided several recommendations for supervisors to incorporate a multicultural focus to their work. These are categorized as awareness, knowledge, and behavior. First, in order to work effectively with their supervisees, supervisors must assess their own racial and cultural identity attitudes along with their supervisees. Both the supervisor and supervisee identify the areas in which they share similar worldviews and be aware of conflicts that may arise with biases and tensions and collaborate together to resolve these. Second, supervisors need to be aware of their supervisees' own areas of anxiety to help them to build skills to confront these biases and anxieties in the supervisory and therapy relationships. Third, supervisors must

be aware of their own and their supervisees' knowledge strengths and weaknesses in working with culturally diverse populations. The initial knowledge should focus on the target population that the institution serves. Last, the supervisor benefits from acknowledging his or her own sensitive issues about racial and cultural issues because the supervisee is influenced by both what the supervisor does and does not do. Ultimately, supervision sessions can focus on responses of avoidance or aggression after the supervisor is aware of his or her own "push buttons", as well as those of the supervisee. Moreover, supervisees also benefit from a supervisor who models behavior demonstrating an active social justice orientation by getting involved in leadership roles related to multicultural advocacy.

Norton and Coleman (2003) suggested another approach to incorporate successful multicultural supervision. If supervisors are "responsible for inducting supervisees into the culture of supervision" (Norton & Coleman, p.128), then supervisors need to explain the goals of supervision with supervisees and discuss how these are culturally derived. This discussion would include clear expectations about the nature of supervision from the supervisor and from the supervisee. Supervisors need to create a safe environment from the beginning of the supervisory relationship and expect to include discussions of race and culture. Second, the tasks of supervision need to be made clear and the supervisor and supervisee should work to establish these collaboratively. Depending upon the culture competence of the supervisee, these tasks need to match the level of the supervisee (e.g., increase racial and cultural awareness by reviewing videotapes of sessions with culturally diverse clients) to facilitate the learning. Thus, by establishing collaborative goals with expectations and tasks that fit the supervisee's



needs, Norton and Coleman (2003) indicated that the working alliance is strengthened in multicultural supervision. Furthermore, this supervisory working alliance is manifest when addressing cultural issues and having dialogue around assessment.

### **Summary**

In this study, the cultural competence program developed for psychologists who supervise graduate students in psychology addressed the needs of future psychologists, the growth of the Latino population, and Latino mental health disparities. Like their physician colleagues, psychologists may benefit from a cultural competency program created specifically to increase sensitivity to Latino culture and language as applied to treatment and supervisory practices. The cultural competency program developed in this study highlighted the need to focus on psychologists as supervisors because multicultural competency is an ongoing, dynamic journey. Although much research has investigated the cultural competence of trainees, this study focused on the supervisor, recognizing the importance of supervision and training of psychologists in the pipeline. This study sought to integrate cultural competence, multicultural supervisory competence, and Latino culture and language issues in an effort toward meeting the ethical standards and multicultural guidelines for psychologists. Overall, this program promoted ongoing enhancement of multicultural competencies within psychology.

### Chapter Three: Hypotheses/Research Questions

#### Research Questions

Can cultural competence with Latino culture and language in clinical and supervisory practices be operationalized and delivered in an online program for psychologists? Does being more culturally competent lead to greater supervisory multicultural competence? Do psychologists' supervisory styles impact levels of cultural competence and also supervisory multicultural competence? Is cultural competence and multicultural supervisory competence related to a psychologist's own race, ethnicity and fluency in other languages?

#### Hypotheses

1. Psychologists will increase their awareness and knowledge of Latino culture and language following completion of the cultural competence program, as measured by the *Latino Culture and Language Knowledge Questionnaire*.
2. Psychologists who have higher levels of cultural competence on the *Cultural Competence Assessment* will be more likely to have greater levels of supervisory multicultural competence on the *Multicultural Supervision Inventory – Brief Scales* than those with lower levels of cultural competence.
3. Psychologists who complete the cultural competence program will demonstrate increased cultural competence scores on the *Cultural Competence Assessment*, post program and also at 2 months follow-up, compared with their cultural competence scores prior to the program.
4. Psychologists who complete the cultural competence program will demonstrate increased supervisory multicultural competence scores on the *Multicultural*

*Supervision Inventory – Brief Scales*, post program and also at 2 months follow-up, compared with their supervisory multicultural competence scores prior to the program.

5. Psychologists who endorse attractive and interpersonally sensitive supervisory styles on the *Supervisory Styles Inventory* will be more likely to have higher levels of cultural competence and also higher levels of supervisory multicultural competence than supervisors with task oriented supervisory styles obtained on the *Supervisory Styles Inventory*.
6. Psychologists who report using languages other than English in their clinical work will demonstrate greater cultural competence and also greater supervisory multicultural competence than psychologists who work monolingually.
7. Psychologists from non-White racial and ethnic backgrounds will demonstrate greater cultural competence and greater supervisory multicultural competence than White psychologists.

### **Justification of Hypotheses and Summary of Relevant Work**

Although the field of psychology attends to the need for diversity training in graduate programs of clinical psychology, less attention has been given to promoting programs for psychologists who supervise trainees. Research on cultural competence training for physicians or other healthcare providers (Beach et al., 2005; Fernandez et al., 2004; Schim, et al., 2006; Thom & Tirado, 2006; Thom, Tirado, Woon, & McBride, 2006; Wilson-Stronks, et al., 2008) can be used to inform cultural competency programs for psychologists. The Cultural Competence Assessment is a useful measure to assess cultural competence of healthcare providers and may be particularly effective with

psychologists in this study. The cultural competency program developed for this study is similar in design to physicians' and other healthcare providers' cultural competence trainings. The Latino Culture and Language Knowledge Questionnaire assessed the learning of key concepts related to Latino culture and language by psychologists who completed the cultural competence program.

Most research has focused on psychology or counseling trainees' multicultural competence (D'Andrea, et al., 1991; LaFromboise, et al., 1991; Ponterotto, et al., 2002; Sadowsky, et al., 1994) but less literature exists on multicultural supervision. The studies included in this review investigated how supervisees perceive their supervisors' multicultural competence and its impact upon supervisees' cultural competence abilities (Inman, 2006) and supervisees' ratings of their supervisors' multicultural competence (Ortega-Villalobos & Pope-Davis, 2007; Pope-Davis, et al., 2003; Wong & Wong, 1998). This study added to the literature investigating supervisors' culturally competent behaviors and multicultural supervision through their own self-reports, going beyond the dimension of awareness. The Multicultural Supervision Inventory – Brief Scales allows supervisors to report on perceptions of their own supervisory multicultural competence. The inclusion of the Supervisory Styles Inventory allows for understanding about the relationship of supervisory styles on the development of cultural competency and on supervisory multicultural competence. Furthermore, the attractive and interpersonally sensitive supervisory styles appear to be very similar to the Latino cultural script called *simpatía* (Triandis, et al., 1984).

## **Chapter Four: Methods**

### **Overview**

The researcher developed a cultural competency program for psychologists who supervise graduate students' clinical training. The program focused on developing and increasing sensitivity to Latino culture and language. It was based upon a review of cultural competency models and best practice applications (Hays, 1995; López, 1997; Organista, 2006; Porter, 1994; Sue et al., 1992; Sue et al., 2009) of culturally and linguistically appropriate psychological treatment for Latinos of Cuban, Puerto Rican, Dominican, and Mexican descent. Ultimately, the cultural competency program for psychologists was expected to impact, favorably, the psychological services delivered to Latino clients and enhance the supervisory process at psychological training sites. The program included five modules: (a) Culture and Cultural Competency, (b) Multicultural Supervision, (c) Culturally Sensitive Treatment for Latinos, (d) Language and Communication, and (e) Cultural Assessment following Porter's (1994) recommendations about content for dealing with Latino mental health issues. (See Appendix A for a description of the five modules and learning objectives).

This study consisted of the development and evaluation of a cultural competency program that integrated components of program evaluation with a single-group pretest-posttest design (Kazdin, 2003; Royse, Thyer, Padgett, & Logan, 2006) and outcome measures of psychologists who participated in the program.

### **Participants**

The total sample comprised six psychologists who completed the program. Psychologists were recruited primarily online via electronic mail and in person at a

workshop and meeting. One clinical psychology doctoral training program and three national organizations affiliated with psychologists were targeted for recruitment: this included supervisors at internships/externships affiliated with the Psy.D. Program in Clinical Psychology of the Philadelphia College of Osteopathic Medicine, members of the National Council of Schools and Programs of Professional Psychology (NCSPP), members of the Association of Psychology Training Clinics (APTC), and members of the Association of Psychology Postdoctoral and Internship Centers (APPIC). Two in-person meetings targeted psychologists for recruitment during a workshop on multicultural supervision, a conference of the Pennsylvania Psychological Association (PPA) and those psychologists attending a PPA meeting.

All potential participants were invited to participate in the online cultural competency program. The psychologists were informed that the Latino cultural competency program was part of a student's research project and a larger effort to enhance multicultural competence for supervisors of doctoral clinical psychology students. (See Appendix B for an example of the recruitment letter and information). The psychologists indicated their interest in participating in the study by sending an email to the researcher. Accordingly, this study was exempt from informed consent.

### **Inclusion and Exclusion Criteria**

Psychologists who supervise clinical psychology doctoral students and whose training sites were affiliated with PCOM's Clinical Psychology program, the National Council of Schools and Programs of Professional Psychology (NCSPP), the Association of Psychology Training Clinics (APTC), or the Association of Psychology Postdoctoral and Internship Centers (APPIC), were eligible for participation. In addition,

psychologists who met the supervision requirement and attended the in-person workshop or meeting affiliated with the Pennsylvania State Psychological Association were eligible for participation.

Participants were excluded if they did not supervise clinical psychology doctoral students.

### **Measures**

Participants completed one pretest and posttest, three surveys and a demographic questionnaire online prior to the program, two surveys online following the program, and two follow-up assessments two months after completion of the program. The online surveys evaluated the program and assessed learning. Assessments took a total of approximately 45 minutes to complete.

*A demographic questionnaire* (see Appendix C) obtained participants' demographics on age, gender, race and ethnic background, highest level of education, occupation, primary theoretical orientation, formal multicultural training (coursework, workshop, other training), supervisor training in supervision and multicultural issues, number of years providing supervision and psychotherapy, languages spoken and languages used in clinical work, and Spanish fluency, estimated current percentage of Latino clientele served at institution, and number of years providing psychological services to Latinos.

The *Latino Culture and Language Knowledge Questionnaire* (see Appendix D) is a 40-item pretest-posttest measure of knowledge specific to Latino culture, values, linguistic issues, treatment, and assessment information. The questionnaire is based upon content from the program in cultural competence for working with Latinos developed by

the researcher. Psychologists completed the questionnaire before and after the cultural competence program.

The *Cultural Competence Assessment (CCA)* (see Appendix E) is a 25-item self-report inventory for various healthcare providers, assessing providers' culturally competent interventions (Doorenbos, et al., 2005; Schim, et al., 2006). The CCA measures cultural diversity experience, cultural awareness and sensitivity, and culturally competent behaviors on a 7-point scale (awareness and sensitivity items: 1 (*strongly disagree*) to 7 (*strongly agree*); behavior items: 1 (*never*) to 7 (*always*) across two factors (behavior, awareness and sensitivity). The inventory takes approximately 20 minutes to complete. Examples of items include, "I include cultural assessment when I do client or family evaluations"; "I learn from my co-workers about people with different cultural heritages", and "Many aspects of culture influence health and healthcare." The CCA also contains 13 items of the Marlowe-Crowne Social Desirability Scale (Reynolds, 1982). Two scores are obtained for the cultural awareness and sensitivity subscale and the cultural competence behavior subscale by summing items and computing averages from items answered, with higher scores indicative of greater levels of cultural competence. An individual social desirability score is obtained by summing items. A higher score on social desirability is indicative of a greater need for approval and a self-report response tendency to present favorably, compared with individuals whose average scores are indicative of more accurate reflections of themselves. Internal test-retest reliability of the CCA was .89 for healthcare providers in nonhospice settings and construct validity for the two factors explained 56% of the variance (Doorenbos et al., 2005). Psychologists



completed the CCA before and after the cultural competence program and at 2 months follow-up.

The *Supervisory Styles Inventory* (SSI) (see Appendix F) is a 33-item self-report inventory available both for supervisees' and for supervisors' reports of the supervisors' styles of psychotherapy (Friedlander & Ward, 1984). The SSI is composed of one word adjective descriptors obtained from analyses of interviews with professional supervisors and a subsequent card sort to develop clusters of supervisory styles. The unipolar items on the inventory are rated on a 7-point scale from 1 (*not very*) to 7 (*very*) to indicate the supervisor's perception of his or her own style as a supervisor. Three possible factor scores are obtained for Attractive (e.g., "warm," "supportive," "friendly," "open," "flexible"), Interpersonally Sensitive (e.g., "invested," "committed," "therapeutic," "perceptive") and Task Oriented (e.g., "goal-oriented," "thorough," "focused," "practical," "structured") by calculating an average of the items with higher ratings reflecting greater endorsement of the specific style. Internal reliability is reported to range from .76 to .93 and convergent validity has been obtained with a measure of supervisory role behavior and supervisory working alliance (Friedlander & Ward, 1984; Ladany, et al., 2001). High intercorrelation was found between the Attractive and Interpersonally Sensitive subscales, indicating that these two styles may be more closely alike than they are different (Ladany, et al., 2001). Psychologists completed the SSI one time prior to the cultural competence program.

The *Multicultural Supervision Inventory – Brief Scales* (MSI-B) (see Appendix G) is an 18-item self-report inventory available both for supervisors and for supervisees that assess perspectives of supervisors' multicultural competence in supervision (Ortega-

Villalobos & Pope-Davis, 2007; Pope-Davis, et al., 2003). The MSI – B contains statements asking the supervisors to rate the frequency of multicultural supervision experiences with a recent supervisee on a 7-point scale from 1 (*never*) to 7 (*always*). The scale consists of two factors: Fostering Multicultural Competence in Supervisees with items such as, “I encouraged my supervisee to think about cultural issues when working with clients” and Culturally Sensitive Collaboration with items such as, “I demonstrated that I respected my supervisee’s cultural beliefs and practices.” A total score for supervisor multicultural competence is obtained by summing the items, with scores ranging from 18-126; higher scores indicate higher levels of a supervisor’s multicultural competence. Internal reliability for the MSI (first version with 19-items) was between .88 and .92. Convergent validity between the MSI and Multicultural Counseling Knowledge and Awareness Scale (MCKAS) (Ponterotto, et al., 2002) accounted for 25% of the variance (Ortega-Villalobos, Pope-Davis, & Merluzzi (2007), as cited in Ortega-Villalobos & Pope-Davis, 2007). Psychologists completed the MSI – B before and after the cultural competence program and at 2 months follow-up.

### **Procedure**

The target population of psychologists was identified in conjunction with addressing the study’s goal to meet the diversity competence in psychology education and training. Several institutions had potential psychologists of interest. First, supervisors at internships and externships affiliated with PCOM’s Department of Psychology were identified in order to advance their cultural competency training and offer an appreciation for their commitment to training doctoral students in clinical psychology at PCOM. Second, as a program of professional psychology, PCOM is a member of NCSPP, a

national organization comprising delegates from 63 programs and schools of professional psychology that advance the development of the highest quality of graduate training in professional psychology. Third, the Association of Psychology Training Clinics (APTC), (formerly ADPTC), is an international organization that focuses on pre internship practicum training in professional psychology and supports directors of psychology training clinics. APTC has 150 full members and 20 associate members. Fourth, members of APPIC were included because they compose internships and postdoctoral training for over 700 programs. Fifth, psychologists affiliated with the Pennsylvania Psychological Association (PPA) were targeted during a workshop on the ethics and practice of multicultural supervision and during a meeting of the association.

The researcher received permission to recruit participants via membership listservs for the NCSPP and APTC. The primary investigator, Dr. Bruce Zahn, sent a research recruitment announcement electronically via the listserv in January, 2010. Two follow-up research recruitment announcements were re-sent over the listservs approximately 30 and 60 days later. In addition, the researcher received permission to recruit APPIC members from hand-culled email addresses from the national directory available on the internet. Dr. Bruce Zahn sent a research recruitment announcement electronically to 666 APPIC members in February, 2010 and a follow-up recruitment email approximately 30 days later.

The researcher provided a brief presentation about the study and the cultural competence program to 60 supervisors from PCOM internships and externships during a “Supervisor Appreciation Day.” This was followed by an electronic research recruitment

announcement sent by Dr. Zahn in January, 2010 to approximately 80 psychologists. A follow-up recruitment email was sent 30 days later.

The primary investigator, Dr. Bruce Zahn, and the researcher, Marie Weil, provided a continuing education workshop to 20 psychologists on the ethics and practice of multicultural supervision at PPA's Annual Ethics Conference in April, 2010. A brief presentation about the study and cultural competence program was provided during the workshop, along with a recruitment letter. In the last phase of recruitment, the researcher provided recruitment letters to 20 psychologists in attendance at a separate PPA Board of Directors meeting in March, 2010.

All research recruitment announcements invited psychologists to participate in a student's dissertation research involving evaluation of an online cultural competence program. They were told that they could increase awareness, knowledge, and skills in working with Latinos and in providing multicultural supervision to psychology trainees by volunteering to participate in the program at no cost. They were informed about the program details and duration of the study along with eligibility requirements. Moreover, they were told that a home study application was being made by PCOM to sponsor continuing education credits for psychologists. Psychologists were instructed to contact the researcher by email to indicate their interest in participating and to obtain a unique identification number and access to the online program.

A cultural competence program for psychologists who supervise doctoral level clinical psychology trainees was developed and implemented online in conjunction with The Philadelphia College of Osteopathic Medicine's (PCOM) Psy.D. Program in Clinical

Psychology. The content of the program targeted clinical and supervisory practices involving Latino culture and language gleaned from a comprehensive literature review.

Five modules addressing culture and cultural competency, multicultural supervision, culturally sensitive treatment, language and communication, and cultural assessment were included in the cultural competence program. The length of each module was approximately 1-2 hours per module, for a maximum of 10 hours, to be completed within 60 days. The web based online curriculum included didactic material, case examples, discussion questions, video clips through links, and recommendations.

Access to the cultural competence program occurred online, utilizing a private webpage (<http://sites.google.com/site/culturalcompetencytraining/>) developed through Google™ Sites by the researcher. Access to the website was limited only to those psychologists who volunteered to participate, along with members of the dissertation committee. After a participant indicated interest in the study by sending an email, the researcher assigned a unique identifier to the participant and sent instructions with a username and password to access the online surveys and cultural competence program. The availability of the website and the surveys to participants concurred with the duration of the study.

All surveys, pretest, posttest, and follow-up measures were developed and distributed using Survey Monkey™ software (<http://www.surveymonkey.com/>). The surveys were assessed for problems prior to the study by fourth-year doctoral clinical psychology students. Participants accessed links to complete the pretest, posttest and surveys on the website. Participants' privacy was protected through Survey Monkey™ with implementation of an enhanced security option. Detailed instructions were provided

on the website for participants. Participants were required to input their unique identifier on all pretest, posttest, and surveys in order to match responses. First, they were instructed to complete all pretest and surveys. Second, they were to begin the cultural competence program and complete it within 60 days. Reminder emails were sent to participants to complete the program prior to the deadline. The program was available for download on the website in a portable document format (PDF). (The cultural competence program PDF file is available for review upon request from the researcher). Third, they were instructed to complete the posttest and surveys after completion of the cultural competence program. Last, they were instructed to print a hard copy of the Satisfaction and Evaluation Form (see Appendix H) and to fax the completed form to PCOM. PCOM kept these forms in a locked cabinet in the Department of Psychology. Finally, at 2 months follow-up, the researcher emailed the participants with a link to complete the follow-up measures within 15 days.

All data were maintained in a Survey Monkey™ professional account accessible only by the researcher. The Google™ email account was protected by username and password that was accessible only by the researcher. Participants' email information and their unique identifiers were maintained in a password protected computer file that was accessible only by the researcher. The most common risks to participants were associated with the material being presented. These included possibilities of feeling upset about one's assumptions or feelings regarding mental health disparities, prejudice and discrimination, and injustices. Other common risks may have included participants' feeling uncomfortable in learning new material associated with these topics. However, the benefits of participating included developing greater awareness, knowledge, and skills

in working with Latinos and in providing multicultural supervision. Content of the program addressed the competence for diversity and ethics for psychologists. Moreover, participants in the study had the potential to contribute to better access and quality of services provided to Latinos and other ethnic and cultural groups in their clinical practices. Finally, participants who completed the program may have been perceived as culturally sensitive with skills to engage in multicultural supervision.

## Chapter Five: Results

### Analyses

Analysis of data was very limited because of the small sample size ( $N = 6$ ). The overall response rate was less than 1%. The data were first examined to determine if there were any outliers or missing variables. One participant did not complete two of the pre-program measures (SSI and CCA). Descriptive statistics were obtained to describe the sample and summarize the data collected. Percentages were reported for gender, level of education, participant racial/ethnic background, primary theoretical orientation, diversity/multicultural training, supervisor training or coursework, supervisor training in multicultural issues, other languages spoken, other languages used in clinical work, Spanish fluency, and ethnic/racial background of current client population. The range, mean, median, standard deviation, skewness, and kurtosis were calculated for the SSI, MSI – B, CCA, Latino Culture and Language Knowledge Questionnaire, participant age, years of providing supervision, years of providing therapy, and years of providing psychological services to Latinos. Split-medians were calculated for the MSI – B and CCA. Data were also checked to determine if they met assumptions of normality.

Given the very small sample size, the pre-post scores on the Latino Culture and Language Knowledge Questionnaire were chosen as the only analysis to perform to determine if data supported the hypothesis that psychologists would show an increase in their awareness and knowledge of Latino culture and language following completion of the cultural competence program.



**Descriptives**

Participants were 42 years old on average ( $M = 42.17$ ,  $SD = 13.22$ ) and ranged from 31 to 60 years of age. As shown in Table 1, the majority of participants were female, White and identified with a cognitive behavioral or eclectic theoretical orientation. As shown in Table 2, psychologists reported that the ethnic/racial background of their clients was primarily White. In terms of experience, psychologists had a range from 8 to 30 years of providing therapy ( $M = 15.17$ ,  $SD = 8.49$ ) and a range from 2 to 30 years of providing supervision ( $M = 10.5$ ,  $SD = 10.2$ ) as presented in Table 3. The majority of psychologists had a history both of multicultural/diversity training and of supervisor training.

Table 1

*Demographics of Psychologists*

Characteristic	% (N = 6)
<b>Gender</b>	
Female	67
Male	33
<b>Education</b>	
Ph.D.	50
Psy.D.	50
<b>Racial/Ethnic Background</b>	
Black/African American	17
White/Caucasian	83
<b>Primary Theoretical Orientation</b>	
Cognitive Behavioral	33
Eclectic	33
Integrative	17
Interpersonal	17
<b>History of Multicultural/Diversity Training</b>	
Yes	100

Type of Multicultural/Diversity Training	
College course for credit	50
Employer sponsored in-house training	33
Continuing Education (CE)	83
Professional conference or seminar/workshop	83
History of Supervisor Training	
Yes	100
History of Multicultural Supervisor Training	
Yes	67
No	33
Other Languages Spoken	
None	100
Other Languages Used in Clinical Work	
None	83
Spanish	17
Spanish Fluency	
Listening	
None	50
Low	50
Speaking	
None	50
Low	50

Reading	
None	67
Low	17
Intermediate	17
Writing	
None	67
Low	33

Table 2

*Ethnic/Racial Backgrounds of Psychologists' Clients*

Ethnic/Racial Background	% (N = 6)
White/Caucasian	73
Hispanic/Latino	10
Black/African American	11
American Indian/Alaska Native	1
Asian	3
Native Hawaiian/Pacific Islander	1
Other	1

Table 3

*Age and Experience of Psychologists*

Characteristic	<i>M</i>	<i>Mdn</i>	<i>SD</i>
Age	42	36	13.2
Years providing supervision	10.5	7.5	10.2
Years providing therapy	15.2	12.5	8.5
Years treating Latinos	11	5	11

**Latino Culture and Language Knowledge**

Descriptive statistics on the pre-post Latino Culture and Language Knowledge Questionnaire are presented in Table 4. A repeated-measures *t*-test indicated that participants' knowledge scores were significantly higher at posttest ( $M = 36.83$ ,  $SD = 2.64$ ) than at pretest ( $M = 30$ ,  $SD = 3.1$ ),  $t(5) = -4.27$ ,  $p < .004$ , one-tailed.

Table 4

*Latino Culture and Language Knowledge Scores*

Scores	<i>M</i>	<i>Mdn</i>	<i>SD</i>	Skewness	Kurtosis
Pre	30	29.5	3.1	.303	-2.33
Post	36.83	37.5	2.64	-1.49	2.29

**Cultural Competence and Supervisory Multicultural Competence**

Two overall measures of cultural competence were obtained at pretest, posttest, and 2 months follow-up as shown in Table 5. First, measures of participants' cultural

competence were obtained by scores on the Cultural Awareness & Sensitivity Subscale (CAS) and Cultural Competence Behavior Subscale (CCB) of the Cultural Competence Assessment (CCA). One participant did not complete the CCA at pretest. CAS and CCB scores were categorized into high or low cultural competence scores, utilizing a split-median. Second, measures of participants' supervisory multicultural competence were obtained by scores on the MSI – B and categorized into high or low supervisory multicultural competence scores, utilizing a split-median.

Table 5

*Cultural Competence and Supervisory Multicultural Competence Scores*

Scores	<i>M</i>	<i>Mdn</i>	<i>SD</i>	Skewness	Kurtosis
Pre CAS	5.91	5.91	.28	-1.28	2
Post CAS	6.3	6.45	.29	-1.27	.31
Follow-up CAS	6.21	6.22	.19	-.05	-1.72
Pre CCB	4.43	4.45	1.01	.70	-.17
Post CCB	4.63	4.64	.81	-1.08	1.63
Follow-up CCB	5.13	4.92	.89	.52	-1.01
Pre SD	6.4	6	2.7	1.7	3.37
Post SD.	4.83	4	2.79	.34	.026
Follow-up SD	6	5.5	3.52	.21	-2.31
Pre MSI – B	85.67	81.5	16.53	.174	-.95
Post MSI – B	88.5	87.5	11.36	-.18	-.86
Follow-up MSI – B	93.17	93.5	5.42	-.48	-1.1

*Note.* CAS = Cultural Awareness and Sensitivity Subscale (range 1 – 7), CCB = Cultural Competence Behavior Subscale (range 1 – 7), SD = Marlowe-Crowne Social Desirability (range 0 – 13), MSI – B = Multicultural Supervisory Inventory – Brief (range 18 – 126).

In terms of cultural competence, one psychologist had low scores on cultural awareness and sensitivity and four had high scores prior to the completion of the cultural competence program. Furthermore, two psychologists had low scores on cultural competence behavior and three had high scores. In terms of multicultural supervisory competence, there was a split; three had low scores and three had high scores prior to the program.

### **Supervisory Style**

Participants were categorized according to their supervisory style (attractive, interpersonally sensitive, task oriented), based upon scores obtained from the SSI. One participant did not complete this measure. Three psychologists reported a task oriented supervisory style and two reported an interpersonally sensitive style. The scores obtained for supervisory style are presented in Table 6.

Table 6

#### *Supervisory Style*

Style	<i>M</i>	<i>Mdn</i>	<i>SD</i>	Skewness	Kurtosis
Attractive	34.97	35.86	3.90	-.66	-1.08
Interp. Sensitive	37.8	41.5	6.85	-.43	-3
Task Oriented	41.22	39.4	3.94	1.24	1.31

**Satisfaction and Evaluation**

Psychologists who completed the program agreed that 90% of the program objectives were met (see Appendix I) and that the cultural competence home study program was adequate and appropriate for psychologists. A total of 100% of participants felt that the program enhanced their professional experiences.



## **Chapter Six: Discussion**

### **Summary of Findings**

This study was designed to develop and evaluate an online cultural competence training program for psychologists. The program was expected to develop and increase psychologists' sensitivity to Latino culture and language and enhance their multicultural competence in supervision. The overall purpose of the study was to address multicultural training gaps between supervisors and doctoral students in psychology and to meet the psychological needs of the largest ethnic minority group, thereby reducing mental health disparities. Moreover, the study expanded the scope of cultural competence training for psychologists by including outcome measures. Given the limited empirical research which examines supervisors' self-reported multicultural supervision competence (Gloria, Hird, & Tao, 2008), the study highlighted important descriptors that may be examined in future research. The original intent of the study was to investigate the relationship among cultural competence, supervisory multicultural competence, and supervisory styles and to determine if these variables were related to psychologists' own races, ethnicities and fluencies in other languages. However, due to the limited sample size, only one analysis was conducted which produced a significant finding about the cultural competence program.

Hypothesis testing revealed that psychologists gained knowledge in Latino culture and language and multicultural supervision following completion of the online cultural competence program. This finding is consistent with research that indicates health providers show knowledge gains in cultural competence (Schim, et al., 2006). This finding is also consistent with research that indicates that psychologists who complete

continuing education feel that they have learned from the program (Neimeyer, Taylor, & Wear, 2009). Furthermore, this finding goes beyond psychologists' reports of satisfaction by including an assessment of knowledge as an outcome measure. Interestingly, although research indicates that psychologists are ambivalent about having CE programs assess their knowledge, few prefer to have a skill assessment of their knowledge to gauge learning (Neimeyer, et al., 2009). This is somewhat paradoxical, given that psychologists advocate for the implementation of evidence-based treatments for clients (APA, 2005). Perhaps this is related to the practice that many CE programs for psychologists do not incorporate knowledge assessments (Neimeyer, et al., 2009), thus psychologists may not be prepared to participate in evidence-based continuing education programs.

The significant finding was inconsistent with research on physician cultural competency training by Thom et al. (2006) that did not find a significant effect from a cultural competence program. This study was a 10-hour program focused on Latinos but the program in Thom et al. (2006) was brief (5 hours) and was general. However, unlike this study, the patients in Thom et al.'s study rated their physicians' cultural competency. Thus, there were methodological differences that complicate the comparison and assessment of the effectiveness of the two cultural competence trainings. Further complications may arise when analyzing different cultural competency curriculum models that utilize distinct assessments. Moreover, patient or client ratings may differ, based upon the operational definitions of cultural competency in the studies and the unique sociocultural values of that population.

The psychologists in this study reported that their clientele included a large percentage of ethnic minority clients. Thus content of the program was relevant to them

for practice. On average, the psychologists had 11 years of experience in treating Latinos. These psychologists appear to be meeting the ethical standard of cultural competence as shown by their training experience both in cultural competence and in supervision. Moreover, the participants in this study were relatively young in terms of their career experiences. The psychologists who self-selected into this study had a history of training with both cultural competence and with supervision. Therefore the results may not be generalizable to a population of psychologists without this a priori training.

In terms of response patterns, psychologists tended to present themselves accurately in their self-report responses, as indicated by average scores obtained for social desirability. Immediately following the cultural competence program, the psychologists tended to respond in ways that indicated they may have had less need for approval. The inclusion of this scale helped to clarify the strength of the participants' responses (Gloria et al., 2008).

An implication of this study's results is that cultural competence training is an effective, promising tool to educate psychologists in cultural and supervisory practices as they relate to the treatment of Latinos. It lends support for further research on cultural competence training specifically for psychologists.

### **Limitations and Suggestions for Future Research**

Limitations of this study warrant discussion and extend to future research. The very small sample cautions generalizability of the findings. The low response rate is far below the average of 30-40% expected for surveys administered by email or online surveys (University of Texas at Austin, 2010). However, the rate may not be as applicable to this study. Although participants were required to complete surveys as part

of the research, the recruitment announcement specified that participants would be completing an online training program. The investment of time was therefore much greater than that of simply completing a survey through an email link or an online survey. Second, the data represent psychologists' self-reports and do not include behavioral and objective data of cultural competence or supervision practices from multiple sources. As indicated by Gloria, Hird, and Tao (2008), objective outcomes collected from psychologists' clients and supervisees is needed to support the effectiveness of cultural competency training.

A number of obstacles related to recruitment of participants were prevalent. Despite targeting psychologists across the nation, the strategies were unsuccessful in obtaining a desired sample of 100 psychologists. Several possible explanations merit discussion. First, given that the cultural competence program remained within a doctoral student's research meant that psychologists had to participate as volunteers and devote a significant amount of time, approximately 10 hours, to completing the training and online surveys. The amount of time required may have been a deterrent. Perhaps more psychologists might have participated if the length of the program and time involved were shortened. However, the program's protocol was developed using five modules to address the important elements in Latino culture and supervisory issues. It was modeled after cultural competence online trainings for health professionals (USDHHS, 2007) that allowed a participant to work independently and within a given time frame.

Another significant obstacle that likely reduced participation included the inability to offer psychologists CE credits. The application was submitted to the American Psychological Association for approval of the cultural competence program as

a home study; CE was denied. Comments from the reviewers of the application included the following: program content must build upon completed doctoral program of study; expertise of instructors must be demonstrated by doctoral degree, competence in area demonstrated by clinical work, research, and teaching; a recommendation for additional posttest questions in awarding of 10 credits (for a total of 60-80 questions vs. 40 proposed); and having an alternative for participants who want to take the course but not participate in the research. On the contrary, feedback from psychologists who participated supported the competence of the program content and the level of expertise (see Appendix I). One stated, "This is very impressive. Much multicultural education has the same old shibboleths. I gained much specific knowledge and would recommend it not only to supervisors, but to clinicians in general" (anonymous psychologist, personal communication, May 2, 2010). Regarding the credits, at least one potential participant inquired about the status of CE credits offered before declining to participate. Thus, psychologists who decided to participate ultimately risked *not* receiving CEs because the recruitment announcement they received clearly stated that the application for CE offering was in process. For some, the costs of participating may have outweighed the benefits.

Finally, the ethical standard of cultural competency as well as the psychologist's own identity with multiculturalism and diversity may have impacted one's choice to participate. One explanation is that perhaps psychologists with prior workshop or training experience related to Latinos and those with previous supervisory training felt that their experience might be sufficient and decided not to invest time in another similar program. Unfortunately, this parallels an undesirable model found in some training programs. For

example, some programs may include a requirement for students to take *one* multicultural course in order to meet the diversity requirement for accreditation (APA Office of Ethnic Minority Affairs, 2010). This type of mindset inappropriately perpetuates a message that diversity competence is achieved in one course or workshop versus the reality that becoming multiculturally competent is a life-long process. Moreover, despite the ethical standard related to cultural competency, a majority of psychologists' identities may not include aspects of multiculturalism and diversity as suggested by White (APA Office of Ethnic Minority Affairs, 2010). White notes that asking senior faculty and clinicians to make a multicultural paradigm change is difficult. Thus, a second explanation for non-participation is that those psychologists who identified less with topics of multiculturalism and diversity may have chosen not to participate in this study. This latter explanation may seem more plausible than the first given, that 100% of psychologists in this study had a history of training in cultural competence and supervisory issues. Over one-half of the psychologists had high scores on cultural competence before completing the program, yet there was an equal distribution of low and high scorers on multicultural supervisory competence.

A prominent goal of cultural competence advocacy and training is to reach an audience of providers beyond those who are already active with these issues. The process of delineating how curriculums or advocates can go beyond "preaching to the choir" in order to reach psychologists who may not practice multiculturally remains an important area to explore. Regrettably, the low participation outcome impacts the indirect intervention targets of this study. The access to culturally competent mental health services for Latinos increases with culturally knowledgeable and skilled clinicians and

supervisors. Given that the number of psychologists who identify as racial or ethnic minorities still remains low (6% compared with 70% who identify as White) in the world's largest psychological association (APA Office of Ethnic Minority Affairs, 2008), the strategy of employing cultural competency programs to train clinicians remains a priority. If culturally competent providers continue to be limited, then the ability to impact mental health disparities is restricted.

Despite its limitation and obstacles, the study contributed to the ongoing development of multicultural psychology. A number of suggestions for future training and research on cultural competency are gleaned from this study. These suggestions include types and locales of training, level and length of training, continuing education mandates in multiculturalism, model curriculums for psychology, CE credit approval, and homestudy programs.

1. *Training types and locales.* The delivery of cultural competency programs onsite at providers' practices is ideal. Not only might this support an organization's commitment to diversity, but it also reinforces the importance of the application of content to the local practice. Moreover, retention of participants may increase because providers would not have to sacrifice personal time for the training. Onsite cultural competence training may also address the barrier of reaching psychologists who fall within the training gap and may not otherwise self-select into this type of training.
2. *Level and length of training.* It is important to match the level of training to psychologists' competency levels (e.g., low, medium, high). Furthermore, a screening tool that obtains both self-report and objective and behavioral measures

of competency may be helpful for accurate assessment to meet psychologists' needs (e.g., beginner, intermediate, advanced). Additionally, time requirements for programs may vary. Five to 30 credits of training may be delivered, depending upon the type and locale of the training. For an online program involving outcomes, strong consideration of shorter programs may help to increase retention. Over half of the participants in this study reported that they preferred full-day programs. Further research delineating demographics of participants in online continuing education training is warranted, along with assessment of specific program needs for cultural competency within local psychological communities. A needs assessment for a particular community of psychologists may be ideal.

3. *Continuing education mandates in multiculturalism.* Many states have mandated CE requirements that include mandated training for a specific number of credits in addition to credits in specific content areas such as ethics (Neimeyer et al., 2009). Neimeyer et al. (2009) found significant differences showing that mandated psychologists complete more credits than do non mandated psychologists. Perhaps the key to reaching those psychologists *beyond the choir* is to require CE credits in cultural competency, thereby placing an importance on obtaining training in multiculturalism and in having it enforceable under the licensing law. For example, the state of Massachusetts was one of the first to require diversity experience for licensure as a psychologist in 1993.
4. *Model curriculums for psychology.* As Arredondo indicated, it is essential to have curriculum models for psychology, whereby multiculturalism is infused into the



set of graduate courses (APA Office of Ethnic Minority Affairs, 2010). For example, research and curriculum development have occurred for family physicians to help them develop the competencies required to improve the quality of care for ethnically diverse communities (USDHHS, 2007). Moreover, efforts to develop evidence-based cultural competence programs for psychologists that include multiple sources of knowledge and skill assessment outcomes are warranted.

5. *Approval for CE.* In terms of future cultural competence home study programs, the ability to offer CE credits for psychologists may certainly help recruit participants. In the event that the sponsoring institution is not approved by the American Psychological Association (APA) to sponsor continuing education for psychologists, efforts to obtain input from the APA continuing education office on the proposed curriculum and assessments are recommended prior to the program's implementation.
6. *Research on home study participant response rates.* Finally, because many psychologists obtain CE credits via home study programs, future research may focus on investigating cultural competency programs of study for psychologists. Response rates for these specific programs may provide information to compare and contrast with survey response rates or other home study programs. Research that investigates the content of these programs may also contribute to developing model programs on cultural competence, especially as more state and national psychological associations offer such educational opportunities.

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## Appendix A

## Cultural Competence Program Modules Content and Learning Objectives

Module 1: Culture and Cultural Competency

The module begins with the participant completing a cultural self-awareness assessment. In this first module, the participant reviews definitions of culture and cultural competency. Several models describe culturally sensitive treatment and dimensions of personal identity. The process of acculturation provides a foundation for assessment of the Latino client. The participant learns about general Latino cultural values such as *familismo*, *personalismo*, *simpatía*, *respeto*, *confianza*, and others. The module presents traditional Latino cultural groups including Puerto Ricans, Cubans, Mexicans, and Dominicans. A video with a Latina psychologist discusses developing cultural competency. The module concludes with a discussion about ethics and the APA Guidelines for Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists

Module 2: Multicultural Supervision

In this second module, the participant begins with a multicultural self-assessment in preparation for a review of core concepts of supervision and the supervisory working alliance. Models and definitions of multicultural supervision inform case examples of how race and ethnicity merge in supervision. A number of interventions and recommendations offers the psychologist ample methods to include multiculturalism in supervision. Specific attention is given to multicultural supervisory practices. The module concludes with a discussion of incorporating diversity initiatives into practice.

Module 3: Culturally Sensitive Treatment for Latinos

The third module explains how cultural adaptations of cognitive behavioral therapy are used with Latinos in treatment. A comparison of CBT values highlights differences in mainstream U.S. culture and traditional Latino culture. Cognitive and behavioral implications and recommendations related to specific Latino cultural values offer the psychologist specific culturally competent practices. Several proverbs or *dichos* increase one's cultural sensitivity to innovative methods to reach a diverse Latino clientele. A review of four outcome studies assessing the effectiveness of CBT with Latinos is included. The module concludes with a review of cultural specific mental health and healing and implications for treatment.

#### Module 4: Language and Communication

The fourth module encompasses an effort to familiarize the psychologist with an understanding of the importance of communication. The use of Spanish and how miscommunication occurs is presented with case examples. The participant learns about federal requirements regarding the provision of services to limited English proficient clients and views the impact of medical interpretation in a video. Communication in one's preferred language highlights the effectiveness and quality of treatment provided. The concepts of interpretation vs. translation are explained with a focus on current interpreter certification requirements for Pennsylvania. Additionally, the crucial role of the interpreter as a cultural broker is discussed. Recommendations and resources for psychologists offer concrete steps to incorporate into practice.

#### Module 5: Cultural Assessment

The final module in the program discusses the need for a culturally informed assessment. Information on how to assess a bilingual client's language proficiency is offered. The use of the *DSM-IV Outline for Cultural Formulation* and cultural adaptations reviews how to evaluate and determine the impact of a client's culture on clinical issues. A video presentation by Francis Lu, M.D. discusses diagnosis and treatment planning in working with culturally diverse patients to impact the outcomes and reduce mental health disparities with use of the cultural outline. Several additional assessments are provided as resources to enhance cultural assessments by psychologists including a careful consideration of children's behavior in a cultural context.

Learning Objectives

At the completion of this program, supervisors of psychology will be able to:

1. Demonstrate knowledge of cultural competence to dimensions of Latino identity and cultural values.
2. Demonstrate use of the *APA Multicultural Guidelines* to inform culturally competent ethical practice with Latinos.
3. Demonstrate assessment of multicultural supervision practices in review of case examples.
4. Identify diversity initiatives to implement at the participant's institution.
5. Describe culturally sensitive treatment adaptations for Latinos.
6. Explain best practices for communicating with limited English proficient clients.
7. List recommendations for use of interpreters in clinical practice.
8. Apply recommendations for assessment of a bilingual client's language proficiency.
9. Demonstrate how to use cultural assessments to determine the impact of the client's culture in a clinical context.
10. Explain the use of the *DSM-IV Outline for Cultural Formulation* for diagnosis and treatment planning with culturally diverse clients.

## Appendix B

## Recruitment Letter/Email

TO: Psychologists

FROM: Bruce S. Zahn, Ed.D., ABPP, Professor and Director of Clinical Training  
Philadelphia College of Osteopathic Medicine (PCOM)  
Department of Clinical Psychology  
Principal Investigator

Marie C. Weil, MA, LPC, Doctoral Candidate  
Philadelphia College of Osteopathic Medicine (PCOM)  
Department of Clinical Psychology

**Research Recruitment Announcement – Cultural Competency Program for Psychologists:  
Clinical and Supervisory Practices with Latino Culture and Language**

As part of my dissertation research approved by the Philadelphia College of Osteopathic Medicine Institutional Review Board (IRB) Protocol # H09-030-X, I have developed an online cultural competency program for psychologists who supervise graduate students of clinical psychology at practica sites or externships. **The focus of the program is on developing and increasing sensitivity to Latino culture and language.** It is part of an effort to enhance multicultural competence for supervisors of doctoral clinical psychology students.

As a participant, you may benefit by increasing your awareness, knowledge, and skills in working with Latinos and providing multicultural supervision to psychology trainees. The program includes didactic material, case examples, discussion questions, video clips, and recommendations in five modules:

1. Culture and Cultural Competency
2. Multicultural Supervision
3. Culturally Sensitive Therapy for Latinos
4. Language and Communication
5. Cultural Assessment

The program is online and takes 1-2 hours per module, to be completed within 60 days. A homestudy application is being made by PCOM to sponsor 10 hours of continuing education for psychologists for this program; PCOM is approved by the American Psychological Association to sponsor continuing education for psychologists. PCOM maintains responsibility for this program and its content. The home study online program will take approximately 10 hours to complete.

You will be asked to complete one pretest and posttest, three surveys and demographics online prior to the program, two surveys online following the program, and two follow-up assessments two months after you complete the program. The online surveys evaluate the program and assess your learning in order to obtain continuing education credit. There is *no cost* for your participation in this project. Assessments will take about 45 minutes to complete. In order to participate, you must be a psychologist who supervises doctoral clinical psychology students at practica sites or externships. You may be affiliated with PCOM, or affiliated with member institutions who participate in NCSPP, ADPTC, or APPIC. Psychologists must obtain access to the program by contacting Marie Weil.

Please send an email to the researcher at [mweilculture@gmail.com](mailto:mweilculture@gmail.com) indicating your interest and eligibility, in order to be assigned a unique identifier and obtain access to the online program.

Participants with questions about the project may contact the principal investigator, Dr. Bruce Zahn, Professor and Director of Clinical Training, Psy.D. Program in Clinical Psychology, Philadelphia College of Osteopathic Medicine, 4190 City Avenue, Philadelphia, PA 19131 or by phone at (215) 871-6498 or email: [brucez@pcom.edu](mailto:brucez@pcom.edu).

## Appendix C

## Demographic Questionnaire

**Please complete the following demographic information:**

**Age:** \_\_\_\_\_

**Gender:** \_\_\_\_\_

**Highest level of education completed:**

- Ph.D.
- Ph.D./J.D.
- Psy.D.
- Ed.D.
- MA/MS

**Occupation:**

- Psychologist
- Other (specify): \_\_\_\_\_

**Indicate your racial/ethnic background:**

**Mark 'X' for all that apply**

- Hispanic/Latino
- White/Caucasian
- Black/African American
- American Indian/Alaska Native
- Asian
- Native Hawaiian/Pacific Islander
- Other (specify): \_\_\_\_\_

**Indicate your primary theoretical orientation:**

- Behavioral
- Integrative
- Eclectic
- Psychodynamic/Psychoanalytic
- Biological
- Interpersonal
- Systems
- Cognitive Behavioral
- Humanistic/Existential
- Other (specify): \_\_\_\_\_

**Have you ever participated in multicultural/diversity training?**

- Yes
- No

**If you have had prior diversity/multicultural training, check all that apply below:**

- College course for credit
- Employer sponsored in-house training
- Continuing Education (CE) offering
- On-line training
- Professional conference or seminar/workshop
- Other (specify): \_\_\_\_\_

**Have you had supervisor training or coursework in supervision?**

- Yes
- No

**Have you had supervisor training in multicultural issues?**

- Yes
- No

**Indicate the number of years you have been providing supervision:** \_\_\_\_\_

**Indicate the number of years you have been providing psychotherapy:** \_\_\_\_\_

**What other languages besides English do you speak?**

- Spanish
- French
- German
- Vietnamese
- Other: \_\_\_\_\_
- Italian
- Russian
- Yiddish
- Hebrew
- American Sign Language

**What other languages besides English do you use in your clinical work?**

- Spanish
- French
- German
- Vietnamese
- Other: \_\_\_\_\_
- Italian
- Russian
- Yiddish
- Hebrew
- American Sign Language

**Spanish fluency:** Please rate your Spanish-language abilities by marking your choice:

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
	<i>None</i>	<i>Low</i>	<i>Intermediate</i>	<i>Advanced</i>	<i>Native-Like</i>
Listening	1	2	3	4	5
Speaking	1	2	3	4	5
Reading	1	2	3	4	5
Writing	1	2	3	4	5

**Estimate the current client population at your institution (total in all categories equals 100%):**

- \_\_\_\_\_ Hispanic/Latino
- \_\_\_\_\_ White/Caucasian
- \_\_\_\_\_ Black/African American
- \_\_\_\_\_ American Indian/Alaska Native
- \_\_\_\_\_ Asian
- \_\_\_\_\_ Native Hawaiian/Pacific Islander
- \_\_\_\_\_ Other (specify): \_\_\_\_\_

**Indicate the number of years you have provided psychological services to Latinos:** \_\_\_\_

## Appendix D

## Latino Culture and Language Knowledge Questionnaire

Please indicate your response to the question by marking your choice below.

## Module 1: Culture and Cultural Competency

1. Culturally sensitive treatment includes all of the following *except*:
  - (a) Culturally adapted treatment
  - (b) Relinquished values in treatment \***
  - (c) Cultural characteristics and an appropriate treatment modality
  - (d) Increased accessibility
  
2. Cultural factors appear related to mental health disparities in that:
  - (a) Latino immigrants utilize less mental health treatment \***
  - (b) Ethnic and cultural groups have greater access to mental health treatment than Whites
  - (c) Latinos do not utilize conventional or alternative general health treatment
  - (d) Culturally sensitive treatment is widely available
  
3. Include all of the following in your clinical assessment to assess a Latino client's acculturation, *except*:
  - (a) Place of birth
  - (b) Language(s) spoken
  - (c) Personal cultural identity
  - (d) Income level \***
  
4. The *Dimensions of Personal Identity* Model indicates:
  - (a) We are all cultural beings
  - (b) Cultural elements include predetermined less changeable characteristics (gender, etc.)
  - (c) Opportunities and access to privileges such as educational background
  - (d) All of the above \***
  
5. According to Sue, Arredondo, and Davis (1992), a culturally competent counselor has all of the following *except*:
  - (a) Cultural awareness and beliefs
  - (b) Limited self-awareness \***
  - (c) Cultural knowledge
  - (d) Cultural skills



6. The Latino cultural value of *personalismo* is best described as:
  - (a) The inability to develop interpersonal relationships
  - (b) The tendency to shy away from disclosing personal history
  - (c) The importance placed upon the person in relationships vs. other factors\***
  - (d) The tendency to disregard time orientation
  
7. The Latino cultural value of *familismo* is best described as:
  - (a) A pathological enmeshed family
  - (b) A pathological codependent couple
  - (c) Close family connections \***
  - (d) The tendency to not disclose issues about one's family
  
8. For many Latinos, religion and spirituality:
  - (a) Are intricately connected
  - (b) Offer cultural explanations about illness
  - (c) Influence behavior that may be perceived as odd or unusual by majority providers
  - (d) All of the above \***
  
9. The term "commuter nation" refers to:
  - (a) Migration of Puerto Ricans to the mainland \***
  - (b) The intergenerational conflicts that occur with Dominicans frequent travel to the island
  - (c) Cuban migration to the U.S. following the Cuban revolution
  - (d) The wave of immigration that brought Mexican farm workers to the U.S.

#### Module 2: Multicultural Supervision

10. *Multicultural supervision* is best described as:
  - (a) The dynamic process involved when supervisors address multicultural issues with supervisees that ultimately impact clients
  - (b) The process that occurs when supervisors and supervisees explore various aspects of culture
  - (c) When a supervisor and supervisee are from different racial or ethnic groups
  - (d) All of the above \***
  
11. Supervisees today may be reluctant to initiate discussions of culture with supervisors due to all of the following *except*:
  - (a) Fear of poor evaluation
  - (b) Expectation that the supervisor is the expert
  - (c) Fear of repercussions to personal and professional development
  - (d) No exposure to multiculturalism in their training programs \***

12. Which of the following are successful multicultural supervisory behaviors?
- (a) Creating a aversive environment
  - (b) Supporting supervisee's own racial and ethnic identity development \***
  - (c) Developing biases and judgments
  - (d) Ignoring uncomfortable feelings
13. Supervisors can incorporate a multicultural focus to their work by including all of the following *except*:
- (a) Be aware of supervisee's anxiety
  - (b) Assess their own and supervisees' strengths and weaknesses
  - (c) Let the supervisee initiate dialogue of multicultural issues \***
  - (d) Explain goals of supervision to include race and culture
14. In a social justice approach to supervision, it is recommended that supervisors:
- (a) Assist supervisees in developing critical consciousness
  - (b) Discuss parallel processes
  - (c) Present at conferences with an activist focus with trainees
  - (d) All of the above \***

### Module 3: Culturally Sensitive Treatment for Latinos

15. Culturally sensitive treatment may include:
- (a) Language and cultural components
  - (b) Culturally adapted manualized treatments
  - (c) Emphasis on important Latino cultural values
  - (d) All of the above \***
16. When therapists engage in *plática* with Latino clients, this means:
- (a) Challenging of clients
  - (b) Small-talk and self-disclosure \***
  - (c) Inquiring about family history
  - (d) Engaging in strained conversation
17. Organista recommends use of the "Yes, but..." technique in order to:
- (a) Help clients with self-affirmation
  - (b) Help clients with cognitive restructuring \***
  - (c) Help clients engage in a cost-benefit analysis
  - (d) Help clients schedule activities
18. Comas-Díaz and Duncan recommend cultural adaptations of assertiveness training with Latinos by using:
- (a) "I" statements
  - (b) "With all due respect..." prefacing statements \***
  - (c) Expression of emotions
  - (d) Modeling of majority values and norms

19. Which of the following groups has research indicated has the worst mental health status of all Latinos?
- (a) Mexicans
  - (b) Dominicans
  - (c) **Puerto Ricans \***
  - (d) Cubans
20. Which of the following mainstream American values may differ from traditional Latino values?
- (a) Task orientation
  - (b) Individualistic orientation
  - (c) Direct expression of feelings
  - (d) **All of the above \***
21. One way that psychological providers can be sensitive to the Latino cultural value of *respeto* (respect) is:
- (a) **Avoid asking personal questions prior to establishing trust \***
  - (b) Maintain a neutral physical environment in the clinical setting
  - (c) Accept head nods to indicate tacit agreement
  - (d) Avoid exploring early learning experiences and cultural expectations
22. An implication of *machismo* and *marianismo* may be all of the following *except*:
- (a) Men may be reluctant to discuss sexual matters with a female therapist
  - (b) Women may prioritize family needs above keeping therapy appointments
  - (c) Women may be hesitant to complain of problems or loved ones
  - (d) **Men may gain respect in the family due to changes in labor markets and limited economic access to jobs\***
23. The culture-bound syndrome *mal de ojo* is best described as:
- (a) A nerve attack
  - (b) Indigestion
  - (c) **Evil eye \***
  - (d) Anxiety

#### Module 4: Language and Communication

24. Providing therapy in the client's primary language may benefit the client because:
- (a) Bilingual clients do not switch languages in psychotherapy
  - (b) **Therapeutic progress may be related to client's identity and pride \***
  - (c) Psychological training is not helpful for bilingual psychologists
  - (d) This guarantees cultural sensitivity and competence

25. Common translation problems of clinical work in Spanish into documentation in English includes:
- (a) Minimization of error related to dealing within only one context
  - (b) Multiple meanings of words and misinterpretation \***
  - (c) The requirement that all potential clients must read English
  - (d) Choosing the most reliable translation software program
26. Under the law, LEP individuals are entitled to:
- (a) Receipt of language resources at no cost
  - (b) Language assistance in receiving services
  - (c) No assistance
  - (d) Both a and b \***
27. In order to avoid confusion during interpretation in an interview, an interpreter should:
- (a) Use first person voice \***
  - (b) Always use third person voice
  - (c) Advise and interject his or her opinion
  - (d) None of the above
28. A cultural broker:
- (a) Relies solely on spoken language
  - (b) Is always a separate role and provider from the interpreter
  - (c) Clarifies the intent of the speakers \***
  - (d) Emphasizes only commercial aspects of culture
29. The U.S. Census 2000 indicates what percentage of the total population reported that they speak a language other than English at home?
- (a) 18% \***
  - (b) 40%
  - (c) 5%
  - (d) 50%
30. Interpreters and translators are specialists due to all of the following *except*:
- (a) A high degree of experience and training are required
  - (b) They have fluency and knowledge in at least two languages
  - (c) Being bilingual insures knowledge and competency \***
  - (d) There are various modes in which languages can be converted
31. Certification of interpreters and translators in the United States is:
- (a) Universal
  - (b) Required
  - (c) Ethical \***
  - (d) Standardized

32. When using an interpreter for an interview, it is recommended that you:
- (a) **Discuss confidentiality \***
  - (b) Plan on taking the same amount of time for an interpreted interview compared to non-interpreted interviews
  - (c) Address and direct your comments directly to the interpreter
  - (d) Assume the interpreter has received professional interpreter training

Module 5: Cultural Assessment

33. Santiago-Rivera proposes an integrative framework to incorporate culture and language into treatment with all of the following dimensions *except*:
- (a) Language and culture of the client
  - (b) Level of acculturation of the client
  - (c) Therapeutic approaches and intervention strategies
  - (d) **Setting where psychological services are provided \***
34. When assessing the client's psychological and physical health, consider:
- (a) Perception and expression of symptoms
  - (b) Cultural basis for somatic problems
  - (c) Psychosocial stressors
  - (d) **All of these \***
35. According to Santiago-Rivera and Altarriba, which of the following should be considered when assessing a bilingual client's language proficiency?
- (a) Current age
  - (b) **Language spoken at home with family \***
  - (c) Presence of accent when speaking English
  - (d) Current job
36. Cultural formulation, according to Dr. Francis Lu, includes:
- (a) Understanding how culture impacts the individual's explanation of illness
  - (b) Understanding how culture impacts the clinician-client relationship
  - (c) Understanding how culture affects the client's support system
  - (d) **All of the above \***
37. A Latino's cultural identity:
- (a) Is the same for all Latinos
  - (b) Includes only race and ethnicity
  - (c) **Is impacted by multiple factors \***
  - (d) Can be assessed by language proficiency alone

38. Migration history incorporates:
- (a) Premigration history
  - (b) Losses
  - (c) Work history
  - (d) All of the above \***
39. La Roche and Maxie recommend all of the following *except*:
- (a) Addressing both cultural similarities and differences with your clients
  - (b) Addressing presenting problem and level of distress of the client
  - (c) Assuming clients bring particular experiences based upon their demographics \***
  - (d) Considering cultural differences as strengths
40. When working with children from cultural minority groups, consider the interpretation that the child's aloof behavior may indicate:
- (a) Identity group problems
  - (b) Limited language abilities
  - (c) Newness to the community
  - (d) All of these \***

## Appendix E

## Cultural Competence Assessment

This survey is designed to explore your knowledge, feelings, and actions when you work with others in the context of providing psychological services.

Questions on this survey are intended to gather information about how you personally think, feel, and act. Some questions may not fit your situation. Please try to answer every question. If you are unsure or have no opinion on an item, use the “No Opinion” or “Not Sure” options. There are no “right” or “wrong” answers.





8. Individual people may identify with more than one cultural group.  
 Strongly Agree  Agree  Somewhat Agree  Neutral  Somewhat Disagree  Disagree  Strongly Disagree  No Opinion
9. Language barriers are the only difficulties for recent immigrants to the United States.  
 Strongly Agree  Agree  Somewhat Agree  Neutral  Somewhat Disagree  Disagree  Strongly Disagree  No Opinion
10. I believe that everyone should be treated with respect no matter what their cultural heritage.  
 Strongly Agree  Agree  Somewhat Agree  Neutral  Somewhat Disagree  Disagree  Strongly Disagree  No Opinion
11. I understand that people from different cultures may define the concept of “health care” and “mental health care” in different ways.  
 Strongly Agree  Agree  Somewhat Agree  Neutral  Somewhat Disagree  Disagree  Strongly Disagree  No Opinion
12. I think that knowing about different cultural groups helps my direct work with individuals, families, groups, and organizations.  
 Strongly Agree  Agree  Somewhat Agree  Neutral  Somewhat Disagree  Disagree  Strongly Disagree  No Opinion

**For each of the following statements put an “X” in the box that best describes how often you do the following:**

13. I include cultural assessment when I do individual or organizational evaluations.  
 Always  Very Often  Somewhat Often  Often  Sometimes  Few times  Never  Not Sure
14. I seek information on cultural needs when I identify new people in my practice or college/university.  
 Always  Very Often  Somewhat Often  Often  Sometimes  Few times  Never  Not Sure
15. I have resource books and other materials available to help me learn about people from different cultures.  
 Always  Very Often  Somewhat Often  Often  Sometimes  Few times  Never  Not Sure



**Your answers to these last few questions will help us understand responses from different kinds of people who complete the survey. ALL answers are strictly confidential.**

**Read each item below and decide whether the statement is true or false as it pertains to you personally. Mark your answers with an “X” in the True or False box.**

27. It is sometimes hard for me to go on with my work if I am not encouraged.  
 TRUE    FALSE
28. I sometimes feel resentful when I don't get my way.  
 TRUE    FALSE
29. On a few occasions, I have given up doing something because I thought too little of my ability.  
 TRUE    FALSE
30. There have been times when I felt like rebelling against people in authority even though I knew they were right.  
 TRUE    FALSE
31. No matter who I'm talking to, I'm always a good listener.  
 TRUE    FALSE
32. There have been occasions when I took advantage of someone.  
 TRUE    FALSE
33. I'm always willing to admit it when I make a mistake.  
 TRUE    FALSE
34. I sometimes try to get even rather than forgive and forget.  
 TRUE    FALSE
35. I am always courteous, even to people who are disagreeable.  
 TRUE    FALSE
36. I have never been irked when people expressed ideas very different from my own.  
 TRUE    FALSE
37. There have been times when I was quite jealous of the good fortune of others.  
 TRUE    FALSE
38. I am sometimes irritated by people who ask favors of me.  
 TRUE    FALSE
39. I have never deliberately said something to hurt someone's feelings.  
 TRUE    FALSE

## Permission to use Cultural Competence Assessment (CCA)

From: "Stephanie Schim" <s.schim@wayne.edu>  
To: "Marie Weil" <mariewe@pcom.edu>  
Date: Saturday - January 3, 2009 2:18 PM  
Subject: RE: Cultural Competence Assessment Instrument Request

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Dear Marie -

I am delighted to learn of your interest in the Cultural Competence Assessment instrument I developed with my colleagues. I am sending along several files for your review:

- 1) a copy of the most recent version of the CCA tool itself
- 2) a page that describes the coding of the tool
- 3) a bibliography of papers that describe various aspects of tool development, use to date, and theory (I see that I need to update this now!)

We do not currently charge for use of the instrument by students and faculty for research. We ask only that you assign credit appropriately when citing our work and that you let us know how the tool worked for you if you decide to use it in your research. The more feedback we get from those using the tool with various populations, the better we can make the ongoing revisions and refinements.

If you have any additional questions or there is anything else I can assist you with, please do not hesitate to contact me.

Best Regards and Happy New Year! Stephanie

Stephanie Myers Schim, PhD, RN, PHCNS-BC  
Associate Professor / College of Nursing  
240 Cohn Building 5557 Cass Avenue  
Detroit MI 48202  
(313) 577-4034 [s.schim@wayne.edu](mailto:s.schim@wayne.edu)

Appendix F

Supervisory Styles Inventory

**Supervisors: Please indicate your perceptions of your style as a supervisor of psychotherapy/psychology on each of the following descriptors. Circle/check the number on the scale from 1 to 7, which best reflects your view of yourself.**

		<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
		<i>Not very</i>						<i>Very</i>
1.	Goal-oriented	1	2	3	4	5	6	7
2.	Perceptive	1	2	3	4	5	6	7
3.	Concrete	1	2	3	4	5	6	7
4.	Explicit	1	2	3	4	5	6	7
5.	Committed	1	2	3	4	5	6	7
6.	Affirming	1	2	3	4	5	6	7
7.	Practical	1	2	3	4	5	6	7
8.	Sensitive	1	2	3	4	5	6	7
9.	Collaborative	1	2	3	4	5	6	7
10.	Intuitive	1	2	3	4	5	6	7
11.	Reflective	1	2	3	4	5	6	7
12.	Responsive	1	2	3	4	5	6	7
13.	Structured	1	2	3	4	5	6	7
14.	Evaluative	1	2	3	4	5	6	7
15.	Friendly	1	2	3	4	5	6	7
16.	Flexible	1	2	3	4	5	6	7
17.	Prescriptive	1	2	3	4	5	6	7
18.	Didactic	1	2	3	4	5	6	7
19.	Thorough	1	2	3	4	5	6	7
20.	Focused	1	2	3	4	5	6	7
21.	Creative	1	2	3	4	5	6	7
22.	Supportive	1	2	3	4	5	6	7
23.	Open	1	2	3	4	5	6	7
24.	Realistic	1	2	3	4	5	6	7
25.	Resourceful	1	2	3	4	5	6	7
26.	Invested	1	2	3	4	5	6	7
27.	Facilitative	1	2	3	4	5	6	7
28.	Therapeutic	1	2	3	4	5	6	7
29.	Positive	1	2	3	4	5	6	7
30.	Trusting	1	2	3	4	5	6	7
31.	Informative	1	2	3	4	5	6	7
32.	Humorous	1	2	3	4	5	6	7
33.	Warm	1	2	3	4	5	6	7

Permission to use Supervisory Styles Inventory (SSI)

From: "Myrna L Friedlander" <MFriedlander@uamail.albany.edu>

To: "Marie Weil" <mariewe@pcom.edu>

Date: Wednesday - March 4, 2009 8:15 AM

Subject: RE: Request - Supervisory Styles Inventory SSI

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Hello, Marie. You have my permission to use the SSI. The trainee version is attached, and you'll find the directions for the supervisor version in the 1984 JCP article (Friedlander & Ward). It has been used in probably dozens of studies, so I suggest you do a good search for your lit review. Best wishes with your dissertation.

Appendix G

Multicultural Supervision Inventory – B (Supervisor Version)

In this inventory the terms “culture/cultural” refer to race, ethnicity, gender, class, religion, sexual orientation, and physical disability. In completing this inventory consider that the process of developing multicultural competencies is an ongoing endeavor; therefore, it is understood that most practicing supervisors may have areas of limited experience.

**Instructions:** Read the following questions regarding your current or most recent multicultural supervision experience. Please consider the interactions with only one supervisee when answering each question (if you had more than one supervisee, select one). Because the term "culture" has been defined broadly, when answering questions about cultural matters please consider only those dimensions that were meaningful.

**Please use the following rating scale:**

**1= Never 2= Rarely 3= Occasionally 4= Sometimes 5= Often 6= Very Often 7= Always**

		Never			Sometimes			
<b>Always</b>								
1.	I demonstrated that I respected my supervisee’s cultural beliefs and practices.	1	2	3	4	5	6	7
2.	I encouraged my supervisee to think about cultural issues when working with clients.	1	2	3	4	5	6	7
3.	I helped my supervisee think of how their cultural identity is relevant to their identity as a counselor.	1	2	3	4	5	6	7
4.	I helped my supervisee understand how cultural communication styles might affect their interactions with his/her clients.	1	2	3	4	5	6	7
5.	I brought up discussions about potential cultural differences in our supervisory relationship.	1	2	3	4	5	6	7
6.	I am knowledgeable about groups who are different from me culturally.	1	2	3	4	5	6	7
7.	I helped my supervisee identify other opportunities for multicultural counseling experience.	1	2	3	4	5	6	7
8.	I interacted with my supervisee in ways that did not stereotype him/her.	1	2	3	4	5	6	7
9.	I informed my supervisee about resources he/she can use to learn more about cultural issues in counseling.	1	2	3	4	5	6	7
10.	I am aware of how cultural issues may have influenced our supervisory relationship.	1	2	3	4	5	6	7
11.	My supervisee felt comfortable talking to me about differing opinions due to cultural matters.	1	2	3	4	5	6	7
12.	I helped my supervisee understand how the major theoretical orientations in psychology have value related assumptions relevant to multicultural counseling.	1	2	3	4	5	6	7
13.	I understood how cultural communication styles might affect the interactions between my supervisee and myself.	1	2	3	4	5	6	7

1= Never 2= Rarely 3= Occasionally 4= Sometimes 5= Often 6= Very Often 7=Always

Always		Never			Sometimes			
		1	2	3	4	5	6	7
14.	I fostered a collaborative working relationship with my supervisee.	1	2	3	4	5	6	7
15.	I was aware of certain cultural beliefs and norms that are (were) important to my supervisee.	1	2	3	4	5	6	7
16.	I encouraged my supervisee to express his/her opinions and concerns about client conceptualization freely.	1	2	3	4	5	6	7
17.	In evaluating my supervisee's counseling skills, I took into account their performance in multicultural situations.	1	2	3	4	5	6	7
18.	I valued learning from my supervisee and our supervisory relationship.	1	2	3	4	5	6	7



**Multicultural Supervision Inventory – Brief Scales (MSI--B)  
Utilization Request Form**

In using the Multicultural Supervision Inventory – Brief Scales (MSI-B), I agree to the following terms and conditions:

1. I understand that the MSI – B is copyrighted by Lideth Ortega-Villalobos and Donald B. Pope-Davis at the Department of Psychology, 300 Main Building, University of Notre Dame, Notre Dame, IN 46556, (574) 631-5716; Fax: 574-631-4782; e-mail: [dpd@nd.edu](mailto:dpd@nd.edu)
2. I am a trained professional in psychology or a related field. I have completed relevant coursework in multicultural issues, psychometrics, and research ethics. Or, I am working under the supervision of a professional who has met the above conditions.
3. In using the MSI-B, I and any other individuals or organizations with which I am affiliated, agree to comply with all ethical standards of the American Psychological Association or the ethical standards of a related professional organization. I will ensure that my use of the MSI – B complies with “Research with Human Subjects” guidelines specified by my university, college, institution, or professional setting. These ethical considerations include, but are not limited to, informed consent, confidentiality of records, adequate pre-and post-briefing of subjects, and subject opportunity to receive a summary of the study once it is completed.
4. I will save and protect my raw data for a minimum of five years as is consistent with accepted professional practice. I will make the raw data available to Dr. Pope-Davis and Dr. Ortega-Villalobos and to other students and professionals, by request. I understand that it is the ethical responsibility of Dr. Pope-Davis and Dr. Ortega-Villalobos to monitor the use of and developments on the MSI – B for reliability, validity, and other issues.
5. For any study in which I use the MSI-B, I will send a copy of my research results in manuscript form and the raw data in electronic form to Dr. Pope-Davis regardless of whether the study is published, presented, or fully completed.

Signature: 

Date: March 10, 2009

Name: Marie C. Weil, MA, LPC

Phone: (717) 580-8035

Address: PO Box 10567, Harrisburg, PA 17105

If student, supervisor/mentor's name and phone number, affiliation, and signature:

Name: Bruce S. Zahn, Ed.D., ABPP

Phone: 215-871-6498

Affiliation: Associate Professor in Clinical Psychology, Director of Clinical Training, Department of Psychology, Philadelphia College of Osteopathic Medicine

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

FAX to: Sue Dull, at 574-631-2103

Appendix H

Satisfaction and Evaluation Form

Topic Title: **A Cultural Competency Program for Psychologists: Clinical and Supervisory Practices with Latino Culture and Language**

Bruce Zahn, Ed.D, ABPP and Marie C. Weil, MA, LPC

Type of Contact Hours: \_\_\_ Psychologists \_\_\_ Counselors \_\_\_ Social Workers Other: \_\_\_\_\_

Participant's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

**EVALUATION TOOL**

We appreciate your help in evaluating this program. Please indicate your rating of the presentation in the categories below by circling the appropriate number, using a scale of 1 (Strongly Disagree), 2 (Disagree), 3 (Neutral), 4 (Agree), and 5 (Strongly Agree). Please fill out all 3 pages of this form:

**OBJECTIVES**

This program met the stated objectives of:

- |  |           |
|--|-----------|
| 1. Demonstrate knowledge of cultural competence to dimensions of Latino identity and cultural values   | 1 2 3 4 5 |
| 2. Demonstrate use of the <i>APA Multicultural Guidelines</i> to inform culturally competent ethical practice with Latinos                     | 1 2 3 4 5 |
| 3. Demonstrate assessment of multicultural supervision practices in review of case examples  | 1 2 3 4 5 |
| 4. Identify diversity initiatives to implement at the participant's institution  | 1 2 3 4 5 |
| 5. Describe culturally sensitive treatment adaptations for Latinos   | 1 2 3 4 5 |
| 6. Explain best practices for communicating with limited English proficient clients  | 1 2 3 4 5 |
| 7. List recommendations for use of interpreters in clinical practice   | 1 2 3 4 5 |
| 8. Apply recommendations for assessment of a bilingual client's language proficiency   | 1 2 3 4 5 |
| 9. Demonstrate how to use cultural assessments to determine the impact of the client's culture in a clinical context                           | 1 2 3 4 5 |
| 10. Explain the use of the <i>DSM-IV Outline for Cultural Formulation</i> for diagnosis and treatment planning with culturally diverse clients | 1 2 3 4 5 |

**CULTURAL COMPETENCY HOMESTUDY PROGRAM**

- 1. Was adequate and appropriate for psychologists 1 2 3 4 5
- 2. Was easily accessible on the website 1 2 3 4 5

**CONTENT**

- 1. Appropriate for intended audience 1 2 3 4 5
- 2. Consistent with stated objectives 1 2 3 4 5

**TEACHING METHODS**

- 1. Homestudy program, case examples, discussion questions, and video presentations clarified content 1 2 3 4 5
- 2. Teaching methods were appropriate for subject matter. 1 2 3 4 5

<b>PRESENTERS ON VIDEO (LINKS)</b>	Knowledgeable in Content area	Content consistent with objectives	Clarified content in the homestudy program
	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

**COMMENTS:**

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**RELEVANCY**

- 1. Information could be applied to practice 1 2 3 4 5
- 2. Information could contribute to achieving personal, professional goals 1 2 3 4 5

**POST-TEST**

- 1. Was adequate and appropriate for psychologists 1 2 3 4 5
- 2. Was easily accessible on the website 1 2 3 4 5
- 3. Was consistent with content and stated objectives 1 2 3 4 5

This program enhanced my professional expertise. \_\_\_ Substantially \_\_\_ Somewhat  
 \_\_\_ Not at all

I would recommend this program to others. \_\_\_ Yes \_\_\_ No \_\_\_ Not sure

**COMMENTS/PROGRAM IMPROVEMENTS:**

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I would like Philadelphia College of Osteopathic Medicine to provide programs or workshops on the following topics:

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**IN GENERAL**

Do you prefer:    \_\_\_half-day programs    \_\_\_full-day programs    \_\_\_multi-day programs

How much time do you need to respond to a program announcement?  
\_\_\_less than 1 month    \_\_\_4 to 6 weeks    \_\_\_more than 6 weeks

How did you learn about this program?  
\_\_\_brochure    \_\_\_supervisor    \_\_\_colleague    \_\_\_other

How far did you travel to attend this program?  
\_\_\_0-25 miles    \_\_\_25-50 miles    \_\_\_50-100 miles    \_\_\_over 100 miles

If you would like to comment in person, please feel free to call the Department of Psychology at 215-871-6442.

**Please fax this completed 3-page form to the Philadelphia College of Osteopathic Medicine, Department of Psychology at 215-871-6458. Your documentation of Attendance will be mailed to you.**

**THANK YOU.**

## Appendix I

## Satisfaction and Evaluation Summary

**A Cultural Competency Program for Psychologists: Clinical and Supervisory Practices with Latino Culture and Language**  
**Spring 2010, online <https://sites.google.com/site/culturalcompetencytraining/>**

**Presenters: Bruce Zahn, Ed.D., ABPP and Marie C. Weil, MA, LPC**

**Participants: 6**

Please indicate your rating of the presentation in the categories using a scale of 1 (*Strongly Disagree*) to 5 (*Strongly Agree*).

**OBJECTIVES**

**This program met the stated objectives of:**

1. Demonstrate knowledge of cultural competence to dimensions of Latino identity and cultural values ***M* = 4.33**

0%	Strongly Disagree	0%	Neutral	33%	Strongly Agree
0%	Disagree	67%	Agree		

2. Demonstrate use of the *APA Multicultural Guidelines* to inform culturally competent ethical practice with Latinos ***M* = 4.33**

0%	Strongly Disagree	17%	Neutral	50%	Strongly Agree
0%	Disagree	33%	Agree		

3. Demonstrate assessment of multicultural supervision practices in review of case examples ***M* = 4.17**

0%	Strongly Disagree	17%	Neutral	33%	Strongly Agree
0%	Disagree	50%	Agree		

4. Identify diversity initiatives to implement at the participant's institution ***M* = 3.83**

0%	Strongly Disagree	50%	Neutral	33%	Strongly Agree
0%	Disagree	17%	Agree		

5. Describe culturally sensitive treatment adaptations for Latinos ***M* = 4.5**

0%	Strongly Disagree	0%	Neutral	50%	Strongly Agree
0%	Disagree	50%	Agree		

6. Explain best practices for communicating with limited English proficient clients

0%	Strongly Disagree	0%	Neutral	50%	Strongly Agree
0%	Disagree	50%	Agree		<b><i>M</i> = 4.5</b>

7. List recommendations for use of interpreters in clinical practice ***M* = 4.83**

0%	Strongly Disagree	0%	Neutral	83%	Strongly Agree
0%	Disagree	17%	Agree		

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8. Apply recommendations for assessment of a bilingual client's language proficiency  
 0% Strongly Disagree      0% Neutral      50% Strongly Agree  
 0% Disagree      50% Agree      ***M* = 4.5**

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9. Demonstrate how to use cultural assessments to determine the impact of the client's culture in a clinical context  
 0% Strongly Disagree      17% Neutral      66% Strongly Agree  
 0% Disagree      17% Agree      ***M* = 4.5**

---

10. Explain the use of the *DSM-IV Outline for Cultural Formulation* for diagnosis and treatment planning with culturally diverse clients  
 0% Strongly Disagree      17% Neutral      50% Strongly Agree  
 0% Disagree      33% Agree      ***M* = 4.33**

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### CULTURAL COMPETENCY HOMESTUDY PROGRAM

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1. Was adequate and appropriate for psychologists  
 0% Strongly Disagree      0% Neutral      67% Strongly Agree  
 0% Disagree      33% Agree      ***M* = 4.67**

---

2. Was easily accessible on the website  
 0% Strongly Disagree      0% Neutral      67% Strongly Agree  
 0% Disagree      33% Agree      ***M* = 4.67**

---

### CONTENT

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1. Appropriate for intended audience  
 0% Strongly Disagree      0% Neutral      67% Strongly Agree  
 0% Disagree      33% Agree      ***M* = 4.67**

---

2. Consistent with stated objectives  
 0% Strongly Disagree      0% Neutral      67% Strongly Agree  
 0% Disagree      33% Agree      ***M* = 4.67**

---

### TEACHING METHODS

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1. Homestudy program, case examples, discussion questions, and video presentations clarified content  
 0% Strongly Disagree      0% Neutral      40% Strongly Agree  
 0% Disagree      60% Agree      ***M* = 4.4**

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2. Teaching methods were appropriate for subject matter  
 0% Strongly Disagree      0% Neutral      40% Strongly Agree  
 0% Disagree      60% Agree      ***M* = 4.4**

---

**PRESENTERS ON VIDEO (LINKS)**


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1. Knowledgeable in content area					<b><i>M</i> = 4.6</b>
0% Strongly Disagree	0%	Neutral	60%	Strongly Agree	
0% Disagree	40%	Agree			

---

2. Content consistent with objectives					<b><i>M</i> = 4.4</b>
0% Strongly Disagree	0%	Neutral	40%	Strongly Agree	
0% Disagree	60%	Agree			

---

3. Clarified content in the homestudy program					<b><i>M</i> = 4.4</b>
0% Strongly Disagree	20%	Neutral	60%	Strongly Agree	
0% Disagree	20%	Agree			

---

**COMMENTS:**

- I felt some of the videos were superfluous – they hammered in material already addressed in the homestudy program.
- Frank Lu’s hr related to cultural formulation model was very thorough; he also included resources in his talk. Background info in other segments very clear and understandable.
- This was an excellent program and the videos were well chosen. It made me review some aspects (*DSM IV TR*) and introduced me to new material and references. I will definitely review and use in my practicum training.

**RELEVANCY**


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1. Information could be applied to practice					<b><i>M</i> = 4.2</b>
0% Strongly Disagree	0%	Neutral	20%	Strongly Agree	
0% Disagree	80%	Agree			

---

2. Information could contribute to achieving personal, professional goals					<b><i>M</i> = 4.6</b>
0% Strongly Disagree	0%	Neutral	60%	Strongly Agree	
0% Disagree	40%	Agree			

---

**POST-TEST**


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1. Was adequate and appropriate for psychologists					<b><i>M</i> = 4.2</b>
0% Strongly Disagree	0%	Neutral	20%	Strongly Agree	
0% Disagree	80%	Agree			

---

2. Was easily accessible on the website					<b><i>M</i> = 4.6</b>
0% Strongly Disagree	0%	Neutral	60%	Strongly Agree	
0% Disagree	40%	Agree			

---

---

3. Was consistent with content and stated objectives				<b>M = 4.4</b>
0%	Strongly Disagree	0%	Neutral	40% Strongly Agree
0%	Disagree	60%	Agree	

---

This program enhanced my professional expertise				
60%	Substantially	40%	Somewhat	0% Not at all

---

I would recommend this program to others				
100%	Yes	0%	No	0% Not sure

---

**COMMENTS/PROGRAM IMPROVEMENTS:**

- Maybe a time frame expected for each module would be helpful. More emphasis, or further training, on anthropological psychology issues for various cultures would be helpful.
- Excellent. Should be “marketed” to a wide group of psychologists.
- Good. Give suggested exercises that one can do within the homestudy to continue with skill development or knowledge building – for instance Lu’s video gave good websites/reading resources etc.
- It was quite good. Perhaps some feedback and model answers when asked about specific cases within material. I liked Lu’s video.

**I would like Philadelphia College of Osteopathic Medicine to provide programs or workshops on the following topics:**

- See above.
- Subtopics related to multicultural work for instance ethnopharmacology, major differences in family concepts, values re: counseling, couples, and therapy etc. with role of psychiatry.
- Supervision styles.

**IN GENERAL**

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1. Do you prefer:				
33%	half-day programs	67%	full-day programs	0% multi-day programs

---

2. How much time do you need to respond to a program announcement?				
17%	less than 1 month	50%	4-6 weeks	33% more than 6 weeks

---

3. How did you learn about this program?				
0%	brochure	0%	supervisor	50% colleague 50% other

---

4. How far did you travel to attend this program?				
100%	0-25 miles	0%	25-50 miles	0% 50-100 miles 0% over 100 miles