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Multicultural Training of Clinical and Counseling Psychology Doctoral Students: Ideals vs. Practice

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MULTICULTURAL TRAINING OF CLINICAL AND COUNSELING PSYCHOLOGY
DOCTORAL STUDENTS: IDEALS VS. PRACTICE

BY

BRYANA F. C. WHITE

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE
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ABSTRACT

The American Psychological Association (APA), which is the advocating body for the field of psychology, emphasizes the importance of multicultural competencies for researchers and clinicians (APA, 2003; 2010). Graduate students are the field's future professionals. The multicultural training of doctoral level clinical and counseling psychology graduate students is integral to efforts to improve clinical services and the research that provides the foundation for those services. While the literature addresses issues of multicultural competence and training in a general way, few specifics regarding the methods employed by graduate programs to aid their students in the process of developing those competencies are explored.

This study is a survey of doctoral programs. It was hypothesized that many training programs acknowledge the importance of multicultural training but fall far short in their efforts to provide students with sufficient training. Additionally, it was hypothesized that doctoral students who identified their programs as highlighting multicultural competence would have greater multicultural self-efficacy. Graduate students' self-perceived multicultural competence was associated with a number of program training methods. Although analyses yielded clear differences in guidelines and standards adherence between program types, all participating training directors reported that multicultural issues are incorporated into their program training methods. As anticipated, many programs did not directly address multiculturalism and diversity in their training materials. Descriptive information about multicultural training methods, reflection on exemplary training methods, and recommendations for training initiatives are provided.

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PREFACE

In 2008, while riding a train back from a conference in New York, NY during which I had discussed the importance of considering multicultural issues when working with incarcerated adolescents, I reflected on the audience's overwhelmingly positive response to my presentation. I emphasized that the consideration of clients' background and culture facilitates effective treatment. The questions and comments that followed my presentation suggested that they had not previously thought much about such considerations. This struck me as odd. As a person of color as well as a clinical trainee, I was aware of the ways in which non-dominant group membership (in any capacity) impacts the experiences of individuals. I realized that the audience's response was mirrored by my training. I had received little encouragement to address issues of culture in my early clinical training. Only when I took the initiative to consult the literature and raise issues of culture in supervision and at case conferences, did these factors become integrated into my training.

However, taking this initiative was often met with resistance and resentment. My fellow graduate trainees of color had similar experiences. Our recognition of the relevance of cultural factors was substantiated by both our individual experiences and the literature. We realized that engaging in clinical work with underserved and underrepresented populations although helpful, was not in and of itself sufficient for our training. Our broad interest in the interplay between multicultural factors and mental health outcomes did not equate to multicultural competence. Reflecting on my experiences, I decided on this train ride, that I would use my dissertation as a means of investigating specific training issues in other clinical and counseling

programs. I would thoroughly review the literature around multicultural competencies and related training, and provided recommendations based on my findings. It is and was my hope that my dissertation would help me to develop the expertise I lacked during my early training and contribute to a better understanding of what is required to prepare clinicians and trainees to better serve culturally diverse clients.

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CHAPTER 1

INTRODUCTION

The American Psychological Association (APA), which is the advocating body for the field of psychology, emphasizes the importance of multicultural competencies for researchers and clinicians (APA, 2003; 2010). Graduate students are the field's future professionals. The multicultural training of doctoral level clinical and counseling psychology graduate students is integral to efforts to improve clinical services and the research that provides the foundation of those services. While the literature addresses issues of multicultural competence and training, few specifics regarding the methods employed by graduate programs to aid their students in the process of developing those competencies are explored. This study is a survey of doctoral programs. It was hypothesized that many training programs acknowledge the importance of multicultural training but fall far short in their efforts to provide students with sufficient training. Additionally, it was hypothesized that doctoral students who identified their programs as highlighting multicultural competence would have greater multicultural self efficacy than those whose programs did not emphasize the importance of multicultural competence. Descriptive information about multicultural training methods, reflection on exemplary training methods, and recommendations for training initiatives are provided.

Major Assumptions

Among the major assumptions that serve as premises upon which this study is based are the following:

1. The United States is racially and ethnically diverse and clinical populations are reflective of this diversity (APA, 2003). As such it is necessary for those entering the field be thoroughly trained to provide culturally appropriate treatment for all clients and to engage in scholarly work regarding issues related to multiculturalism.
2. Multicultural psychology is not just a specialty area. It needs to be generalized across work with diverse clients and participant groups. According to Sue and Torino (2005),

“Multicultural counseling and therapy can be defined as both a helping role and process that uses modalities and defines goals consistent with the life experiences and cultural values of clients, recognizes clients identities to include individual, group, and universal dimensions, advocates the use of universal and culture-specific strategies and roles in the healing process, and balances the importance of individualism and collectivism in the assessment, diagnosis, and treatment of client and client systems.”

3. Included under the umbrella term, “multicultural” are factors including race, ethnicity, sexual orientation, gender, religion, physical ability, socioeconomic status, geographic region, and other individual differences that impact the human experience and as such are relevant to psychological functioning (Owens & Khalil, 2007).

American Psychological Association Guidelines and Association for Multicultural Counseling and Development Standards

The American Psychological Association (APA) is often the vehicle through which practitioners and researchers collaborate to establish guidelines that aid psychologists in their work (APA, 2013). In 2002, the APA approved the Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists. Contributors to the document established six multicultural guidelines for education, training, research, practice, and organizational change. The first guideline instructs psychologists to be aware of the influence that culture, attitudes, and beliefs have on interactions with people who are ethnically and racially different from themselves (Smith, et al. 2008). The second guideline highlights the importance of cultural sensitivity, responsiveness, knowledge and understanding about different ethnic and racial groups. The third guideline outlines the importance of incorporating multiculturalism and diversity into education. The fourth guideline suggests that psychologists conduct culture-centered and ethically based research practices among minority groups. The fifth guideline emphasizes the importance of culturally appropriate clinical skills. The sixth and final guideline encourages psychologists to actively pursue policy changes that increase the cultural sensitivity at the organizational level (APA, 2003).

The Association for Multicultural Counseling and Development (AMCD) has endorsed 31 specific competencies (see Appendix V) to aid psychotherapists in the provision of culturally sensitive services (Cartwright, et al., 2008). The 31 competencies are outlined under the following broad competency areas: 1)

Counselor awareness of personal cultural values and biases, 2) Counselor awareness of client's worldview, and 3) culturally appropriate intervention strategies. Under the first two broad areas, specific competencies and objectives are provided under the headings of "attitudes and beliefs" and "knowledge." The third area (interventions) includes particular "skills" (Sue, et. al., 1992). Both the APA multicultural guidelines and the AMCD multicultural competencies and standards are especially relevant to this study. The perpetuation of high standards (if followed) that ensure the best care for clients and the solidity of empirical studies that inform clinical treatment depends on the quality of graduate training (Green, 1998). Trainees who experience multicultural activities including personal experiences with diversity and exposure to people who are culturally different, report higher levels of multicultural awareness, knowledge, and skills (Carlson, et al., 1998). Additionally, multicultural training increases clinician's self report of multicultural competencies (Smith, et al. 2008). Despite the positive impact of personal experiences with diversity and multicultural training on self-perceived multicultural competence, Implicit bias has been evidenced by therapists in training who believe themselves to be multiculturally competent (Boysen & Vogel, 2008). These findings support the need for training that targets the first guideline, so that clinicians in training may engage in exploration of the role that their beliefs about others play in their therapeutic interactions.

Resistance to Multicultural Competence

Despite organizational support within the field of psychology, there is some resistance to the concept of multicultural competence. According Sue et al. (2009), resistance to cultural competence takes the form of four main arguments. The first argument is based on a concern that emphasizing multicultural competence encourages therapists (and those in training) to stereotype ethnic minority group members. From this perspective clinicians are discouraged from learning about specific groups and integrating that knowledge into treatment plans. However, research suggests that culture-centered practices help to reduce stereotypes (Fouad, 2006). Knowledge about cultural differences may be prevented from developing into stereotypes if it is coupled with an awareness of individual differences within groups and a sense of humility with regard to our limited capacity to know all things about those who are different from ourselves.

The second source of resistance to cultural competence is the belief that advocating for multicultural competence for ethnic minority groups results in the neglect of other aspects of diversity such as sexual orientation, gender, and social class (Sue et al., 2009). Multicultural competence requires addressing all aspects of identity. Culture and other aspects of client background are not mutually exclusive contexts for therapeutic work. Sue et al. (2009) identify the two remaining sources of resistance to cultural competence as concerns regarding overemphasis of external factors (e.g. racism) and the fear of creating hostility among groups by addressing multicultural issues.

Clinicians who work with marginalized groups must be trained to recognize the psychological effects of systemic oppression and racism (Toporek, & Pope-Davis, 2005). Clinical literature regarding the negative effects of racism and oppression based on cultural differences suggests that clients of color are negatively affected by external sources of discrimination (Smith et al., 2008; Tougas, Desruisseaux, Desrouchers, St. Pierre, Perrino, and Del La Sablonnier, 2004). Thus, it would seem that raising awareness of external factors influencing racism and facilitating a client's ability to cope with such factors should when indicated, be a component of treatment. It should be noted that multicultural competence does not require therapists to uniformly bring culture to the forefront of the therapeutic process. Rather, competence requires that therapists have the awareness, knowledge and skills to identify and appropriately address issues related to gender, sexual orientation, religion, culture, ethnicity, race, and related external stressors only when such factors are relevant to their work with specific clients.

An additional source of resistance is the fear that addressing multicultural competence will lead to hostility among practitioners. Specifically, Sue et al. (2009) note that practitioners have expressed concern that should they refuse to employ culturally competent practices, they will be labeled as "racist" or "ethnocentric." Many practitioners may be uncomfortable with addressing cultural differences (APA, 2003; Gushue and Constantine, 2007; Reeves, 2000). However, given the literature that supporting multicultural awareness, knowledge, and skills in clinical training and work it is clear that ethical provision of services requires practitioners to move

beyond personal discomfort (Park-Taylor, Kim, Budianto, Pfeifer, Laidlaw, Sakurai, & Pfeifer, 2009).

With the increasing diversity in the United States comes the responsibility of psychologist to adapt their practices to diverse populations. The guidelines illustrated by the APA are not mandates; rather they are recommendations that articulate the values of the organization (APA, 2003).

Ethical Implications

A number of sections of the APA's Ethics Code address issues of cultural competence. Specifically Standard 2 of the code entitled "Competence" notes that psychologists may only ethically practice within the boundaries of their competence. An understanding of the implications of race, ethnicity, culture, and national origin is identified as a requisite for effective implementation of services (APA, 2011).

As culture significantly impacts the lives of consumers of psychological services, multicultural competence is required to meet the principles of beneficence and nonmaleficence (Principle A), fidelity and responsibility (Principle B), Justice (Principle D), and respect for people's rights and dignity (Principle E). To serve all clients well and avoid inflicting harm, treatment must be tailored to their individual needs. Addressing external factors such as racism, sexism, heterosexism, and other forms of oppression is imperative and developing the cultural awareness, knowledge, and skills needed to appropriately address presenting problems requires consideration of multicultural factors. Clinicians are responsible to their clients and training programs are responsible to their students. Researchers are required to produce work that accurately reflects and informs service of the population.

Fulfilling this responsibility includes engaging in competent practices and training future clinicians and researchers to be multiculturally competent. There are innumerable race-based healthcare inequities; in the interest of justice, psychologists must provide the most appropriate treatment to clients from all cultural backgrounds (Sue et al., 2009). The diversity-related components of the APA Code of Ethics and Standards of Practice should in fact also be generalized to other marginalized populations based on individual factors outside of culture such as sexual orientation (APA Division 44, 2000). Clients must be treated as fully human; which requires honoring of all aspects of their identity.

The APA's Ethics Code Principle E (Respect for People's Rights and Dignity) associates respect with an appreciation for culture, and highlights the danger of failing to competently address culture (APA, 2010). Similarly, the American Counseling Association (ACA) emphasizes the importance of understanding clients from diverse cultural backgrounds (ACA, 1995). The intent of the present study is to survey doctoral level counseling and clinical psychology programs that have been accredited by the APA to determine how they provide graduate students with multicultural training.

Defining and Demonstrating Multicultural Competence

The guidelines established by the APA broadly address areas of multicultural competencies. Cultural competence is an active process rather than a finite goal. It requires three specific but interrelated dimensions. Sue and Sue (2008) identify a) awareness of personal assumptions about human behavior, values, biases, preconceived notions, and personal limitations b) efforts to understand the world

views of culturally different clients, and c) constantly evolving efforts to develop and practice appropriate, relevant, and sensitive intervention strategies and skills in working with culturally different clients. Multicultural competence may be defined as follows:

Cultural competence is the ability to engage in actions or create conditions that maximize the optimal development of client and client systems. Multicultural counseling competence is defined as the counselor's acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds), and on a organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups.

(Sue & Torino, 2005)

Case example. Often the consideration of multicultural factors and adherence to APA and AMDC guidelines and standards is discussed as an ideal. Illustrations of the ideals in practice are often the best means of highlighting the importance of the the cultural context when providing clinical services. The following case example from this researcher's clinical training is an illustration of multiculturally competent clinical practice.

Background. Few clinical settings are as racially and ethnically diverse as the United States prison system. Unfortunately, ethnic minority group members are disproportionately represented in prisons (Brown, Carney, Currie, Duster, Oppenheimer, Shultz, & Wellman 2003). This 16 year old, Cape Verdean, male presented with symptoms of depression and oppositional defiant disorder and was referred to individual psychotherapy for anger management and behavioral problems. These presenting problems led to the client's residence in a juvenile

detention center. Some of the details of this case included below are purposely vague to insure confidentiality.

Awareness. The first step in my attempt to provide the most culturally appropriate, evidenced-based services required becoming aware of my biases and limited knowledge related to the setting and the clients with whom I would work. I reflected on my biases about the prison system. One prejudice I held regarding the imprisoned was the belief that generally people who are in prison are there because they committed a crime. This is a value judgment that might have affected the care that I would provide. I worked to reframe this judgment and came to the conclusion that my personal and professional value of providing equitable care superseded the importance of guilt. People who experience psychological distress deserve psychological services regardless of their culpability.

I also explored my race-related perceptions of the prison system and found that as an African American woman, based on my own experiences of racism, and given my academic coursework related to race discrimination, power, and privilege I had a sense of the prison system as an institutional representation of the systematic disadvantaging of and racism toward people of color. I explored the relationship between my assertion that individuals who commit crimes go to prison, and my theories on why they commit crimes as well as the circumstances that facilitate crime (e.g. disenfranchisement, lack of access to resources, and experiences of oppression). I considered the possible implications of this belief and decided that it would facilitate rather than hinder the quality of care I would provide given that it was substantiated by sociological and psychological research and it would provide a

framework for understanding the current predicament of my clients. In particular, it would enable me to empathize with clients and to help address factors that would be relevant to preventing recidivism once they were released back into the community.

Knowledge. Prior to beginning my work at the adolescent detention facility, I worked to increase my multicultural knowledge about incarcerated adolescents, their presenting problems, and related evidence-based treatments by engaging in a review of the available literature. I found that among the psychological concerns of incarcerated adolescents are anxiety, depression and other mood disorders, oppositional defiant disorder, substance abuse, adjustment disorder, eating disorders, somatoform disorders, familial concerns, financial pressures, and issues related to identity development (Bell, 2006). I also found research that indicated that cultural contexts that should be considered when engaging in work with incarcerated adolescents include a) the client's family culture and home environment, b) demographic factors such as race, ethnicity, primary language, gender, socioeconomic status, sexual orientation, and religion (Harmon, Langley, & Ginsburg, 2006), (c) the client's family structure and role within that structure, d) the culture of the detention center, e) the client's self perception (Rodriguez, Umana-Taylor, Smith, & Johnson, 2009), f) the client's values and treatment goals, and g) the client's perception of the therapist and the therapeutic process. Additionally, the available literature noted that given differences in symptom expression between people of different backgrounds, the cultural context must be considered when treating diverse clients (Harmon, Langley, & Ginsburg, 2006; Langhinrichsen-

Rohling, Friend, & Powell, 2009). All of the aforementioned literature aided both case conceptualization and the treatment planning.

Skills. During the initial sessions with this client, I worked to learn about who he was and what he hoped to gain from therapy. I solicited his narrative, which provided me with information about the values that were the foundation for his behaviors. His narrative also provided me with information about how he judged others, how he measured success, how he felt about family members, as well as the relationship of the aforementioned factors to Cape Verdean culture. I asked specific questions about how he felt about his current situation (being incarcerated) and about what he wanted for his future. I learned that this client grew up in a single parent household and struggled with issues related to masculinity. His role within his household was to serve as the “man in the house” for his mother and siblings. He identified his role as a caretaker as being a culturally-based role that he took on with pride, during middle school. He felt significant pressure to assert his masculinity both within and outside of his household, leading to anger-related behavioral problems based on his need to be “the man.” In turn he felt threatened by all of his mother’s partners (in terms of their potential to replace him as the male household head) and resented what he viewed as their attempts to “be his father.” He also struggled with the knowledge that his father was alive and well, living in Cape Verde without him. Throughout sessions he professed to be unaffected by his father’s absence, often denigrating him out of hurt and anger for his failure to serve as a role model for him. He resented being imprisoned but acknowledged his behavior as the reason for his incarceration.

Clinical implementation of awareness, knowledge, and skills. The above conceptualization was helpful in understanding my client's worldview. It helped me to tailor cognitive behavioral and interpersonal interventions to fit his belief system. Having the knowledge of this client's background helped me to respect his values and find pro-social interpretations of masculinity (e.g. serving as a role model to his siblings by being able to cope appropriately with his emotions rather than engaging in violence to show his peers that he "can't be messed with"). Related to his emphasis on being powerful and masculine, his symptoms of depression were primarily expressed through anger toward the people around him. Learning to recognize his emotions and exploring them in a safe space (where he would not be judged as less masculine) was helpful in reducing his symptoms. Once his mood improved, his irritability and related behavioral outbursts decreased. He also became better able to conceptualize his relationships with others through discussions about his values (e.g. we spoke about his difficulty trusting women related to his sense of his mother as being unstable and untrustworthy).

Throughout the course of our 24 sessions, we were able to address the psychosocial factors that were related to his everyday stressors. Specifically, discussing racial and class-based inequities helped him to understand why "people in his neighborhood" were more likely to turn to illegal means of making money and more likely to be discovered and penalized for such behaviors. He was able to move from being angry about his situation to understanding the roots of his reality. He was able to establish goals for the future, as well as identify potential obstacles while working to develop contingency plans in preparation for his release from the

juvenile detention center. Taking into account his cultural context facilitated our therapeutic alliance, allowing us to more fully understand his presenting problems, and to adapt my clinical skills to best meet his needs.

Training Models from the Existing Literature

An urban counseling psychology department training model. Since the publication of the 2003 APA guidelines, there has been extensive discussion of multicultural competencies. However, there continues to be a relative lack of literature focusing on the role of training programs (Green, 1998). In one of the few attempts to evaluate multicultural training, Fouad (2006) engages in an evaluation of her urban counseling psychology doctoral program's efforts to train practitioners, researchers, and teachers. She addressed the following seven components of multicultural guideline implementation at her institution: a) explicit commitment to diversity, b) active recruitment and retention of diverse students, c) retention and recruitment of diverse faculty, d) equitable admissions, e) aiding student in the development of relevant awareness, knowledge, and skills, f) culture-centered courses and curricula, and g) annual evaluation of cultural competence. Fouad suggests that the program's efforts to address these seven components into its organizational structure reflects successful adherence to APA Guidelines 3 and 6 which call psychologists to incorporate considerations of culture in education work toward systemic change (APA, 2003).

Fouad reports that her program articulates its commitment to multiculturalism explicitly in all program materials (e.g. web sites and brochures). The program's efforts to retain graduate students from diverse populations have

been successful; all graduate students of color have graduated. Recruitment efforts are passive and include advertising their multicultural training efforts and research opportunities in program material. One third of their graduate students are people of color but that group is relatively homogenous as it is comprised of African Americans (50%) and Asian or Asian Americans (50%). The program recruits persons of color for faculty position but has had little success. Fouad suggests that increased funding for pipelines (e.g. postdoctoral positions) would aid this effort. Retention is facilitated by the departmental and campus-wide mentoring programs as well as the positive climate for diversity on campus. Faculty research interests are consistent with the program's commitment to diversity. The program's admission processes (which are outlined for applicants to promote transparency) are fair and meet standards for the field.

Fouad's program requires all students to engage in clinical work with ethnically diverse clientele and has practicum placements at a number of community mental health centers. The program provides required proseminars to infuse diversity into all aspects of their curriculum, meeting weekly and covering topics such as diagnosis, interviewing, specific therapy modalities, and psychotherapy research. These proseminars address issues of culture that are related to each topic area. While the program infuses culture-centered approaches into core courses, there is no examination of foundation and research courses for multicultural content. The program does require students to provide annual self-evaluation of multicultural skills. Specifically students are required to outline clinical accomplishments with diverse clients, and multicultural knowledge is measured by preliminary exams and

supervisor evaluations. Nevertheless, as Fouad notes that neither student cultural awareness nor cultural competence of supervisors is assessed.

Strengths and limitations. As the Director of Training, Fouad is invested in the reputation of her program so her role in the program may limit the objectivity of the report. On the other hand a program a Training Director may having the most intimate knowledge of a program be in the most appropriate position to summarize and evaluate its training methods. Additionally, Fouad highlights both the successes and limitations of the program's multicultural training efforts. Despite the admitted limitations it would seem that in terms of prioritizing multiculturalism, infusing it into the curriculum, and providing practical experiences for graduate students, this program is exemplary. The self-reflective nature of Fouad's article is a model for other programs. It is important for programs to model the self-awareness that they encourage in graduate trainees.

The brookline community mental health center multicultural training model. Although many gradate students will be exposed to a great diversity in client population during practicum placements at community mental health centers, there are not many generalizable multicultural training models employed at fieldwork (Park-Taylor et al., 2009). Park-Taylor and colleagues (2009) outline the reflective practice methods employed at the Brookline Community Mental Health Center (BCMHC) in their multicultural training efforts. This training model encourages learning through reflection, experience, and building relationships. Within the framework of this model, reflection is defined as the process of examining past experiences, theories, beliefs, and assumptions. Graduate trainees engage in a

metacognitive exploration through which they assess their assumptions. They discuss issues of power and privilege, identities, and significant world events, with the goal of establishing more accurate and culturally informed theories, beliefs, and assumptions that will be reflected in improved clinical experiences.

At the BCMHC, reflection is practiced in diversity teams led by supervisors. These teams meet on a biweekly basis and serve to support individuals in their reflective process. Participation in the diversity teams is optional and the group collaboratively establishes the agenda for the year. Confidentiality, openness, and respect are cornerstones of the group's functioning. The meetings provide individual trainees with the opportunity to a) gain awareness through exploration, b) improve sensitivity and responsiveness to others, and c) improve knowledge and understanding about others. Often, the topics discussed result in panel discussions by other members of the center. Thus the organization as a whole engages in the reflective process and supports multicultural training. APA Guidelines 1, 2, and 6 are met by this practice.

Experiential learning at the BCMHC takes place within the context of different cultural groups within the local community. In addition to completing work at the center, trainees participate in multicultural teams that provide services that meet the specific needs of the group with which they work. Team members learn about the culture-specific needs of various populations by meeting with school administrators, teachers, and guidance counselors. They address issues that are pertinent to specific groups of children in local schools. The multicultural teams address culturally appropriate practice and organizational change (APA guidelines 5 and 6).

In the biweekly meetings, trainees build relationships with each other and with supervisors through open personal dialogues, during which honest, challenging self-examinations are encouraged. Additionally, supervisors model engaging in self-reflection. Working alliances with peers, supervisors, and other clinicians at the center, as well as with those at local schools and community centers provide trainees with further opportunities to enhance their multicultural competence (Park-Taylor et al, 2009).

Strengths and limitations. A pilot assessment of the reflective training model at the BCMHC's reflective training model suggests that the multicultural competence of graduate students improved as a result of this training model. Overall, this approach seems to meet the multicultural training needs of graduate students. Especially important is the modeling that occurs on the part of supervisors and the openness of the organization. The model attends to APA Guidelines. As it is outlined by Park-Taylor et al., (2009) their training model could be implemented in other settings including graduate programs by facilitating diversity and multicultural teams into courses accompanying practicum experiences.

Although the program seems to be a comprehensive means of facilitating the development of multicultural competence, some limitations including sample size (N=19) are apparent. For example, failure to group students by level of awareness in terms of the diversity teams may result in frustration on the part of those who are more culturally aware. The pilot assessment revealed that at least one graduate student of color felt burdened by the fact that participants in the training experience were at "very different places." Supervisor and client ratings of multicultural

competence before and after graduate students complete their training process would help to evaluate the model's effectiveness.

Multicultural Competence

Despite the limited number of empirical evaluations of training programs, there has been substantial exploration of the relevance of the competencies that programs hope to impart. In a review of twenty years of literature on multicultural competencies up through the year 2005, Worthington et al. (2007) summarized a number of characteristics relevant to multicultural competencies. They found that out of the 81 studies, 90.1% of articles were quantitative, 4.9% were qualitative, and the remaining 4.9% employed mixed-methods. The majority of the studies of cultural competency (72.7%) used survey methods, with some focusing only on counselors (35%), and others on trainees (27.2%) or clients (21%). Green (1998) suggests that programs may work toward preparing multiculturally competent clinicians by including didactic training, sensitization, personal contact, supervised clinical experiences, and modeling competency through organizational structure.

In 2006 Hansen et al. surveyed a random sample of 149 professional psychologists whose names were furnished by the APA Research Office. The first goal of the study was to explore the relationship between commonly held practitioner beliefs and level of multicultural competency. The second was to determine whether doctoral level psychologists engage in culturally responsive professional behaviors. Participants completed a demographic questionnaire, the Multicultural Practices and Beliefs Questionnaire (Hansen, 2006), and the Multicultural Social Desirability Scale (Sodowsky, et al., 1998).

Hansen et al. found that 35% of the participants developed multicultural competencies by receiving supervision related to diverse cases, 24% completed diversity internships, 18 % of the professional psychologists attended continuing education seminars, 17% cited their work with minority clients while 13% indicated the importance of completing relevant course work. However, significant discrepancies between beliefs about the importance of multicultural factors and actual practices were found. Half of the participants reported that they rarely prepared a culturally informed DSM-IV-TR diagnosis. Moreover, participating psychologists infrequently made efforts to improve multicultural competencies using the following methods: a) implementing a specific plan, b) seeking consultation, c) augmenting treatment with literature, translators, or indigenous healers, d) referring clients to more qualified providers, or e) using sensitive data gathering techniques.

While seasoned professionals stated that they learned the most from practical experience, early career psychologists felt that they developed multicultural competencies best as a result of supervision and didactic experiences. In the present study, there is an exploration of the self-perceived level of multicultural competence of doctoral students relative to their articulation of the aforementioned aspects of training. Irrespective of what they felt led to their development of their multicultural awareness, knowledge, and skills, the Hansen et al. (2006) findings suggest that psychologists frequently fail to engage in culturally responsive practices. Henriksen and Trusty (2005) address the utility and ethical nature of incorporating multiculturalism into all counseling course and practical work. They suggest that multicultural pedagogy may only facilitate the development of competencies when

educators, supervisors, and trainees jointly value diversity. Among other factors, the present study evaluates the extent to which training programs articulate a valuing of diversity in their program materials. Hopefully an evaluation of the consistency between current training program methods, APA guidelines and AMCD competencies, as well as relevant literature will result in the development of more efficacious multicultural training models, in turn leading to an improvement in both clinical services and research.

CHAPTER 2

METHOD

Participants

This study reviewed and approved by the University of Rhode Island Institutional Review Board (IRB); the IRB Chair or Director of Compliance determined that the present study falls in the exempt review category according to federal regulations. The participants for this study were doctoral clinical and counseling programs, their training directors, and students. The accredited counseling and clinical doctoral programs listed in the APA web page (APA, 2010) was used to recruit participants. E-mail addresses for training directors were retrieved from program webpages. E-mails requesting participation were sent at three different time-points. All Training directors received the first e-mail to solicit participation in the study. One month later, those who did not reply to the first e-mail were sent a second request to participate. Finally those who did not respond to either the first or second e-mails were sent a third solicitation e-mail one month after the second e-mail had been sent. Training directors and students who chose to participate completed a consent form indicating their understanding of the process and purpose of the present study and their willingness to participate (Appendix I). All program directors were asked to complete relevant questionnaires and to forward the survey link to their trainees. Participating students and programs were assigned random identification numbers. Participants were not asked to provide their names or the name of the program with which they were affiliated.

Data Cleaning Process

Participants who consented, identified themselves as either a training director or graduate student, but did not complete any other portions of the survey were eliminated (1 training director and 73 students). As a result of the data cleaning process, the final sample for this study consists of 169 graduate students, 38 Training Directors, and 307 training programs.

Training directors. Of the thirty-eight training directors, 36.8% were male (n=14), 60.5% female (n=23), and 2.6% chose not to endorse a gender (n=1). Training directors ranged in age from 38 to 72 years of age. The majority of the training directors (89.5% n =34) identified as White or European American, 5.3% (n=2) as Hispanic/Latino or Hispanic/Latino American, 2.6% (n=1) as Black or African American, and one training director chose not to endorse any racial or ethnic background (See Figure 1).

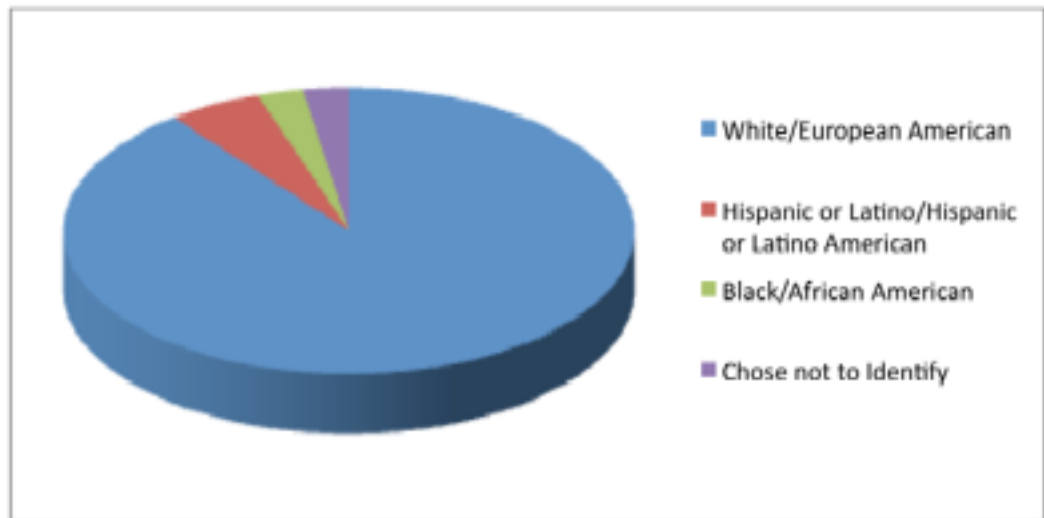


Figure 1: Training director racial/ethnic backgrounds

Figure 1 reflects the racial/ethnic composition of Training directors participant group.

Doctoral students. The graduate student group was more diverse than that of the training directors. The graduate student participants were overwhelmingly female (89%, n=151), 10% being male (n=17), and 1 participant chose not to endorse a gender. Students ranged in age from 20 to 43 with a mean age of 26.73. Asian or Asian Americans comprised 7.1% (n=12) of the participating students, 5.9% (n=10) Black or African American, 3% (n=5) Hispanic/Latino or Hispanic/Latino American, 0.6% (n=1) Native American, with the majority 78.1% (n=132) White or European American, and 4.1% (n=7) mixed heritage, with 1.2% (n=2) choosing not to identify their background (See Figure 2).

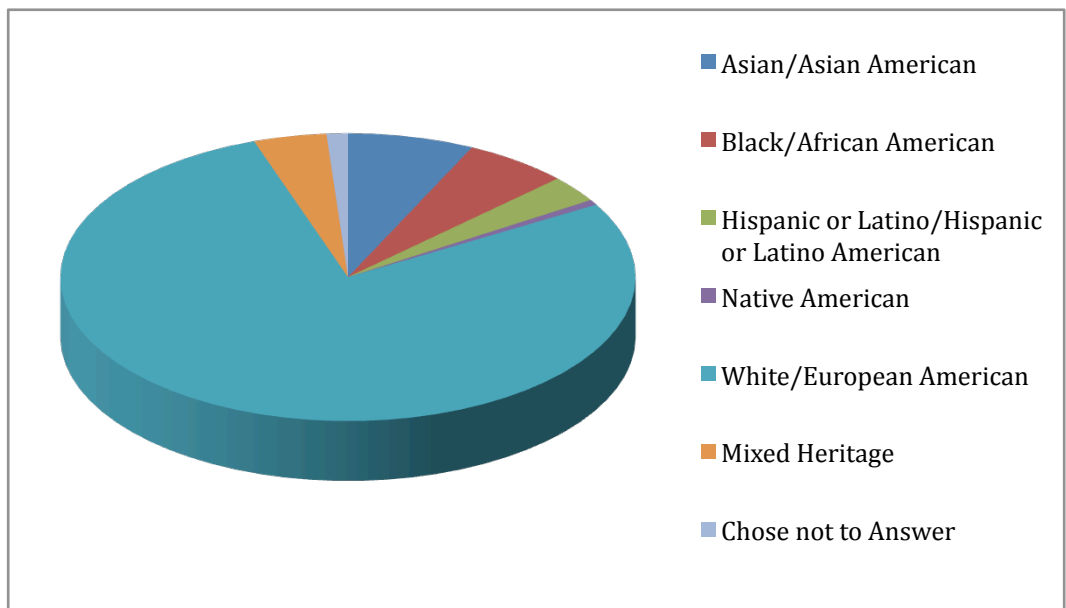


Figure 2: Doctoral student racial/ethnic backgrounds

Figure 2 reflects the racial/ethnic composition of the doctoral student participant group.

Training programs. Three hundred seven APA accredited, doctoral, clinical and counseling programs were reviewed. Both doctor of psychology (Psy.D.) and doctor of philosophy (Ph.D) granting programs were included in the sample. The majority were clinical Ph.D. programs (57.3%, n=176), 21.2% (n=65) grant PhDs in

counseling psychology, 19.9% (n=61) are clinical Psy.D. programs, 1.6% (n=5) grant Psy.D.s in counseling psychology (See Figure 3).

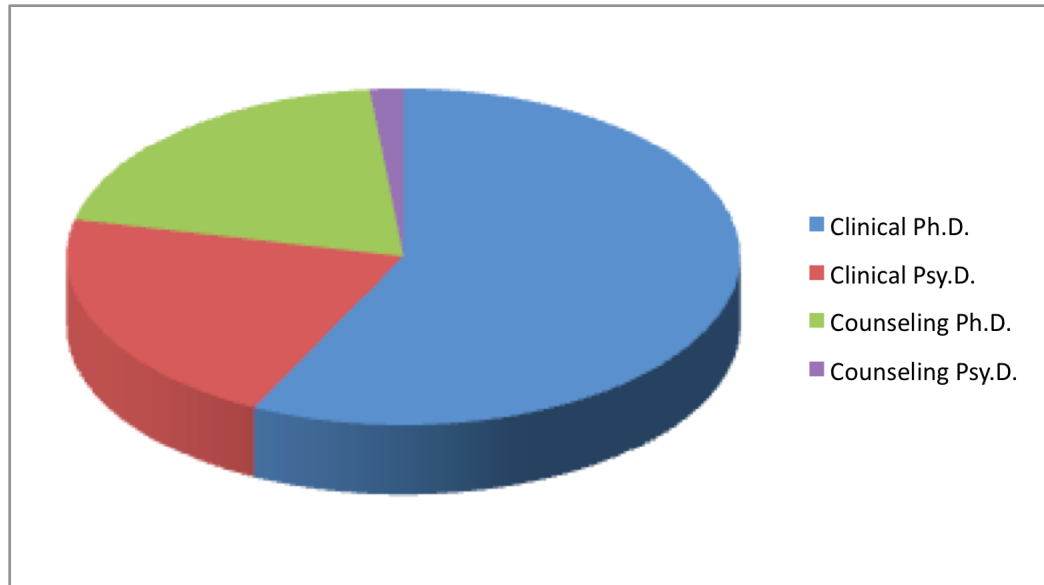


Figure 3: Training program categories

Figure 3 represents the breakdown of clinical and counseling psychology doctoral programs included in the program review by program type.

The training programs are located across a number of regions within the United States; 28.3% (n=87) of the programs are located in the Mid-West, 28.3%(n=87) are in the South, 20.8% (n=64) of the programs are in the West, and 18.2% (n=56) of the programs are in the North-East. The remaining programs are located in the following areas: 3.3% (n=10) in Canada, 0.7%(n=2) in Puerto Rico, and 0.3% (n=1) in the North-East Caribbean (See Figure 4).

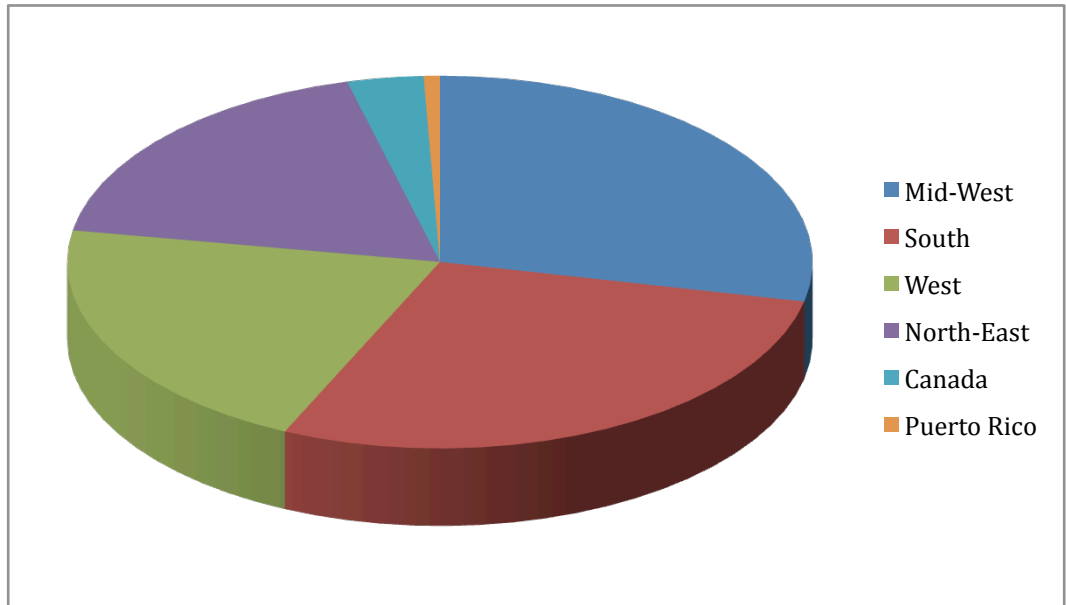


Figure 4: Training program locations

Figure 4 reflects the geographic regions in which training programs included in the review are located.

Hypotheses

A major goal of this study was to determine the extent to which training program methods are consistent with APA guidelines and AMCD standards, as well as with the literature regarding multicultural competencies. The hypotheses of this study are as follows:

1. Inconsistency is anticipated between the areas outlined in APA and AMCD guidelines and standards and the areas of multiculturalism addressed by training programs.
2. Graduate students from programs that emphasize APA and AMDC guidelines are expected to exhibit higher levels of self-perceived multicultural competencies.
3. There will be group differences between graduate students of different racial and ethnic backgrounds.

- a. Those of color being expected to perceive themselves as being more multiculturally competent than their white counterparts.
4. There will be a positive relationship between the duration of time that a program has been accredited and the extent to which it focuses on multicultural training.

Procedure

Training directors were contacted and asked to complete an electronic survey regarding multicultural training efforts in their programs. They were also asked to disseminate an e-mail, describing the study, requesting participation, and providing the link to the electronic survey to graduate student. There was also a review of available program materials including mission statements, handbooks, curriculum/course requirement descriptions, and training goals (See Appendix VIII for the web pages from which information about training methods was retrieved).

Measures

Demographic questionnaire. Participating graduate students were asked to complete a brief demographic questionnaire (Appendix II). The questionnaire contains seven items regarding students' backgrounds and years of training. They were asked to indicate their age, gender, religion, race, sexual orientation, highest level of education, and number of years completed in their current programs.

Multicultural awareness, knowledge, and skills survey-counselor edition-revision (Kim, et al. 2003). Graduate students were asked to complete the Multicultural Awareness, Knowledge Skills Survey-Counselor Edition-Revision (MAKSS-CE-R). The MAKSS-CE-R (Appendix III) is a 33 item, four-point, Likert-type

scale, comprised of three subscales. Kim et al. (2003) provide information regarding the reliability and validity of the revised measure. The overall alpha coefficient for the revised measure is reported as .81, the *Awareness-Revised* subscale .80, the *Knowledge-Revised* subscale .87, and the *Skills-Revised* subscale .85. The MAKKSE-CE-R's construct and criterion validity were evaluated via simultaneous administration of measures of similar constructs and a confirmatory factor analysis.

Training director survey. The brief, 12-item survey for clinical training directors (Appendix IV) was developed for the purpose of this study. The seventh item provides training directors with the opportunity to articulate their programs' multicultural efforts in an open-ended format. The eighth item prompts training directors to identify their racial background. This brief survey was used to identify the range of efforts programs engage in to assist students in the development of multicultural competencies.

Program material review. A content analysis of available program materials including web pages served as the primary means of identifying efforts to produce multiculturally competent graduates. Programs were given one point for specifically addressing each of the 31 AMCD and 6 APA guidelines. For example, identification of training methods that require students to explore their own cultural heritage and related attitudes, values, and biases about psychological processes (AMCD Strategies IA1 and IA2) would be given 2 points. On the other hand, programs were not given points for merely including the guidelines and standards documents in their program materials, they were only given credit for explicit articulation of training efforts related to those guidelines. Total training program scores were calculated by

incorporating two additional items; the first was based on the number of required multicultural courses (one point for each course) and the second was one point given to programs that mentioned multiculturalism in any form in their program materials.

CHAPTER 3

RESULTS

Hypotheses Based on Training Director Reports of Training Methods

Hypothesis 1. It was expected that training directors' would report that their programs value multicultural issues and endorse aspects of the guidelines and standards. To address this hypothesis the responses of training directors to the following items were assessed: incorporation of multiculturalism into training practices, perceived importance of multicultural issues, and perceived importance of multiculturalism for clinical skills. All participating training directors reported that their programs integrated multiculturalism into training practices (N = 38). Similarly, 97.4% of faculty members responsible for overseeing program training practices reported that multicultural considerations were either very important (n=30) or important (n=8) in the development of clinical skills. While the majority of training directors indicated that multicultural competence was considered in student evaluations (86.8%, n = 33) a very small portion of respondents reported that their programs directly assess multicultural competence (13.2%, n = 5).

Hypothesis Related to Graduate Student Variables

Hypothesis 1. There was an expectation that there would be group differences in level of multicultural competence between graduate students of different racial and ethnic backgrounds. To address this hypothesis an analysis of variance (ANOVA) was performed. Students' self-identified race/ethnicity served as the independent variable and MAKSS-CE-R scores were used as the dependent variable. As the individual groups of students from different backgrounds were not

numerically substantial (in some cases $n = <2$) and graduate students who identified as White were overrepresented in the sample ($n=132$), the demographic variables were collapsed into a White/graduate student of color ($n= 35$) dichotomy for the purpose of this analysis. The results were not significant ($F(1, 165) = 1.574, p = .211$) and did not support this hypothesis such an analysis provides some insight into possible group differences, it was not the preferred method as it fails to account for the heterogeneity within groups. Other possible confounding variables are explored in the discussion section.

Hypothesis 2. Graduate students who reported that their training program emphasizes aspects of the APA and AMDC guidelines were expected to exhibit higher levels of self-perceived multicultural competencies. A bivariate Pearson correlation analyses was run to determine whether self-perceived multicultural competence (MAKSS-CE-R score) was associated with the following variables: students' age, current enrollment in a multicultural course, number of multicultural courses completed, number of clients (and years) working with those whose background differs from their own, and perceived importance of multicultural considerations. Additionally, there was an assessment of correlations between students-self perceived multicultural competence and their report of the following training program variables: program type, whether multicultural competence was assessed, whether students were encouraged to include multicultural considerations in research projects, whether there was a requirement of a multicultural course, and whether programs integrate multicultural issues into training practices.

The analysis was one-tailed and an alpha level of .05 was used for the analysis. Significant correlations were found between self-perceived multicultural competence and the following student variables: age ($r = .267, p < .001$), number of multicultural courses completed ($r = .188, p < .01$), number of years working with culturally different clients ($r = .296, p < .01$), number of culturally different clients, ($r = .250, p < .01$), students' perception of the importance of cultural considerations in clinical work ($r = .183, p < .01$). Significant relationships between self-perceived multicultural competences and students' perceptions of the following program variables were also found: whether programs' assess multicultural competence ($r = .161, p < .05$), and whether programs have a multicultural course requirement ($r = .132, p < .05$) (The results are depicted in Figure 5).

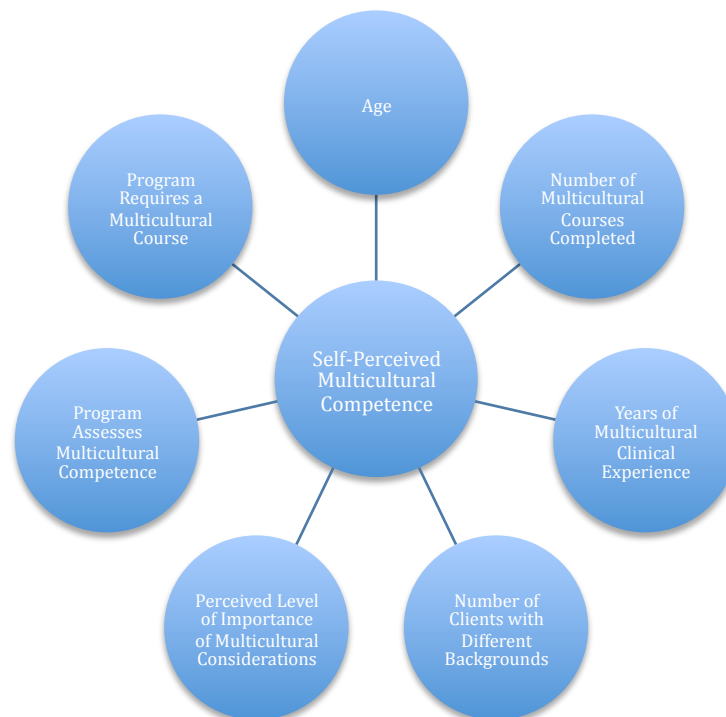


Figure 5: Factors positively correlated with self-perceived multicultural competence

The external spheres in Figure 5 represent the student and program variables that are positively associated with doctoral students' self-identified multicultural competence.

Hypotheses Related to Training Programs

Hypothesis 1. It was anticipated that many doctoral programs would exhibit limited consistency between the professional guidelines and their reported multicultural training methods. Overall, there was an extremely low adherence rate to professional guidelines and standards. There are 31 competencies addressed by the AMCD and 6 guidelines offered by the APA; thus the highest possible program guidelines and standards score was 37. Scores ranged from 0 to 13. The overall mean guidelines and standards score for all reviewed programs was 1.47 (N=307). Counseling psychology Ph.D. programs scored the highest with a mean score of 2.28 (n=65) followed by clinical psychology Ph.D. programs mean = 1.31 (n=176), clinical psychology Psy.D. programs mean = 1.15 (n=61), and counseling psychology Psy.D. programs mean = 0.40 (n= 5). Just under half of the programs (48.2%, n=148), did not mention any of the guidelines or standards. In fact, a smaller portion of the programs, 23.1% (n=71) did not mention any of multicultural issues or diversity in their program materials. Multicultural course requirements were not explicitly addressed in 29.3%(n=90) of the programs' materials. See Table 1 for comparison of mean scores and standard deviations by program.

Program Type	Mean Guidelines and Total Score	Guidelines and Total Score Standard Deviation	Mean Program Total Score	Program Total Score Standard Deviation
Clinical Psychology Ph.D.	1.31	1.95	2.73	2.34
Clinical Psychology Psy.D.	1.15	1.46	2.85	1.99
Counseling Psychology Ph.D.	2.28	2.27	4.00	2.44
Counseling Psychology Psy.D.	0.40	.55	2.60	2.70
Total	1.47	1.97	3.02	2.35

Table 1: Summary of program total and guidelines and standard score means by program type

The above table reflects the mean for each of the four doctoral program types. Notably, these means are affected by the significant proportion of programs in each category type that achieved program total and guidelines and standard scores of 0.

Hypothesis 2. It was anticipated that there would be differences among program types. A one-way ANOVA ($\alpha = .05$) was employed to determine whether there were differences between types of training programs and level of adherence to APA guidelines and AMCD standards. The analysis yielded significant results; group differences in both program total scores $F(3, 306) = 5.009, p < .01$ and group differences in program guidelines and standards scores $F(3, 306) = 5.302, p < .01$ (See Table 2).

		Sum of Squares	df	Mean Square	F	Sig.
Program Total Score * Type of Degree	Between (Combined Groups)	79.519	3	26.506	5.009	.002
	Within Groups	1603.321	303	5.291		
	Total	1682.840	306			
Program Guidelines and Standards Score * Type of Degree	Between (Combined Groups)	59.072	3	19.691	5.302	.001
	Within Groups	1125.319	303	3.714		
	Total	1184.391	306			

Table 2: ANOVA results for program total scores by program type and guidelines and standards scores by program type

The top portion of Table 2 indicates significant differences in program total scores among programs. The lower portion reflects significant differences in endorsement of guidelines and standards among the four program types.

The results of the post-hoc Tukey HSD for program total scores indicate significant differences between counseling Ph.D. and clinical Ph.D. programs ($p=.001$) and counseling Ph.D. and clinical Psy.D. programs ($p=.028$). The results of the post-hoc Tukey HSD for program guidelines and standards scores are similar; differences between counseling Ph.D. and clinical Ph.D. programs ($p=.003$) and counseling Ph.D. and clinical Psy.D. programs ($p=.006$) were significant. These two significant findings are related as program total scores incorporate the same items that comprise the guidelines and standards scores and two additional items (mention of multicultural issues in materials and number of required multicultural courses).

Counseling Ph.D. programs have significantly higher mean scores (program total score mean = 4 guidelines and standards mean score = 2.28) than clinical Ph.D. programs (program total score mean = 2.73 guidelines and standards mean score =

1.31), clinical Psy.D. programs (program total score mean =2.85 guidelines and standards mean score = 1.15), and counseling Psy. D. programs (program total score mean =2.6 guidelines and standards mean score = 0.40). Notably, program total scores and guidelines and standards scores were relatively similar between programs located in the West, Mid-West, South, and Northeast. Programs located in Canada had substantially lower program total scores and Guidelines and standards scores than other programs. The one program located in the North-East Caribbean had program total and guidelines and standards scores that exceeded the means of programs in other geographic regions. See Figure 6 for a comparison of Guideline and Standard Scores and Program total scores between program types and Figure 7 for comparisons of mean scores by location.

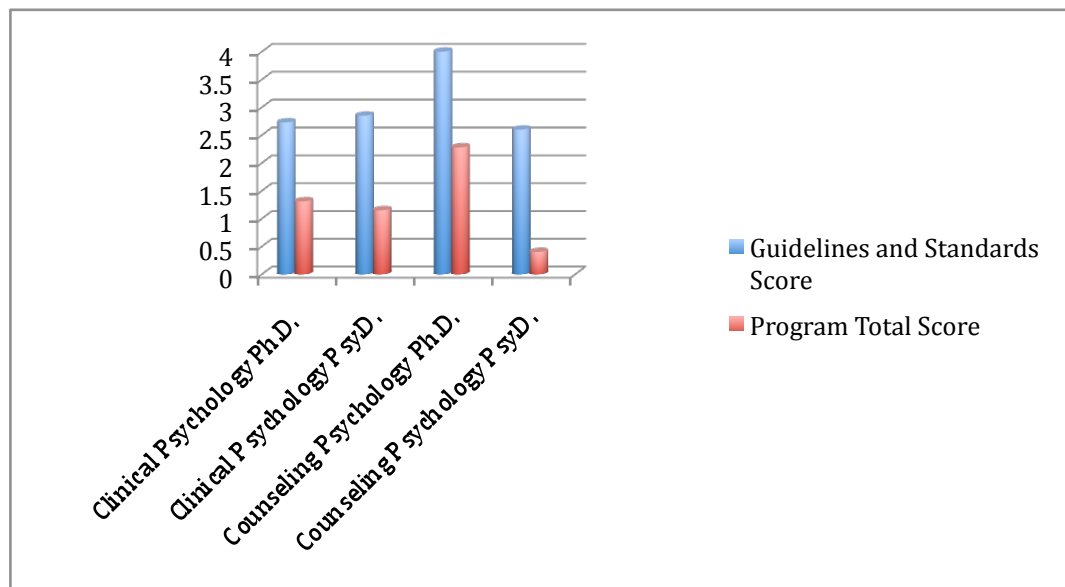


Figure 6: Mean program total scores and guidelines and standards scores by program type

This figure reflects the mean guidelines and standards scores and mean program total scores received by each type of training program included in the review.

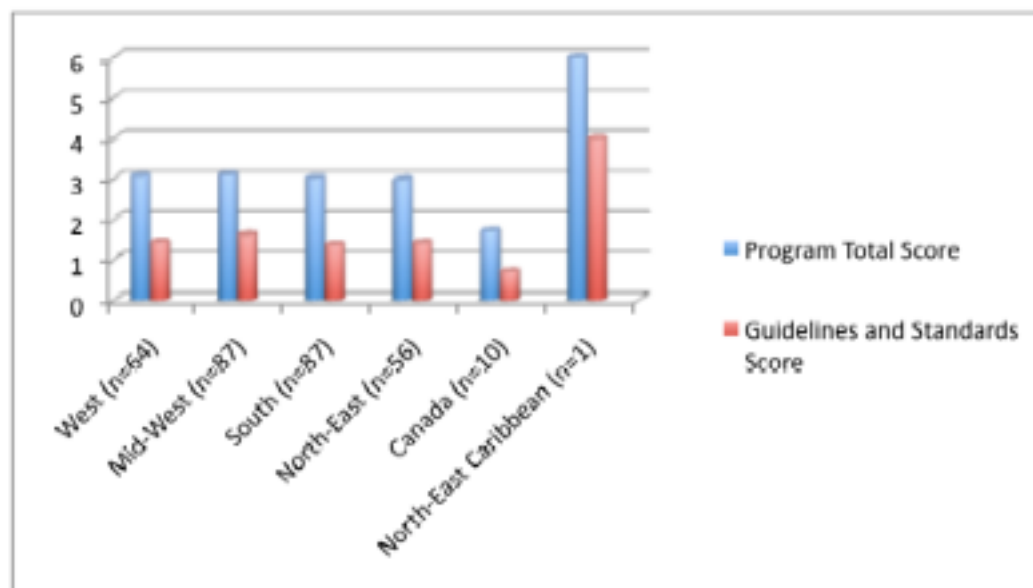


Figure 7: Mean program total scores and guidelines and standards scores by program location

Figure 7 represents differences in mean program scores by geographic location.

Hypothesis 3. Relationships between the number of years programs have been accredited were anticipated with respect to adherence to professional guidelines. To address this hypothesis a one-way bivariate Pearson correlation analysis was run, but no significant findings emerged from this analysis.

Additional analyses. About half (48.2%) of the programs included in this review failed to address any of the APA Guidelines or AMCD Standards. A smaller portion of the 307 programs (23.1%) made no mention whatsoever of multicultural issues (see Figure 8).

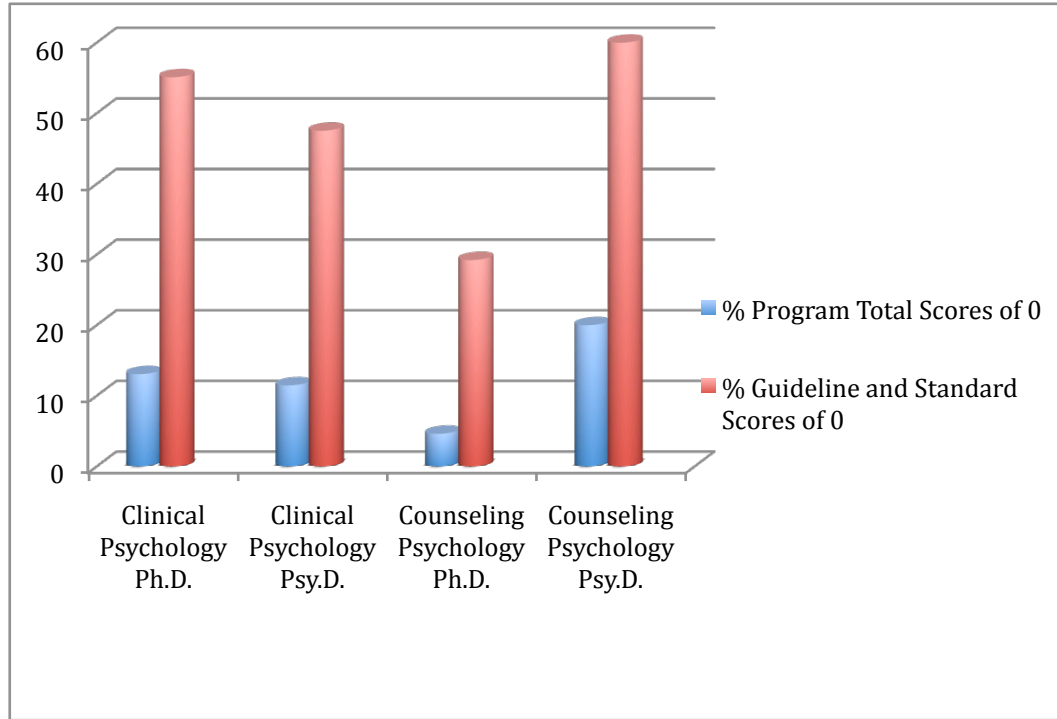


Figure 8: Percentage of training programs with program total and guideline and standard scores of 0 by program type

Figure 8 compares program types based on the percentage of programs within each category that a) did not endorse any of the guidelines and standards and b) failed to make mention of multiculturalism or diversity or require completion of a multicultural course.

While counseling Ph.D. programs were more likely to incorporate multiculturalism into training practices and program materials overall, counseling Psy.D. programs were the least likely to endorse any of the APA guidelines or AMCD standards or mention multiculturalism in program materials. Clinical Ph.D. programs fared less well than clinical Psy.D. programs, exhibiting an increased tendency to neglect multiculturalism in materials regarding training practices. Chi-square analyses yielded significant findings regarding the association between program type and likelihood to attain program total scores of 0: $X^2(36, N=307) = 51.542, p < .05$. However, guideline and standard scores of 0 were not significantly associated with program type: total scores, $X^2(33, N=307) = 33.876, p = .222$.

Exemplary Methods Articulated in Training Program Materials

While no specific hypothesis related to exemplary methods employed by training programs was established, one goal of the present study was to identify novel training methods. To this end, the following is a summary of nine institutional efforts that were unique. These efforts include organizational and structural methods such as diversity committees, explicit communication of program values and philosophies, and focuses on developing competencies to address the needs of specific populations.

Diversity committees and program resources. A number of training programs indicated that diversity committees were a part of their organizational structure. The diversity committees at The University of Massachusetts, Boston and Marquette University have developed a number of practices to promote and facilitate the development of multicultural competences for both doctoral students and faculty members.

The diversity committee within the clinical psychology program at the University of Massachusetts, Boston is comprised of students and faculty members. The committee works to make the program environment inclusive and to contribute to exploration, understanding, and social justice endeavors related to multicultural issues. The committee surveys students to determine their perspective on how issues of diversity are addressed within the context of relationships between students and faculty, and in terms of individuals' experiences of diversity issues pertaining to sexual orientation, social class, and race. The committee also facilitates a discussion series entitled "Building Alliances Community Discussions." These

discussions provide a forum in which department members explore issues relating to the differing statuses of community members. The goal of these discussions are to increase sensitivity, knowledge, and empathy between individuals with varying levels of privilege based on group memberships. The committee developed the “Bridging Perspectives” initiative to address challenging interactions between and among training program members relative to privilege and diversity. Additionally, the diversity committee provides a space for members to process issues that arise in the community and larger society (University of Massachusetts, Boston, 2013).

The diversity committee in the department of psychology at Marquette University houses a Multicultural Awareness and Professional Integration Program (MAPIP) for doctoral students. This program provides clinical psychology Ph.D. students with the opportunity to develop multicultural competence by engaging in specific activities in conjunction with foundational training requirements. Students who complete the MAPIP activities attend six diversity colloquia, 12 campus diversity events, complete self-reflection papers following each event, prepare and deliver a classroom presentation on a diversity issue, develop a clinical case conceptualization demonstrating multicultural competence, as well as writing an integrative reflection paper. Ultimately all of the aforementioned materials are compiled into an organized, coherent, multicultural awareness portfolio. Upon completion of the program students must present their portfolios to the diversity committee and receive feedback from the committee (Marquette University, 2013).

Values and philosophy statements. Program statements of values and philosophy are a potential forum for articulating the ideas and values that serve as a

foundation for their training practices. Many of the programs included in the present study's program review included a statement of the program philosophy or values. Some programs based their program statements on the Counseling Psychology Model Training Value Statement addressing Diversity (Appendix VII). The purpose of the model training values statement is to aid programs in the development of their own articulated training philosophy in the hopes that such statements would connote a) the field of counseling's valuing of diversity and b) impart that value to graduate trainees (Bieschke & Mintz, 2012).

This statement posits that trainers will engage students in a manner that respects their multicultural identities, examine their own biases and prejudices with trainees, provide equal access to students, and model introspection on issues of diversity. Additionally the statement calls for programs to encourage students to engage in introspection and feel safe to self-disclose and self-reflect. Members of the training community are expected to educate one another on forms of prejudice and discrimination and challenge bias, stereotyped thinking and prejudiced beliefs. Counseling programs are directed to facilitate the development of professionally relevant multicultural competencies in trainees (Counsel of Counseling Psychology Training Program, 2013).

Southern Illinois University, Carbondale, The University of Alaska, Anchorage, and The University of Alaska, Fairbanks publish philosophy statements that are particularly noteworthy. The Counseling Psychology Ph.D. Program at Southern Illinois University, Carbondale requires students to sign an adapted version of the Counsel of Counseling Psychology Training Program's training values statement.

This statement is meant to help students focus on the importance of diversity issues, and their commitment to incorporating multicultural values into their training and professional endeavors. Southern Illinois University also includes a statement of their expectations for potential trainees with regard to multicultural competence. Prospective students are expected to be open, curious, courageous, non-defensive, resilient, cognitively complex, respectful, and committed to addressing issues of diversity and engaging in self-reflection (Southern Illinois University, Carbondale, 2009).

The Ph.D. program in clinical-community psychology offered jointly by the University of Alaska, Fairbanks and the University of Alaska, Anchorage emphasizes non-traditional service delivery and social action within indigenous and rural communities (University of Alaska, Fairbanks & University of Alaska Anchorage, 2012). The program philosophy statement states that training is aimed at establishing and disseminating knowledge that is relevant for local communities. The program features, which address the program's philosophy and goals include a focus on rural clinical-community psychology, a cross campus (Fairbanks and Anchorage) cohort culture, and required cultural experiences (University of Alaska, Fairbanks & University of Alaska Anchorage, 2012).

The program has a Cultural Advisor Counsel which helps provide program members with cultural knowledge, advises faculty on course and design, facilitates student development and selection, assists in program development, and provide cultural support and mentorship for department members. Over the course of training, graduate students are offered opportunities to interact with cultural elders

and advisors and engage in other cultural experiences that occur outside of the classroom. This program also houses the Alaska Native Community Advancement in Psychology Program, which works to train Alaska Native and American Indian students to become professional psychologists and behavioral health specialists. A major goal of this program is to provide the opportunity for students to be able to serve in rural Alaska and other areas of Alaska upon graduation (University of Alaska, Fairbanks & University of Alaska Anchorage, 2012).

Programs with a training focus on specific populations. Four programs indicated that their primary focus of training was to facilitate students' development of competencies that are applicable to specific cultural groups. The clinical Ph.D. program at Gallaudet University focuses on deaf and hearing-impaired communities, Carlos Albizu University grants Psy.D. and Ph.D. degrees in clinical psychology with an emphasis on Puerto Rican and other Hispanic populations, and Radford University's Counseling Psy.D. Program trains students to address the needs of individuals who reside in rural areas and emphasizes issues of evidence-based practices, cultural diversity, and social justice.

The clinical Ph.D. program at Gallaudet University specializes in working with deaf and hard of hearing populations (Gallaudet University, 2013). The program trains students who are deaf, hard of hearing, and hearing. The program's training methods include didactic and practical language training requiring that students exhibit a basic level of American Sign Language proficiency prior to engaging in practicum placements with deaf or hard of hearing clients and their families. Additionally, the program material reflects an appreciation for non-hearing-related

issues of diversity. Students are admitted into the program regardless of their level of Sign Language fluency but have access to courses in sign language and other activities that facilitate the development of necessary communication skills.

The program's primary goal is to increase the number of psychologists with competencies sufficient to address the needs of hearing impaired and hearing individuals. Individual differences in physical abilities or functioning are rarely addressed sufficiently in other programs the Gallaudet philosophy and training methods facilitate inclusion by addressing the training needs of deaf and hard of hearing graduate students. Notably, Gallaudet University is the only APA accredited program that mentions the unique mental health concerns of hearing-impaired individuals.

Carlos Albizu University offers two doctoral degrees in clinical psychology. The clinical Ph.D. program works to develop competent researchers and clinicians who approach clinical work from a "holistic, dynamic, and integrated perspective." (Carlos Albizu University, 2006). This Ph.D. program emphasizes the development of awareness and sensitivity to issues that are relevant to Puerto Ricans through didactic coursework, research opportunities, and practicum placements in the community. The Psy.D. program material stresses the program's investment in training Hispanic graduate students. In particular, there is a goal of producing clinically competent graduates who are able to serve as effective administrators and supervisors in mental health programs and to provide professional psychological consultation (Carlos Albizu University, 2006).

The Counseling Psy.D. Program at Radford University identifies four program emphases: evidence-based practice, rural practice, cultural diversity, and social justice. Each of these emphases address multicultural issues along with evidence-based practice as a foundation for all didactic and experiential training. The primary goal of the program is:

“...to train students who can work with people across the lifespan and present with a broad spectrum of issues and severity of psychological conditions; who can provide counseling, assessment, and educational services to individuals, couples, families, and groups in a variety of settings; and who can collaborate with other professionals in their community and region.” (Radford University, 2013).

The program material posits that the above mentioned goals are to be achieved, then ethical and socially conscious students must be trained to attend to the needs of the underserved, including rural and frontier Americans. Program materials indicate that issues of poverty, unemployment, inadequate insurance, limited healthcare access, and availability of service providers significantly impact the experiences of most individuals living in rural Virginia (Radford University, 2013). Accordingly, doctoral students provide much needed services to the local community, receive didactic training on rural practice, and have the opportunity to collaborate with campus organizations such as the Appalachian Regional Studies Center.

Cultural diversity is also addressed by the involvement of faculty in the campus and community organizations such as the Center for Gender Studies, Radford University Safe Zones, and the Women’s Resource Center of the New River Valley. Radford students are also exposed to issues of social justice including oppression, privilege, equity and equality both through coursework and clinical

experiences at the Mental Health Association of the New River Valley's Pro Bono Counseling Program. Additionally, students complete a two-semester social justice practica.

While service to specific cultural groups, issues of cultural diversity, and social justice, are not the primary focus of the majority of accredited clinical and counseling doctoral programs, the above examples may serve as models for smaller-scale efforts to incorporate multicultural issues into training. Like many other programs, University of Alaska Fairbanks, University of Alaska, Anchorage, Gallaudet University, Carlos Albizu University, and Radford University employ coursework, clinical experience, and community involvement to help students develop competence, they differ as they afford students these experiences within the context of the populations of focus. Additionally, these programs' statements of investment in attending to the needs of their populations of interest provide current and perspective students with a sense of the program culture as being in support of multiculturalism.

CHAPTER 4

DISCUSSION

Meeting Trainees' Multicultural Training Needs

The results of the analyses of the self reports of graduate students' suggest that the extent to which training programs manifest a valuing of multiculturalism significantly impacts their perceptions of professional competence. Specifically, when programs require didactic training on multicultural issues, and assess related competencies students are more likely to feel adequately prepared to deal with issues of diversity. Similarly, the personal valuing of multicultural issues by students was also positively associated with feeling competent. Additionally, the increased exposure of students to clients who are different from themselves has positive implications for their multicultural competence. The training methods outlined in the exemplary practices section address the aspects of training which can also lead students to feel more competent.

Counseling Ph.D. programs address the APA guidelines and AMCD standards significantly more often than other types of programs. This may reflect increased valuing of multiculturalism in the field of counseling psychology and a related emphasis dealing with diversity issues in training. This has implications for both the consumers of training and those who receive psychological services or are research participants.

However, it is important to note that despite the significant differences between training program types, all types fared poorly in their available literature regarding multicultural training. Out of a possible 37 points, the average program

received 1.47 points and guidelines and standards scores ranged from 0 to 13. This suggests that doctoral training programs in both clinical and counseling psychology would benefit from closer adherence to suggested guidelines and standards. The field's governing and accrediting bodies, the available literature, and logic dictate that training programs must put forth a better effort in preparing future professionals to address the needs of an increasingly diverse population. It is particularly troubling that nearly half of the accredited programs do not even mention any of the guidelines or standards in their materials. While training materials do not necessarily reflect all of a program's practices, the failure to incorporate any content relating to any of the guidelines or standards at this point in history is unconscionable.

Limitations

There are several limitations of this study design. Respondent groups for both graduate trainees and training directors may be biased toward supporting multicultural competences. As discussed earlier, many professionals within the field are resistant to multicultural competencies (Sue, Zane, Hall, & Berger, 2009). Those who have little professional and personal investment in multicultural issues may have chosen not to participate in the study. While many training directors were contacted to participate in this study, and many stated that they would participate and encourage their students to participate as well, the final sample size of both groups were relatively small. This suggests that many training program members read the solicitation e-mail and simply chose not to participate. Moreover, some training directors did not even reply to e-mail solicitations.

On the other hand, individuals who chose to participate may reflect a subset of training directors and students who are especially invested in multicultural issues, and as a result, spent considerable time and effort studying and developing their competences. If this is the case, the sample may be skewed in favor of multicultural training, so the generalizability of the results is limited. The inclusion of the program material review was aimed at compensating for the aforementioned concern. Nevertheless many hypotheses gained some support; findings from the program review have very important implications. Much “lip service” and little tangible training was evidenced supporting the hypothesis that ideals and practices in the field are vastly different.

Finally, it is important to acknowledge the possible effect of social desirability in this study. Doctoral program materials emphasize program strengths. Training directors are invested in the reputation of their programs and as a result, may over report the quality of their training methods. Students and training directors alike are aware that it “looks better” to report the valuing of diversity. Program materials should be developed to provide both perspective and current students, accrediting bodies, as well as the general public with an accurate overview of training practices. It is hoped that such material emphasizes the multicultural aspects of training accurately.

To lessen the impact of social desirability on training director reports, they were not asked to identify the programs in which they serve. Similarly, students were not asked to identify their training programs, as the request to do so also had the potential to influence their responses. A consequence of this study’s

consideration of social desirability and acknowledgement of the importance of participant anonymity to elicit honest feedback, the design does not provide a direct link between the results of the program material review and responses from training directors or graduate students. As such, this study is a broad report on the state of the field's training programs from three perspectives: program materials, training directors, and students consumers. While direct relationships between responses and training program affiliation would have provided more insight into training methods outcomes, this study may serve as an important first step in improving training methods.

Conclusions, Recommendations, and Future Directions

In keeping with the literature that suggests its efficacy, an awareness, knowledge, and skills based approach to engaging in culturally competent clinical work is recommended. Cultural competences are not merely applicable to clients from underrepresented and underserved groups but to all clinical populations; all treatment should take place within the context of cultural awareness, knowledge, and skills. Dominant group values are woven throughout typical research and treatment practices. This standardization of dominant group values serves to disadvantage clients whose cultures differ from the culture around which methods were based. As such, applying evidence-based practices without consideration of culture is both unethical and unjust (APA, 2010).

Graduate programs are encouraged to have both faculty and students engage in the self-reflective practices such as those discussed by Fouad (2006). Evaluation of the successes and shortcomings of a program with regard to multicultural training

should be an ongoing process. Programs may use preparation for accreditation site visits as an opportunity to engage in such reflection. However, it is recommended that programs engage more regularly in exploration of their multicultural training methods. Graduate students and the consumers of graduate student services as well, should be included in this review process.

Programs may also facilitate the development of multicultural competence by implementing training models such as the one employed at Brookline Community Mental Health Center (Park-Taylor et al., 2009). The practice of clinical and counseling doctoral programs which highlight unique practices pertaining to their diversity committees, program values and philosophy statements, and focus on specific cultural groups should be used as positive frames of reference. The APA guidelines and AMCD competencies in combination with the available literature on culturally competent practices and examples of impressive existing practices by training programs should serve as the foundation upon which multicultural training is developed. Adequate multicultural clinical training will facilitate our ability to meet the needs of diverse populations. One of the benefits of the existence of 307 accredited programs is the fact that programs that do not adequately incorporate multicultural issues into training need not reinvent the proverbial wheel; they need only look as far as other programs' training material to gain ideas for program development and organizational change.

Future research should include site visits to directly witness relevant training methods. For example, attending multicultural courses, observing trainees with underserved populations, and gaining direct feedback from department members

would produce a more comprehensive picture of program practices. Additionally interviews with clients and research participants would provide a consumer perspective regarding the multicultural competence of trainees. Since visiting training programs would be a particularly expensive undertaking, phone interviews with trainers and trainees could be a meaningful alternative. Alternately, collaboration among researchers would allow for regional observers to evaluate programs that are geographically close.

Researchers should strive to identify training models that may be implemented into programs. This would be especially helpful for programs that thus far paid little attention to professional standards regarding the importance of multicultural values. It will be important for researchers to pay particular attention to programs identified as employing exemplary training methods. These programs may potentially serve as models for more multidimensional training approaches which general multicultural training models may be established. While there are some counseling and clinical psychology doctoral programs that employ innovative methods, the majority have much room for improvement. The findings of the present study reflect a need for guidance and support in the development of more effective multicultural training methods. Ultimately, the goal of future research should be to provide training programs with the means for actualizing the ideals and values regarding multiculturalism and diversity through practice and explicit training methods.

APPENDIX I

Training Directors and Graduate Student Consent Form

The University of Rhode Island
Department of: Psychology
Address: Chafee Building Kingston, RI 02881-0808
Title of Project: Multicultural Training of Clinical and Counseling Psychology
Doctoral Students: Ideals vs. Practice

Consent Form for Research

You are being invited to take part in a research project described below. If you have questions regarding the study aims or processes you may contact, Bryana White, M.A. the person mainly responsible for this study at, bryana_white@my.uri.edu. You must be at least 18 years old to be in this research project.

Description of the project:

You have been asked to take part in the study that explores the multicultural training methods of clinical and counseling psychology doctoral programs and graduate trainee's self perceived multicultural competence.

What will be done:

If you decide to take part in this study here is what will happen: You will complete the following questionnaires online. The completion of these questionnaires will take approximately 25 minutes.

Risks or discomfort:

The risk for discomfort resulting from your participation in this study is minimal.

Benefits of this study:

Although there will be no direct benefit to you for taking part in this study, the researcher may learn more about the relationship between doctoral programs' multicultural training methods and graduate trainee's sense of multicultural self-efficacy.

Confidentiality:

Your part in this study is confidential. You will not be asked to identify yourself by name rather you will complete the survey measures anonymously online. All records will be kept in an encrypted electronic document. The document will only be accessible by the researcher. Data for this study will be discussed in aggregate.

Decision to quit at any time:

The decision to take part in this study is up to you. You do not have to participate. If you decide to take part in the study, you may quit at any time. Whatever you decide

will in no way negatively affect your course grade. If you wish to quit, simply close your browser window or inform the researcher, Bryana White via e-mail (bryana_White@my.uri.edu) of your decision.

Rights and Complaints:

If you are not satisfied with the way that this study is performed, you may discuss your complaints with Bryana White, anonymously, if you choose. In addition, you may contact the office of the Vice President for Research, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: (401) 874-4328.

You are at least 18 years old. You have read the consent form and your questions have been answered to your satisfaction. Your filling out the survey implies your consent to participate in this study.

Please print a copy of this form for your records

APPENDIX II
Demographic Questionnaire

Instructions: Please answer the following questions about your background.

1. What is your age? ____
2. What is your gender?
 - a. Male
 - b. Female
 - c. Transgender
 - d. Prefer not to answer
3. What is your religious affiliation?
 - a. Protestant Christian
 - b. Roman Catholic
 - c. Evangelical Christian
 - d. Jewish
 - e. Muslim
 - f. Hindu
 - g. Buddhist
 - h. No religious affiliation
 - i. Other: _____
4. What is your Race? Check all that Apply
 - a. Asian, Asian American
 - b. Black or African American
 - c. Hispanic or Latino
 - d. White, Caucasian, European, not Hispanic
 - e. American Indian
 - f. Mixed
 - g. Other (write in): _____
5. What is your Sexual Orientation?
 - a. Heterosexual
 - b. Homosexual
 - c. Bisexual
 - d. Queer
 - e. Questioning
 - f. Other
6. What is your highest level of education in the field of psychology?
 - a. Bachelor of Arts Bachelor of Sciences
 - b. Master of Arts or Master of Sciences
 - c. Doctoral Degree
 - d. Postdoctoral work completed
7. How many years have you completed in your doctoral program?
 - a. < 1 year
 - b. 1 year
 - c. 2 years
 - d. 3 years

- e. 4 years
- f. 5 years
- g. 6 years
- h. 7 years
- i. > 7 years

APPENDIX III

Multicultural Awareness, Knowledge, and
Skills Survey – Counselor Edition -
Revised
(MAKSS-CE-R)

Bryan S. K. Kim

University of California, Santa Barbara

Brenda Y. Cartwright

University of Hawaii at Manoa

Penelope A. Asay

University of Maryland, College Park

Michael J. D'Andrea

University of Hawaii at Manoa

Kim, B. S. K., Cartwright, B. Y., Asay, P. A., & D'Andrea, M. J. (2003).
A revision of the Multicultural Awareness, Knowledge, and Skills Survey
– Counselor Edition. *Measurement and Evaluation in Counseling and
Development*, 36, 161-180.

Before the MAKSS-CE-R is copied or distributed, permission must be
obtained from one of these authors:

Michael J. D'Andrea, Ed.D.: michael@hawaii.edu

Bryan S. K. Kim, Ph.D.: bkim@education.ucsb.edu

This survey is designed to obtain information on the educational needs of counselor trainees. It is not a test. No grade will be given as a result of completing this survey.

Please complete the demographic items listed below.

Following the demographic section, you will find a list of statements and/or questions related to a variety of issues related to the field of multicultural counseling. Please read each statement/question carefully. From the available choices, circle the one that best fits your reaction to each statement/question. Thank you for your participation.

-
1. Gender: MALE FEMALE

 2. Age _____

 3. Race _____

 4. Ethnic/Cultural Background _____

 5. State of residence: _____

 6. Highest educational degree earned: _____

- In the specialty area of (check one) _____ Counseling
- College Student Personnel
 - Community Counseling
 - Counselor Education
 - Counseling Psychology
 - _____
 - Rehabilitation Counseling
 - School Counseling

___ School Psychology

Other: _____

7. If a current student, educational degree sought: _____

In the specialty area of (check one) ___ College Student Personnel
Counseling

___ Community Counseling

___ Counselor Education

___ Counseling Psychology

___ Rehabilitation Counseling

___ School Counseling

___ School Psychology

Other: _____

8. Are you currently enrolled in a course on multicultural counseling?
___ YES ___ NO

9. Number of completed courses on multicultural counseling: _____

10. Years of experience working with clients who were racially/ethnically
different from you:

___ Less than 1 year

___ 1-2 years

___ 3-4 years

___ 5 years or more

11. Number of past and current clients who were racially/ethnically different
than you: _____

12. Current occupation (if not a full-time student) _____

13. Annual Family Income

(Check one):

_____ \$7,500 or less

_____ \$7,501 - 15,000

_____ \$15,001 - 25,000

_____ \$25,001 - 35,000

_____ \$35,001 - 50,000

_____ \$50,001 or more

1. Promoting a client's sense of psychological independence is usually a safe goal to strive for in most counseling situations.

Strongly Disagree Disagree Agree Strongly Agree

2. Even in multicultural counseling situations, basic implicit concepts such as "fairness" and "health", are not difficult to understand.

Strongly Disagree Disagree Agree Strongly Agree

3. How would you react to the following statement? In general, counseling services should be directed toward assisting clients to adjust to stressful environmental situations.

Strongly Disagree Disagree Agree Strongly Agree

4. While a person's natural support system (i.e., family, friends, etc.) plays an important role during a period of personal crisis, formal counseling services tend to result in more constructive outcomes.

Strongly Disagree Disagree Agree Strongly Agree

5. The human service professions, especially counseling and clinical psychology, have failed to meet the mental health needs of ethnic minorities.

Strongly Disagree Disagree Agree Strongly Agree

6. The effectiveness and legitimacy of the counseling profession would be enhanced if counselors consciously supported universal definitions of normality.

Strongly Disagree Disagree Agree Strongly Agree

7. Racial and ethnic persons are under-represented in clinical and counseling psychology.

Strongly Disagree Disagree Agree Strongly Agree

8. In counseling, clients from different ethnic/cultural backgrounds should be given the same treatment that White mainstream clients receive.

Strongly Disagree Disagree Agree Strongly Agree

9. The criteria of self-awareness, self-fulfillment, and self-discovery are important measures in most counseling sessions.

Strongly Disagree Disagree Agree Strongly Agree

10. The difficulty with the concept of "integration" is its implicit bias in favor of the dominant culture.

Strongly Disagree Disagree Agree Strongly Agree

At the present time, how would you rate your understanding of the following terms:

11. "Ethnicity"

Very Limited Limited Good Very Good

12. "Culture"

Very Limited **Limited** **Good**
Very Good

13. "Multicultural"

Very Limited **Limited** **Good**
Very Good

14. "Prejudice"

Very Limited **Limited** **Good**
Very Good

15. "Racism"

Very Limited **Limited** **Good**
Very Good

16. "Transcultural"

Very Limited **Limited** **Good**
Very Good

17. "Pluralism"

Very Limited **Limited** **Good**
Very Good

18. "Mainstreaming"

Very Limited **Limited** **Good**
Very Good

19. "Cultural Encapsulation"

Very Limited **Limited** **Good**
Very Good

20. "Contact Hypothesis"

Very Limited **Limited** **Good**
Very Good

21. At this point in your life, how would you rate your understanding of the impact of the way you think and act when interacting with persons of different cultural backgrounds?

Very Limited **Limited** **Fairly Aware**
Very Aware

22. At this time in your life, how would you rate yourself in terms of understanding how your cultural background has influenced the way you think and act?

Very Limited **Limited** **Fairly Aware**
Very Aware

23. How well do you think you could distinguish "intentional" from "accidental" communication signals in a multicultural counseling situation?

Very Limited **Limited** **Good**
Very Good

24. How would you rate your ability to effectively consult with another mental health professional concerning the mental health needs of a client whose cultural background is significantly different from your own?

Very Limited **Limited** **Good**
Very Good

25. How well would you rate your ability to accurately assess the mental health needs of lesbian women?

Very Limited **Limited** **Good**
Very Good

26. How well would you rate your ability to accurately assess the mental health needs of older adults?

Very Limited **Limited** **Good**
Very Good

27. How well would you rate your ability to accurately assess the mental health needs of gay men?

Very Limited **Limited** **Good**
Very Good

28. How well would you rate your ability to accurately assess the mental health needs of persons who come from very poor socioeconomic backgrounds?

Very Limited **Limited** **Good**
Very Good

29. How would you rate your ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons from different cultural/racial/ethnic backgrounds?

Very Limited **Limited** **Good**
Very Good

30. How would you rate your ability to accurately assess the mental health needs of men?

Very Limited **Limited** **Good**
Very Good

31. How well would you rate your ability to accurately assess the mental health needs of individuals with disabilities?

**Very Limited Limited Good
Very Good**

32. How would you rate your ability to effectively secure information and resources to better serve culturally different clients?

**Very Limited Limited Good
Very Good**

33. How would you rate your ability to accurately assess the mental health needs of women?

Very Limited ___ Limited Good Very Good

SCORING INSTRUCTIONS

For the Awareness Scale: Reverse score items 1, 2, 3, 4, 6, 8, and 9. Then, sum the scores from these items plus the scores from items 5, 7, and 10.

For the Knowledge Scale: Sum the scores for items 11 to 23.

For the Skills Scale: Sum the scores for items 24 to 33

For the Total Scale: Sum all of the reverse scored items and the rest of the items.

APPENDIX IV

Training Director Survey

Instructions: Please respond to the following questions regarding your program's clinical training practices and your background.

1. Does your program integrate multiculturalism into the clinical training of graduate students?
 - a. Yes
 - b. No
2. Please indicate how long your program has been working to incorporate multiculturalism and diversity into clinical training
 - a. < 1 years
 - b. 1-5 years
 - c. 5-10 years
 - d. 10-15 years
 - e. 15-20 years
 - f. 20-25 years
 - g. 25 -30 years
 - h. >30years
3. How important are multicultural considerations in the development of clinical skills?
 - a. Very important
 - b. Important
 - c. Neither important nor unimportant
 - d. Unimportant
 - e. Very unimportant
4. Are multicultural competencies considered in your evaluation of graduate students?
 - a. Yes
 - i. If yes, please provide a brief description of your program's multicultural competency evaluation methods

 - b. No
5. Do you assess students' multicultural competencies
 - a. Yes
 - i. If yes, please provide a brief description of your program's multicultural competency assessment methods

 - b. No
6. Does your program encourage graduate students to incorporate issues of diversity into their research projects?
 - a. Yes

- i. If yes, please provide a brief description of how your program encourages students to incorporate issues of diversity into their research projects
-

b. No

7. Please provide a brief description of your program's efforts to train graduate students with respect to clinical multicultural competences.
-

8. What is your Race? Check all that Apply
- a. Asian, Asian American
 - b. Black or African American
 - c. Hispanic or Latino
 - d. White, Caucasian, European, not Hispanic
 - e. American Indian
 - f. Mixed
 - g. Other (write in): _____
9. What is your age? ____
10. What is your gender?
- a. Male
 - b. Female
 - c. Transgender
 - d. Prefer not to answer
11. What is your religious affiliation?
- a. Protestant Christian
 - b. Roman Catholic
 - c. Evangelical Christian
 - d. Jewish
 - e. Muslim
 - f. Hindu
 - g. Buddhist
 - h. No religious affiliation
 - i. Other: _____
12. What is your Sexual Orientation?
- a. Heterosexual
 - b. Homosexual
 - c. Bisexual
 - d. Queer
 - e. Questioning
 - f. Other

APPENDIX V

Association for Multicultural Counseling and Development Multicultural Counseling Competencies and Standards

I. Counselor Awareness of Own Cultural Values and Biases

A. Attitudes and Beliefs

1. Culturally skilled counselors believe that cultural self-awareness and sensitivity to one's own cultural heritage is essential.
2. Culturally skilled counselors are aware of how their own cultural background and experiences have influenced attitudes, values, and biases about psychological processes.
3. Culturally skilled counselors are able to recognize the limits of their multicultural competency and expertise.
4. Culturally skilled counselors recognize their sources of discomfort with differences that exist between themselves and clients in terms of race, ethnicity and culture.

B. Knowledge

1. Culturally skilled counselors have specific knowledge about their own racial and cultural heritage and how it personally and professionally affects their definitions and biases of normality/abnormality and the process of counseling.
2. Culturally skilled counselors possess knowledge and understanding about how oppression, racism, discrimination, and stereotyping affect them personally and in their work. This allows individuals to acknowledge their own racist attitudes, beliefs, and feelings. Although this standard applies to all groups, for White counselors it may mean that they understand how they may have directly or indirectly benefited from individual, institutional, and cultural racism as outlined in White identity development models.
3. Culturally skilled counselors possess knowledge about their social impact upon others. They are knowledgeable about communication style differences, how their style may clash with or foster the counseling process with persons of color or others different from themselves based on the A, B and C, Dimensions, and how to anticipate the impact it may have on others.

C. Skills

1. Culturally skilled counselors seek out educational, consultative, and training

experiences to improve their understanding and effectiveness in working with culturally different populations. Being able to recognize the limits of their competencies, they (a) seek consultation, (b) seek further training or education, (c) refer out to more qualified individuals or resources, or (d) engage in a combination of these.

2. Culturally skilled counselors are constantly seeking to understand themselves as racial and cultural beings and are actively seeking a non racist identity.

II. Counselor Awareness of Client's Worldview

A. Attitudes and Beliefs

1. Culturally skilled counselors are aware of their negative and positive emotional reactions toward other racial and ethnic groups that may prove detrimental to the counseling relationship. They are willing to contrast their own beliefs and attitudes with those of their culturally different clients in a nonjudgmental fashion.

2. Culturally skilled counselors are aware of their stereotypes and preconceived notions that they may hold toward other racial and ethnic minority groups.

B. Knowledge

1. Culturally skilled counselors possess specific knowledge and information about the particular group with which they are working. They are aware of the life experiences, cultural heritage, and historical background of their culturally different clients. This particular competency is strongly linked to the "minority identity development models" available in the literature.

2. Culturally skilled counselors understand how race, culture, ethnicity, and so forth may affect personality formation, vocational choices, manifestation of psychological disorders, help seeking behavior, and the appropriateness or inappropriateness of counseling approaches.

3. Culturally skilled counselors understand and have knowledge about sociopolitical influences that impinge upon the life of racial and ethnic minorities. Immigration issues, poverty, racism, stereotyping, and powerlessness may impact self esteem and self concept in the counseling process.

C. Skills

1. Culturally skilled counselors should familiarize themselves with relevant research and the latest findings regarding mental health and mental disorders that affect various ethnic and racial groups. They should actively seek out educational experiences that enrich their knowledge, understanding, and cross-

cultural skills for more effective counseling behavior.

2. Culturally skilled counselors become actively involved with minority individuals outside the counseling setting (e.g., community events, social and political functions, celebrations, friendships, neighborhood groups, and so forth) so that their perspective of minorities is more than an academic or helping exercise.

III. Culturally Appropriate Intervention Strategies

A. Beliefs and Attitudes

1. Culturally skilled counselors respect clients' religious and/ or spiritual beliefs and values, including attributions and taboos, because they affect worldview, psychosocial functioning, and expressions of distress.

2. Culturally skilled counselors respect indigenous helping practices and respect help~iving networks among communities of color.

3. Culturally skilled counselors value bilingualism and do not view another language as an impediment to counseling (monolingualism may be the culprit).

B. Knowledge

1. Culturally skilled counselors have a clear and explicit knowledge and understanding of the generic characteristics of counseling and therapy (culture bound, class bound, and monolingual) and how they may clash with the cultural values of various cultural groups.

2. Culturally skilled counselors are aware of institutional barriers that prevent minorities from using mental health services.

3. Culturally skilled counselors have knowledge of the potential bias in assessment instruments and use procedures and interpret findings keeping in mind the cultural and linguistic characteristics of the clients.

4. Culturally skilled counselors have knowledge of family structures, hierarchies, values, and beliefs from various cultural perspectives. They are knowledgeable about the community where a particular cultural group may reside and the resources in the community.

5. Culturally skilled counselors should be aware of relevant discriminatory practices at the social and community level that may be affecting the psychological welfare of the population being served.

C. Skills

1. Culturally skilled counselors are able to engage in a variety of verbal and nonverbal helping responses. They are able to send and receive both verbal and nonverbal messages accurately and appropriately. They are not tied down to only one method or approach to helping, but recognize that helping styles and approaches may be culture bound. When they sense that their helping style is limited and potentially inappropriate, they can anticipate and modify it.
2. Culturally skilled counselors are able to exercise institutional intervention skills on behalf of their clients. They can help clients determine whether a "problem" stems from racism or bias in others (the concept of healthy paranoia) so that clients do not inappropriately personalize problems.
3. Culturally skilled counselors are not averse to seeking consultation with traditional healers or religious and spiritual leaders and practitioners in the treatment of culturally different clients when appropriate.
4. Culturally skilled counselors take responsibility for interacting in the language requested by the client and, if not feasible, make appropriate referrals. A serious problem arises when the linguistic skills of the counselor do not match the language of the client. This being the case, counselors should (a) seek a translator with cultural knowledge and appropriate professional background or (b) refer to a knowledgeable and competent bilingual counselor.
5. Culturally skilled counselors have training and expertise in the use of traditional assessment and testing instruments. They not only understand the technical aspects of the instruments but are also aware of the cultural limitations. This allows them to use test instruments for the welfare of culturally different clients.
6. Culturally skilled counselors should attend to as well as work to eliminate biases, prejudices, and discriminatory contexts in conducting evaluations and providing interventions, and should develop sensitivity to issues of oppression, sexism, heterosexism, elitism and racism.
7. Culturally skilled counselors take responsibility for educating their clients to the processes of psychological intervention, such as goals, expectations, legal rights, and the counselor's orientation.

Arredondo, P., Toporek, M. S., Brown, S., Jones, J., Locke, D. C., Sanchez, J. and Stadler, H. (1996) Operationalization of the Multicultural Counseling Competencies. AMCD: Alexandria, VA

APPENDIX VI

American Psychological Association Guidelines on Multicultural Education, Training, Research, Practice, and Organizational

Guideline #1: Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves.

Guideline #2: Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically and racially different individuals.

Guideline #3: As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education.

Guideline #4: Culturally sensitive psychological researchers are encouraged to recognize the importance of conducting culture-centered and ethical psychological research among persons from ethnic, linguistic, and racial minority backgrounds.

Guideline #5: Psychologists strive to apply culturally-appropriate skills in clinical and other applied psychological practices.

Guideline #6: Psychologists are encouraged to use organizational change processes to support culturally informed organizational (policy) development and practices.

APPENDIX VII
**Counseling Psychology Model Training Values Statement Addressing
Diversity¹**

Respect for diversity and for values different from one's own is a central value of counseling psychology training programs. The valuing of diversity is also consistent with the profession of psychology as mandated by the American Psychological Association's Ethical Principles and Code of Conduct (2002) and as discussed in the Guidelines and Principles of Programs in Professional Psychology (APA, 2005). More recently there has been a call for counseling psychologists to actively work and advocate for social justice and prevent further oppression in society. Counseling psychologists provide services, teach, and/or engage in research with or pertaining to members of social groups that have often been devalued, viewed as deficient, or otherwise marginalized in the larger society.

Academic training programs, internships that employ counseling psychologists and espouse counseling values, and post-doc training programs (herein "training programs") in counseling psychology exist within multicultural communities that contain people of diverse racial, ethnic, and class backgrounds; national origins; religious, spiritual and political beliefs; physical abilities; ages; genders; gender identities, sexual orientations, and physical appearance. Counseling psychologists believe that training communities are enriched by members' openness to learning about others who are different than them as well as acceptance of others. Internship trainers, professors, practicum supervisors (herein "trainers") and students and interns (herein "trainees") agree to work together to create training environments that are characterized by respect, safety, and trust. Further, trainers and trainees are expected to be respectful and supportive of all individuals, including, but not limited to clients, staff, peers, and research participants.

Trainers recognize that no individual is completely free from all forms of bias and prejudice. Furthermore, it is expected that each training community will evidence a range of attitudes, beliefs, and behaviors. Nonetheless, trainees and trainers in counseling psychology training programs are expected to be committed to the social values of respect for diversity, inclusion, and equity. Further, trainees and trainers are expected to be committed to critical thinking and the process of self-examination so that such prejudices or biases (and the assumptions on which they are based) may be evaluated in the light of available scientific data, standards of the profession, and traditions of cooperation and mutual respect. Thus, trainees and trainers are asked to demonstrate a genuine desire to examine their own attitudes, assumptions, behaviors, and values and to learn to work effectively with "cultural, individual, and role differences including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status" (APA Ethics Code, 2002, Principle E, p. 1063). Stated simply, both trainers and trainees

are expected to demonstrate a willingness to examine their personal values, and to acquire and utilize professionally relevant knowledge and skills regardless of their beliefs, attitudes, and values.

Trainers will engage trainees in a manner inclusive and respectful of their multiple cultural identities. Trainers will examine their own biases and prejudices in the course of their interactions with trainees so as to model and facilitate this process for their trainees. Trainers will provide equal access, opportunity, and encouragement for trainees inclusive of their multiple cultural identities. Where appropriate, trainers will also model the processes of personal introspection in which they desire trainees to engage. As such, trainers will engage in and model appropriate self-disclosure and introspection with their trainees. This can include discussions about personal life experiences, attitudes, beliefs, opinions, feelings, and personal histories. Assuming no one is free from biases and prejudices, trainers will remain open to appropriate challenges from trainees to their held biases and prejudices. Trainers are committed to lifelong learning relative to multicultural competence.

Counseling psychology training programs believe providing experiences that call for trainees to self-disclose and personally introspect about personal life experiences is an essential component of the training program. Specifically, while in the program trainees will be expected to engage in self-reflection and introspection on their attitudes, beliefs, opinions, feelings and personal history. Trainees will be expected to examine and attempt to resolve any of the above to eliminate potential negative impact on their ability to perform the functions of a psychologist, including but not limited to providing effective services to individuals from cultures and with beliefs different from their own and in accordance with APA guidelines and principles.

Members of the training community are committed to educating each other on the existence and effects of racism, sexism, ageism, heterosexism, religious intolerance, and other forms of invidious prejudice. Evidence of bias, stereotyped thinking, and prejudicial beliefs and attitudes will not go unchallenged, even when such behavior is rationalized as being a function of ignorance, joking, cultural differences, or substance abuse. When these actions result in physical or psychological abuse, harassment, intimidation, substandard psychological services or research, or violence against persons or property, members of the training community will intervene appropriately.

In summary, all members of counseling psychology training communities are committed to a training process that facilitates the development of professionally relevant knowledge and skills focused on working effectively with all individuals inclusive of demographics, beliefs, attitudes, and values. Members agree to engage in a mutually supportive process that examines the effects of one's beliefs, attitudes, and values on one's work with all clients. Such training processes are

consistent with counseling psychology's core values, respect for diversity and for values similar and different from one's own.

¹This document was endorsed by the Association of Counseling Center Training Agencies (ACCTA), the Council of Counseling Psychology Training Programs (CCPTP), and the Society for Counseling Psychology (SCP) in August of 2006. The joint writing team for this document consisted of members from ACCTA, CCPTP, and SCP, including Kathleen J. Bieschke, Ph.D., Chair, (SCP), Arnie Abels, Ph. D., (ACCTA), Eve Adams, Ph.D., (CCPTP), Marie Miville, Ph.D., (CCPTP), and Barry Schreier, Ph.D., (ACCTA). This document is intended to serve as a model statement for counseling psychology training communities and we encourage sites to adapt the CPMTVSD to reflect their particular environment. The writing team for this document would like to acknowledge Laurie Mintz, Ph.D. and her colleagues at the University of Missouri-Columbia; the values statement for their program served as the starting point for the current document. Correspondence regarding this document should be directed to Kathleen J. Bieschke, Ph.D., 306 CEDAR Building, University Park, PA, 16802 or to kbieschke@psu.edu.

APPENDIX VIII

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