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Assessing cultural and linguistic competencies in doctoral clinical psychology students

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Assessing Cultural and Linguistic Competencies in Doctoral Clinical Psychology Students

A clinical dissertation submitted in partial satisfaction

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by

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ABSTRACT

With an increase of Spanish-speakers residing in the United States, there is an increase in the need for Spanish-speaking mental health providers. Psychologists have to undergo years of education and extensive training in order to get licensed to provide services. However, little is known about the education and training of psychologists who are bilingual Spanish-English speakers providing mental health services to monolingual Spanish-speaking clients. This qualitative study gathered feedback via phone interviews from seven doctoral level psychology students who identified as bilingual Spanish-English. Feedback gathered was on the Spanish Language Assessment measure created by Dr. Rogelio Serrano in the hope of modifying the measure for future use. In addition, feedback was gathered on each participant's experience in graduate school as it relates to preparedness for working with the Spanish-speaking population, suggestions for improving education and training in this area, and their understanding of cultural and linguistic competence. A thematic analysis outlined themes in participant responses. The findings will help shed light on the assessment for linguistic and cultural competence in bilingual Spanish-English clinicians, in addition to exploring ways to improve clinical graduate training for those working with Spanish-speaking populations.

Keywords: bilingual, assessment, evaluation, training, cultural competence, linguistic competence, graduate training

Introduction

As the population of Latinos/as continues to grow in the United States (U.S.), psychologists serving these communities need to be trained to deliver culturally and linguistically competent services. According to the United States Census Bureau (2014), there are 54 million people of Hispanic origin in the U.S., making it the nation's largest ethnic minority (U.S. Census Bureau, 2014). It is also projected for the year 2060 that close to 129 million people of Hispanic origin will reside in the U.S. In addition, among Hispanics who endorsed *"hablan español en casa"* (Spanish spoken in the home), there was a 121% increase from 1990 to 2014. Among the states with the most Hispanics were California, Arizona, Colorado, Connecticut, and Florida. Mental health professionals must be prepared to serve these communities. An extension of the American Psychological Association Guidelines specific to culturally diverse populations addresses this need by recommending that psychologists provide services in the language requested by and understandable to the client (APA, 2017). It is also expected for psychologists treating clients of diverse backgrounds to acknowledge culture when conceptualizing and treating clients in therapy.

The skills required to conceptualize using a cultural framework should be taught during graduate training. APA-accredited graduate programs in psychology are required to meet competency benchmarks when training their students as it relates to culture and diversity. Unfortunately, there currently is no standardized way of measuring linguistic competency for those who provide mental health services in Spanish, which poses an ethical concern for the Spanish-speaking clients receiving these services. It is necessary that mental health clinicians who provide services to Spanish-speaking clients be adept both linguistically and culturally. Furthermore, it is especially important to know how to effectively assess the level of competence in these two areas in order to ensure adequate and ethical treatment to Spanish-speaking clients.

Review of the Literature

There is significant diversity among Latinos in the United States, and the terminology can vary. The term Hispanic, which is used by the U.S. Census, can be defined as representative of people who originate from Spain without indigenous influences (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). The term Latino, however, is a term representative of people from Latin America who have indigenous roots (Santiago-Rivera et al., 2002). According to the U.S. Census, 64% of Hispanics in the U.S. are of Mexican background, close to 10% are of Puerto Rican background, close to 4% are Salvadorian, close to 4% are Cuban, and the remainder are of other Central American, South American, or of other Hispanic origins (U.S. Census Bureau, 2014). Latinos are not only very diverse as it relates to nationality, but also as it relates to socioeconomic status and access to health insurance coverage. The mean income for Latinos is $39,000 and 30% lacked health insurance (U.S. Census Bureau, 2014). Even Latinos who do have health insurance may neglect to seek mental health services due to the cultural stigma or linguistic limitations. A systematic literature review found evidence that Latinos with limited proficiency in English are at risk for experiencing decreased access to care and decreased quality of care (Timmins, 2002). Other variations among Latinos include variations in cultural values, immigration status and history, and religious beliefs.

A review of the literature will aim to further understand the constructs of cultural competence and linguistic competence. These are two skills necessary in clinicians when working with Spanish-speaking populations. It is important to note that there is a distinction between the different degrees of language competence and cultural competence. A clinician can be culturally competent, but lacking in linguistic competence. Similarly, one can be linguistically competent, but lacking in cultural competence. Just because a clinician speaks Spanish fluently, this does not equate to having cultural competence. Many graduate programs offer multicultural classes in psychology that aim to increase knowledge of different cultures and

learning to be more culturally sensitive when using different therapy modalities (Barrera & Castro, 2006). However, the cultural knowledge we possess as clinicians is most useful when we speak the language of the client. Training clinicians who will be treating the monolingual Spanish-speaking population should include skills training that aim at both cultural and linguistic competence since both are equally important.

Cultural Competence

The American Psychological Association has implemented ethical guidelines to ensure ethical practices for working with diverse populations. The implementation of the APA's Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists requires psychologists to be aware of their personal thoughts, assumptions, and beliefs about others, especially how these may influence psychological practices (APA, 2017). These guidelines outline the importance of self-awareness, awareness of one's worldview, cultural biases one might possess, and encourages the increase in knowledge of the values, history, and worldview of diverse groups. More specifically, it is important to understand concepts related to historical forms of oppression, impact of stigma for some populations, and immigration patterns when working with diverse populations. While these guidelines encourage awareness and education in these very important areas, these terms could be perceived as very broad and difficult to measure (Hwang & Wood, 2007). Furthermore, having the knowledge and awareness of these concepts does not necessarily mean that one has the skills necessary to be a culturally competent clinician. Cultural knowledge is important, but it must be understood in a specific context taking into consideration the subjective experience of each client's feelings, cognitions, and behaviors (Toporek & Reza, 2001).

Clients respond to the multidimensional aspects of clinician's cultural competency. Knipscheer and Kleber (2004) demonstrated that clients are more satisfied with their clinician when they perceive the practitioner to be culturally competent, compassionate and able to understand their worldviews. Prior to defining cultural competency, there needs to be a clear

understanding of the meaning of culture. According to Kagawa-Singer et al. (2014) culture can be defined as “a shared ecological schema or framework that is internalized and acts as a refracted lens through which group members ‘see’ reality and, in which both the individual and the collective group experiences the world” (p. 29). Culture can also be seen as the dynamic process of groups of people representing shared meaning, ideas, beliefs, values, norms, attitudes, language, spirituality, practices, and symbols particularly in relation to positions of power, privilege, and oppression (Vargas, Porter, & Falender, 2008). Furthermore, the concept of culture may be more complex than what it appears to be at face value. Culture is interwoven throughout every human experience in ways that may or may not be easily observed (Vasquez, 2014). Thus, the task of defining cultural competence in the field of psychology may be challenging at best. It has also proven to be a term that is not only difficult to define, but difficult to teach because of its complexity (Hwang & Wood, 2007).

The term cultural competence can be defined as possessing the cultural knowledge and skills of a particular culture to deliver effective interventions to members of that culture (Sue, 1998). More specifically, cultural competence is the process by which one is able to frame one’s assumptions, knowledge, and meaning from a cultural perspective when working with clients of diverse backgrounds (Dunaway, Morrow, & Porter, 2012; Stanhope, Solomon, Pernell-Arnold, Sands, & Bourjolly, 2005). Cultural competence can also be seen as a skill that is ever evolving in clinicians. One does not achieve cultural competence and then stops growing in this area because there will always be more to learn and understand about others (Doutrich & Storey, 2004). A generally accepted paradigm on how to attain cultural competence is based on the work of Sue, Arredondo, and McDavis (1992) who propose that cultural competence can be understood as having three important elements: cultural awareness (i.e. of values, attitudes, beliefs, and biases of the client and self), cultural knowledge (i.e. understanding the cultural heritage of the client and self), and cultural skills (i.e. regularly seeking training, consultation, and a deeper understanding of culture and its impact).

It has been suggested that cultural competence may not be the most accurate or appropriate term to use because it implies an expert status. Other more appropriate terms have been proposed such as cultural responsiveness, cultural humility, and cultural empathy (Arredondo, Gallardo-Cooper, Delgado-Romero, & Zapata, 2014; Comas-Diaz & APA, 2012; Tervalon & Murray-García,1998). For one to be considered culturally responsive, one must know oneself, one's values, assumptions, and worldviews that inform one's assessment of self in addition to the assessment of others (Arredondo et al., 2014). Cultural humility can be defined as incorporating "a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations" (Tervalon & Murray-García,1998, p. 117). Having this perspective when working with clients of different backgrounds can be a healthy reminder that not only does the client learn from the clinician, but the clinician also has a lot to learn from the client and his or her culture. Lastly, cultural empathy can be described as the ability to develop vicarious experiences such as thoughts and feelings revolving around the cultural well-being of each client (Comas-Diaz & APA, 2012).

Training and Assessment of Cultural Competence

The development of competence as a clinician requires both academic education and clinical training. Cultural competence is fostered and achieved through the development of culturally sensitive knowledge, skills, and attitudes (Falender, Shafranske & Falicov, 2014). Unfortunately, the training of multicultural competence in graduate programs often relies on requiring students to take a single course on the topic. Dickson and Jepsen (2007) believe that a multicultural framework that is integrated into the program's curriculum, supervision, and recruitment is the key element that contributes to higher rated student competencies. It is proposed that in order to create a culturally competent curriculum, faculty must demonstrate multicultural expertise, which includes awareness of one's own biases and prejudices, in

addition to making course content more inclusive of different underprivileged groups (Fouad & Arredondo, 2007). Fouad and Arredondo (2007) also propose that a culturally competent education and institution would include culture as part of their mission statement, diversity would be reflected in both staff and students alike, and diversity and culture would be an important element in the development of class curriculum.

The American Psychological Association's Commission on Accreditation (APA-CoA) makes it mandatory for graduate programs to include courses on multicultural issues in order for programs to be accredited. Unfortunately, there is data indicating that only about 67% of APA accredited programs surveyed require a multicultural course (Sherry, Whilde & Patton, 2005). It is also more common for graduate schools in counseling psychology programs to require a multicultural course as opposed to doctoral level clinical psychology programs. Furthermore, just because a multicultural class may be taught in a program, this does not ensure that cultural competence is being taught as part of its curriculum, nor does it ensure that this skill is being attained.

There have been efforts to develop measures for assessing cultural competence in clinicians. Researchers have created self-report measures based on a model of multicultural competence which consist of three dimensions including beliefs and attitudes, knowledge, and skills (Sue, Arredondo, & McDavis, 1992; Kim, Cartwright, Asay & D'Andrea, 2003). There are three surveys, each assessing one of the three specific areas. The measures include (a) the Multicultural Awareness, Knowledge, and Skills Survey- Counselor Edition, which focuses on the therapist's' level of knowledge, awareness, and skills; (b) the Multicultural Counseling Knowledge and Awareness Scale, which focuses the therapist's' level of knowledge and awareness; and (c) the Multicultural Counseling Inventory, which highlights awareness of cultural issues separate from the therapist process as an additional element of self-awareness (D'Andrea, Daniels, & Heck, 1991; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002; Sodowsky, Taffle, Gutkin, & Wise, 1994). Another similar measure, the California Brief

Multicultural Competence Scale, is also a self-report measure aimed at assessing cultural competence in behavioral health staff based on the following four areas: cultural knowledge, awareness of cultural barriers, sensitivity and responsiveness to consumers, and socio-cultural diversities (Gamst, Dana, Der-Karabetian, Aragon, Arellano, Morrow, & Martenson, 2004). These measures have been primarily developed to assess for cultural competence, but the information gathered can also be used to gauge for areas requiring further training in clinicians. These measures have been used to explore the connection between cultural competence, therapeutic alliance, treatment satisfaction, and the client's perceptions of empathy coming from the therapist (Fuertes et al., 2006). Although self-report appears to be the most common measure for assessing cultural competence, self-report is not known to be the most accurate method of assessment (Miller, 2008). It is recommended that cultural competence measures should be developed based on specific observable behaviors as this will enhance the accuracy of self-reports (Eva & Regehr, 2011).

The Role of Language in Psychology

Language has been described as instrumental in the development of one's self, reality, and schemas that make up one's subjective experiences (Witkin, 2011). Language is what encodes our cognitions and the encoding of our cognitions inevitably influences our experiences. Research has shown that using one's native language is connected to one's emotional development (Stern, 1985). Whorf (1956) was among the first to propose that language plays a role in the way humans think, perceive, analyze, and behave. He defined the role of language as *linguistic determinism* or the *linguistic relativity* hypothesis (Whorf, 1956). Boroditsky (2001) also supported similar views stating that the way one thinks is shaped by language and experience. Everett (2012) went a step further and stated that culture is an interceding influence to language and experience. Needless to say, one cannot look at culture without looking at language. One must take into account language when trying to understand a client's thoughts, feelings, and experiences in general.

As it relates to the therapeutic relationship, language influences the way both the client and therapist connect and communicate (Iannaco, 2009; Kokaliari, 2011). The American Psychological Association Guidelines specific to culturally diverse populations suggest that psychologists should provide services in the language requested by and understandable to the client (APA, 2017). Language serves as a vehicle with which a client taps into episodic memory and retells events from his or her life in therapy. Spanish-speaking clients who speak English as their second language are shown to benefit from having therapy sessions in their native tongue given that, in doing so, they are able store more information, recall more events, and experience reduce interference than using English would cause (Altarriba & Isurin, 2012).

Boroditsky (2001) was able to illustrate the importance of language as it relates to abstract and relational concepts such as time, but not necessarily so much for concrete and sensory-based objects. This has implications for therapy since much of what is discussed in therapy is, indeed, abstract. Culture itself, with all of its layers, can also be considered abstract and the nuances in the client's language can create difficulty in the therapist understanding the client if the therapist does not possess the ability to detect these nuances. Language can also pose a problem when the therapist attempts to communicate abstract concepts and ideas to the client, such as theories for understanding human behavior. Language communicates both information and prosody, which can vary depending on culture and experience. Weiste and Peräkylä (2014) were able to show how the prosody and intonation in language used by a clinician can influence the direction of therapy. Furthermore, it is self-evident that language is a crucial element to therapy when working with Spanish-speaking populations.

Bilingualism

The diversity among Spanish-speakers extends to the degree in which Spanish is spoken, including the types of bilingualism and degree of acculturation. The term native Spanish speaker refers to an individual who was raised and educated in Spanish (Brecht & Ingold, 1998;

Lewelling & Peyton, 1999). A heritage Spanish speaker refers to someone who learned Spanish as a first language at home from family or learned English simultaneously but was primarily educated in English (Brecht & Ingold, 1998; Lewelling & Peyton, 1999). A bilingual speaker is defined as an individual who can function in two languages in both oral and written form (Johannessen & Bustamante-Lopez, 2002). Relatedly, the term biculturalism refers to an individual who is comfortable and proficient with the culture of origin of his or her heritage and the culture of the country or region in which he or she has settled (Schwartz & Unger, 2010). A linguist by the name of Weinreich (1953) suggested there were two types of bilingualism, a *compound* bilingual and a *coordinate* bilingual. A compound bilingual consists of someone who, although speaks two languages, only has one representational system of meaning. He proposed that this happens when someone grows up learning two languages simultaneously. On the other hand, a coordinate bilingual is defined as someone who has two representational systems of meaning, each one pertaining to a specific language. This is seen in individuals who learn one language first and then the other (Kolers, 1963). This has implications in therapy as it relates to working with Spanish-speaking clients because speaking the same language does not ensure that both the client and clinician are tapping into the same system of meaning.

Code Switching

More recent work on bilingualism addresses the concept of code switching. Code switching, also known as language switching or language mixing, refers to switching back and forth between two languages (Altarriba & Santiago-Rivera, 1994). Heredia and Altarriba (2001) suggest that code switching happens in bilinguals because of issues in proficiency and words in one language (likely the primary language) may be more accessible than in the second language. It is also suggested that code switching happens in therapy as a defense mechanism by clients when they wish to maintain a distance from uncomfortable emotions (Heredia & Altarriba, 2001). It was proposed that code switching can actually be used as a therapeutic intervention when a bilingual clinician is working with a bilingual client (Pitta, Marcos & Alpert,

1978). This was determined because a bilingual therapist would be more adept at understanding the code switching that the bilingual client does, further gaining insight on the client and improving the therapeutic alliance.

Training and Assessment of Linguistic Competence

It can be argued that language competence is equally as important to cultural competence when working with Spanish-speaking clients. There seems to be a slightly better understanding of the importance of cultural competence by psychology graduate programs since most of them at least have a class covering the topic. However, it is rare for psychology doctorate programs to provide classes covering linguistic competence for their bilingual Spanish-English psychology students. Although there is very little known about assessing for linguistic competence in bilingual Spanish-English clinicians in a therapeutic setting, there is some research covering the assessment of linguistic proficiency in an educational setting. In his work, Cummins (2000) makes a distinction between Basic Interpersonal Communication Skills (BICS) and Cognitive Academic Language Proficiency (CALP). He makes the point that just because a student may possess the ability to effectively engage in social language, this does not necessarily mean that the student also possesses the ability to effectively engage in academic language (Cummins, 2000). The reason for this is because social language does not demand much cognitively from an individual. On the other hand, academic language does demand more at the cognitive level because it includes academic components such as listening, reading, and speaking about specific topics.

The same principles of BICS and CALP can be applied when evaluating the linguistic competence of bilingual psychology trainees and interns. Since CALP is “the ability to make complex meanings explicit in either oral or written modalities by means of language itself rather than paralinguistic cues,” this can facilitate assessment on specific linguistic skills in Spanish (Cummins, 2000). Specific linguistic skills that can be assessed would include higher order of

thinking skills such as the ability to hypothesize, infer, and evaluate clinical content all in Spanish. These are skills relevant to a clinician through case conceptualization, diagnosis, and treatment planning. Since BICS has been known to be “conversational language” (versus academic), it relies more on contextual and interpersonal cues (i.e. gestures, tone of voice, facial expressions, and body language). This, too, is a skill necessary in a clinical setting. Unlike CALP, this type of communication often depends on the visual and physical context evident in social interactions with others (Cummins, 2000). Possessing both of these skills is necessary when working with Spanish-speaking populations. Knowing and using psychological language and being competent at conceptualizing a case does not necessarily enhance the connection between the clinician and client. However, having both the BICS (social language) and CALP (academic language) skills together would allow for the best outcome in a clinical setting.

Studies evaluating the development of BICS and CALP in second language learner immigrant children suggest a developmental process that occurs in which BICS develops before CALP when learning a second language (Cummins, 1981). Research also suggests that just because a student demonstrates BICS in a second language, this does not mean that the student is also capable of CALP skills which would include the ability to complete academic work (Collier, 1987; Cummins, 1981b; Schon, Shaftel, & Markham, 2008). This is useful information to consider when evaluating linguistic competence in clinicians since linguistic competence in a social setting is different than linguistic competence in academia. Since heritage Spanish speakers are not educated in Spanish like native Spanish speakers are, it would be expected that heritage speakers are more developed in BICS than in CALP. It is also likely that heritage speakers may benefit from formal education and training using Spanish in the academic sense.

The concept of Global Language Proficiency has also been proposed as a theory by which one can assess for linguistic competence (Oller, 1979). This theory proposes that

language proficiency can be accounted by just one underlying factor (Oller, 1979). However, this notion leads to concerns because language proficiency contains aspects that are both global and aspects that are more specific as BICS and CALP more accurately describe (Baker, 2011; Cummins, 2000). The acquisition of linguistic competence is very complex and it is evident that it is a construct that would be difficult to measure. However, BICS and CALP provide a framework by which our field can begin to understand linguistic competence in a clinical setting.

Purpose of Research Study

Additional research is needed to investigate the current methods utilized to assess for linguistic and cultural competence in clinicians. This holds true for graduate programs preparing bilingual Spanish-English students and the training sites where these same students gain clinical experience. This study will provide a unique contribution to the training of bilingual students since there is very limited research on the topic. Language is a critical component of culture and cultural competence is a necessary skill when working with diverse populations. At this time, there are no standardized measures that assess linguistic or cultural competence in bilingual Spanish-English psychology students at the doctoral level. The objective of this study was to elicit feedback from doctoral level psychology students on the Spanish Language Assessment measure created by Dr. Rogelio Serrano in the hopes of using that information to make improvements to the measure. Following the administration of the measure, participants were also interviewed to provide feedback on their training experience as it relates to cultural and linguistic competence in addition to their understanding of these two concepts. It is the aim of the researcher that the feedback on the measure will eventually lead to modifications to the measure and future studies that lead to its standardization. In addition, it is the hope that feedback on student's graduate experience and training will lead to changes made at an

institutional level to better train bilingual clinicians preparing to work with Spanish-speaking populations.

Methodology

Research Approach and Rationale

The current study uses a qualitative approach that evaluates the effectiveness of the Spanish Language Assessment created by Dr. Rogelio Serrano. This assessment is currently used with bilingual master's level psychology students. The purpose of the assessment is to measure the degree of cultural and linguistic competence of bilingual Spanish-English students. The measure has not been validated or standardized and is in the beginning phases of development. It is important to understand how psychology doctoral level students react to the measure. Interviews with each participant were done to gain insight on their experience using the measure, how accurately they believe the measure reflects their linguistic and cultural competence, and input on changes that can be made to the measure to make it a better indicator of proficiency in these areas. The interview also inquired as to each participant's training experience as it relates to working with Spanish-speaking clients. This also consisted of gathering feedback on how to improve the education and training of psychology doctoral level graduate programs in order for bilingual clinicians to be better prepared for working with Spanish-speaking populations.

Qualitative Design Using Thematic Analysis

There are benefits to using a qualitative approach when the goal is to learn about the subjective experience of individuals. I opted to use the method of thematic analysis for analyzing the data gathered. This is done in order to address gaps in the current research relating to the assessment and training experience of psychology students in the areas of linguistic and cultural competence. Thematic analysis is the most common form of analysis in qualitative research. It emphasizes pinpointing, examining, and recording patterns (or "themes") within data. Themes are patterns across data sets that are important to the description of a phenomenon and are associated to a specific research question (Braun & Clark, 2006). In this study, questions relate to the participants' experience of the measure being used and gathering

feedback to improve both the measure and the overall graduate level training for bilingual psychologists. Although the measure was administered to all of the participants in the study, it was not scored. Since the measure is in the beginning stages of development and not yet validated, the administration of the assessment was primarily used as a tool to solicit feedback from the participants. The interview after the measure which consisted of five open ended questions provided rich qualitative information that was later transcribed for themes in the data.

A systematic framework proposed by Braun and Clark (2006) was used for coding the qualitative data obtained from the transcripts. This consisted of the following steps: re-reading and reviewing the data in the transcript, generating initial codes for interesting and important answers to each question, organizing codes into potential themes, refining the specifics of each theme, extracting compelling examples of the themes identified in participant responses, and finally relating them back to the research question and literature. To simplify the process, the steps for coding and thematic analysis outlined here were done for each of the five questions in the interview. Since each question covered a specific topic, it made sense to look for themes under each of those topics. The themes that were detected for each response in the interview became categories for analysis and will be outlined in the results section.

Researcher as Instrument

The researcher plays a crucial role in qualitative data, particularly thematic analysis, because it is through the eyes of the researcher that the data is analyzed for themes. Thematic analysis requires for the researcher to use their judgement to determine the themes in the data and it is encourage for the researcher to be “flexible” when identifying themes (Braun & Clarke, 2006). In essence, thematic analysis research provides an interpretation of participants’ meaning and responses (Crowe, Inder, & Porter, 2015). It is highlighted by Braun and Clarke (2006) that themes are not necessarily dependent on quantifiable measures, but rather on whether or not responses capture something important in relation to the overall research question. Thus, subjectivity plays a role and biases need to be evaluated by the researcher.

For this study, I served as the primary investigator, point of contact, and the interviewer. I designed, with the help of my dissertation chair, the way in which the assessment would be used, the interview questions, the execution of the research, and the way in which the data would be analyzed. Throughout the process of the study, I maintained a keen awareness of my biases through much self-reflection, debriefing with my peer research group, and consultation with my advisor.

As an immigrant to this country, I can relate to many of the clients I serve in therapy. I learned to speak English as a second language and I know what it is like to not speak the dominant language of the dominant culture. Despite Spanish being my first language, I would identify as a heritage speaker since I was primarily educated in English in the US. I first noticed at the master's level of my education when I first started treating Spanish-speaking clients in therapy that there was a gap in my training. I learned so much from my professors and practicum supervisors, but there was a rift in my ability to fully transfer all the knowledge I had into my work with Spanish-speaking clients. I felt that because the knowledge I learned was stored in English, it was at times difficult for me to verbalize certain terms or concepts in Spanish for my Spanish-speaking clients. I always considered myself fluent in Spanish given that it is my first language, but it was not until I started treating Spanish-speaking clients that I realized the unique linguistic skill required to provide mental health services in Spanish. Upon entering my doctorate program I began to realize that the lack of education and training for bilingual clinicians who serve Spanish-speakers was really a disservice to the Spanish speaking communities we serve. It is for this reason that I became interested in doing this study in the hopes of sparking an interest in other bilingual clinicians who work with Spanish-speakers to question the entities that train and prepare us. Perhaps this study would initiate an interest for further research on the topics of education, training, and assessment of linguistic and cultural competence in bilingual Spanish-speaking clinicians.

As a researcher for this study, it is important to acknowledge my expectations on what I would find. This is especially important because I am a student at the same or similar level as the participants. For one, I expected participants to rate their confidence level using Spanish in a clinical setting to be a 7 or below. This is because my confidence level is at about a 7 on a scale from 1 to 10, 10 being the highest. I also expected for most participants to state that they did not believe their graduate education and clinical training had prepared them for working with the Spanish-speaking population since that is what my experience had been. However, I tried to remain neutral and open minded about the fact that people do have different subjective experiences and I was interviewing students who were not in my program. I was also expecting for students to state that they believed graduate programs training bilingual clinicians should ideally have classes taught in Spanish and field training should include include supervision in Spanish. As we review the results of this study, it will be evident that some expectations were fulfilled while others may not have been.

Participants and Recruitment Strategy

Data from this study was obtained from bilingual Spanish-English doctoral level psychology students. Participants were students recruited from graduate schools in California that provide clinical doctoral level training in psychology. Although the results of the study cannot be generalized to all doctoral level students, this ideographic approach will provide a deeper understanding of students' experiences with respects to the measure and to their education and training. Those eligible to be included in the study met the following criteria of (a) being enrolled in a clinical psychology doctoral program and (b) identifying themselves as bilingual in Spanish-English and (c) are using or intending to use their bilingual language skills in a clinical setting to provide therapy.

Recruitment of participants in this study was through different types of sampling. The first will be a purposive criterion sampling strategy which requires that participants meet the

aforementioned criteria. Convenience sampling was also used, which consisted of emailing flyers advertising the study to psychology doctorate level program advisors and clinical supervisors. Finally, snowball sampling will involve reaching out to individuals known to the researcher, and asking them to inform individuals in their networks about this study. The flyer included information on the purpose of the study, the small monetary incentive of a $10 gift card to a coffee shop, the voluntary and confidential nature of the study, and how the information obtained aims to help the field of psychology, in particular the benefit to the Spanish-speaking community receiving mental health services (see Appendix B). Those who were interested in being part of the study were asked to provide an email address and phone number where they can be reached.

The goal was to recruit 6 to 8 participants since it is a qualitative study in which thematic analysis would be used. A total of seven participants responded to my flyer and were able to participate in the study as they all met the criteria for participating. The participants interested in the study were informed about the purpose of the study, the process by which information would be gathered, the Spanish language assessment that will be administered, the interview following the assessment, how the data would be used, the audio recording of the assessment and interview, and the incentive for participating. Participants were notified, as indicated in the flyer, that they would be compensated with a $10 gift card to a coffee shop for participating in the study. They were also reminded of the voluntary nature of the study. However, they were informed that if they chose to terminate the assessment and interview prematurely, they would not receive the gift card. Limits of confidentiality and informed consent were reviewed and obtained before the assessment during the phone call. Participants were allowed to ask questions regarding the study before the assessment was administered.

Procedures

Upon the recruitment of the seven participants, appointments were scheduled to take place by phone. Participants were told that the entire process would require about 30-45 minutes of their time. Participants were also told that they would need to have access to their email since part of the Spanish Language Assessment consists of giving the participants a handout with ten questions, five of which needed to be replied to in written form and the other five that needed oral responses (Appendix C). In line with the assessment instructions, the participants were told that the case vignette can only be read once more after being read the first time (a total of two times if needed). The case vignette was read in Spanish by the examiner and the entire assessment and interview process was audio-recorded to be transcribed at a later time. The participants were told that they had up to ten minutes to answer the first five of the ten questions, but none of them required that much time. Their typed responses were emailed back to the examiner prior to the examiner asking the final 5 oral questions as part of the assessment. These last five oral questions took a little longer, but all of the participants were able to answer every question on the assessment. Upon completion of the assessment, the phone call continued with the interview questions. At the start of the interview, participants were asked brief demographic questions on background information such as age, ethnicity, comfort level using Spanish in a clinical setting, and acquisition of the Spanish language (heritage vs native Spanish-speaker; Appendix G). The interview consisted of five open ended questions inquiring about the participants' experience taking the assessment and their thoughts about its effectiveness, participant's understanding of linguistic and cultural competence, and their experience in their program related to preparedness for working with Spanish-speaking clients (Appendix E). At the completion of the interview, it was requested for the participants to provide the researcher with an address to where the gift card would be mailed.

Sources of Data

There were three primary materials used as sources of data: 1) the Spanish Language Assessment created Dr. Rogelio Serrano that was used with his permission and 2) the Interview Questions aimed at gathering feedback from the participants on their experience of the assessment, their understanding of cultural and linguistic competence, and their experience on the training and education they have received for working with Spanish-speaking clients (Appendix C and E). Lastly, a Brief Demographic Questionnaire was used to gather basic background information and relevant data to the study (Appendix G).

Brief demographic questionnaire. Participants were asked about relevant background information such as gender, age, ethnicity, acquisition of the Spanish language, graduate school and type of degree, year in their program, and comfort level using Spanish using a Likert scale ranging from 0 to 10 with 10 being the highest (Appendix G).

Spanish language assessment. The Spanish Language Assessment was developed by Dr. Rogelio Serrano who is a faculty member at Pepperdine University. He is a bilingual psychologist and is part of the Aliento program which is a Master's level program aimed at preparing Master's level clinicians for working with Latinos. The assessment was created to use as a pre-assessment of Spanish proficiency in first year students. The assessment consists of a case vignette in Spanish that is read by the person administering the assessment. The vignette is then followed by 5 written questions that need to be replied to in writing and then 5 oral questions that need to be replied to orally. Thus, the measure is designed to assess for written and oral proficiency in Spanish. The first 5 written questions are very direct and consist of things such as identifying the symptoms presented in the vignette. The 5 oral questions are much more complex and consist of things such as identification of treatment directions, possible theories that can be used, and reasoning behind using a specific theory. The measure uses a rating scale based on the American Council Teaching of Foreign Languages Proficiency Guidelines (2012). The ACTFL is a tool used to assess foreign language proficiency in teachers.

The Spanish Language Assessment is scored based on five levels of proficiency which include: Distinguished, Superior, Advanced, Intermediate, and Novice. There is a maximum score of 30 points that can be obtained in the measure, 9 points of which are for the written responses and 21 points are for the oral responses. The assessment is usually administered and scored by an instructor from the program Aliento.

Interview questions. There were five carefully crafted open ended interview questions, all of which were designed to facilitate a discussion on the topic and to allow the researcher to ask follow up questions as needed (Appendix E). The Interview Questions were developed with the purpose of the study in mind, which was to elicit feedback on the Spanish Language Assessment, in addition to gathering feedback on each participant's training experience in regards to working with Spanish-speaking populations. Thus, the two first questions directly related to the assessment by asking the participants what they liked about the measure and what they would change. The second two questions asked about their understanding of both cultural and linguistic competence and ways they believed these constructs could be measured in clinicians. Lastly, there was one question asking about their graduate education and training and if they believed it was preparing them to work with Spanish-speaking clients. The last question led to suggestions provided by participants on how graduate programs can better prepare bilingual Spanish-English clinicians.

Ethical Considerations

As it relates to confidentiality, only the researcher had access to the participant's identifying information. Identifying information included demographics such as name and the graduate school they are attending. All participants were de-identified by assigning pseudonyms for each which was needed to identify their data and transcripts. After a pseudonym was assigned, the consent forms with the participants' contact information were placed in a locked file, separate from the transcripts. To ensure privacy of electronic information that was

exchanged, the email address used has a username and password and the emails corresponding with participants were encrypted for added security. In addition, upon completion of the study, all emails from participants were deleted. Regarding protected health information (PHI), because protected health information is not being collected, HIPPA does not apply.

Since the interviews needed to be transcribed, all the interviews were audio recorded using a digital recorder with the knowledge and consent of each participant. To protect confidentiality of the participants, no one else was present in the room when the interviews were taking place. The data from the digital audio recorder was transferred to a memory thumb drive and it is kept locked in a filing cabinet. The audio recorded interviews were then deleted from the audio recorder. Each interview was entirely transcribed, de-identified, and kept in a Microsoft Word document that is secured with a password. The document containing these de-identified transcriptions is saved in my personal computer, which is kept locked and requires a password to use. The data will be kept for five years and then all of it will be permanently deleted.

Ethical considerations were also taken when it was decided that the Spanish Language Assessment would not be scored. This was decided after careful consultation with IRB and my dissertation chair. Had the assessment been scored, there would be questions as to who scored the assessment and whether or not that individual (who also happens to be a student with similar training and education as the participants) was proficient enough to score the assessment. Another ethical concern was the fact that the participants may want to know their score on the measure, but the assessment is not yet validated or standardized. In addition, receiving a lower score than expected may lead to uncomfortable feelings related to their perceived cultural and linguistic competence.

Despite the fact that the measure was not scored, the interview questions may have still triggered some distress in the participants. Risks that include qualitative interviews include

feelings being brought up related to the content of what is being discussed. The subject matter can be very personal in nature. This is especially true when subjects are being asked about their personal experience and opinions about something that is likely highly valued, such as their career choice and educational experience. It is for this reason precautions were taken and a list of mental health referrals was provided for each of the participants (Appendix F).

Results

Demographic Characteristics of Participants

Demographic data on the participants was collected over the phone at the start of the phone call. The demographic information gathered included gender, age, and ethnicity. Other background information gathered included: name of graduate school and degree (Ph.D. vs Psy.D.), year in their program, acquisition of the Spanish language (native speaker vs. heritage speaker), and their self-reported comfort level using Spanish on a scale from 1 to 10 (1 being the lowest and 10 being the highest).

The demographic and background information on the participants is outlined in Table 1. A total of 7 students were screened and met the criteria for inclusion in the study. All of the participants were part of a doctoral-level clinical psychology program, identified as bilingual Spanish-English speaking, and all were already using or intending to use Spanish in a clinical setting. All of the participants were either in the 3rd or 4th year of their graduate training. This may result in a more accurate reflection of their training since they are towards the end of their respective programs. In addition, they all disclosed having experience working with Spanish speaking clients in a clinical setting at the time of the interview. The participants consisted of 2 males and 5 females and their ages ranged from 27 to 44. They were all asked to self-identify their ethnicity and two described themselves as Mexican, two as Mexican American, one was Central American, one was Colombian, and one was Spanish. Of the seven participants, all of whom were bilingual, two were native speakers and five were heritage speakers. The two native speakers received formal education in their home countries thus qualifying them as native speakers. The other five either learned Spanish first or at the same time as English, but were formally educated in English.

Table 1

Demographic Characteristics of Participants

Gender	*n* (%)
Male	2 (28%)
Female	5 (72%)
Age	
21-30	1 (14%)
31-40	4 (57%)
41-50	2 (28%)
Ethnicity	
Mexican	2 (28%)
Mexican American	2 (28%)
Colombian	1 (14%)
Central American	1 (14%)
Spanish	1 (14%)
Degree Program	
Psy.D.	7 (100%)

(continued)

Year in Graduate Program	
3rd	5 (72%)
4th	2 (28%)
Language Acquisition	
Native Speaker	2 (28%)
Heritage Speaker	5 (72%)

All of the participants reported having some experience working with Spanish-speaking clients in a clinical setting and when asked how comfortable they felt using Spanish in session, most participants reported a comfort level of 7 or above. All of the participants were able to answer both the written and oral questions to the vignette. Although the vignette was not scored by the researcher, it was observed that all of the participants were able to communicate effectively and clearly in Spanish. There were two participants who used English briefly to describe a term or intervention (as part of the last oral question for the vignette). It was noted that these two individuals were the ones who scored their comfort levels for using Spanish lower than the other participants (at a 5 and 7 out of 10).

Table 2

Comfort Level Using Spanish in Therapy

Participant	Comfort Level on a Scale from 1-10 (1 being the lowest and 10 the highest)
Sofia 1	9
Sofia 2	9
Sofia 3	9
Sofia 4	5
Sofia 5	9
Jose 1	10
Jose 2	7

The Researcher's Reflection on the Spanish Language Assessment

Initially, the study was designed with the intention of scoring the Spanish Language Assessment. However, based on feedback from the Institutional Review Board, and discussion

with my advisor, I eventually determined that the responses to the Spanish Language Assessment should not be scored. There were several factors at play when making this decision. The measure has not been standardized and is in the beginning stages of development. Thus, the degree to which it has construct validity and reliability is uncertain. Another factor considered was that I am at a very similar phase in my training as the participants. The scoring of the assessment is relatively subjective, and my own level of clinical and linguistic proficiency is still developing. I was concerned that this would compromise accurate scoring of the assessment. Finally, another factor was the fact that the participants may want to know their score for the assessment after the study, which would be a reasonable request, but they may not be in agreement or may feel discouraged by the score they receive.

The Interview

Although the responses to the Spanish language assessment were not scored, the interview following the assessment allowed for valuable information and feedback. The interview consisted of five open ended questions, two of which were directly related to the assessment, another two on linguistic and cultural competence as understood by each participant, and the last question on overall graduate training and how well they believe they are prepared for working with Spanish speaking clients (Appendix E). The interview was analyzed for general themes in participants' responses. Themes identified in participant responses for each question will be discussed in detail in the following paragraphs. Direct quotes will be used at times to demonstrate responses to some questions. To keep confidentiality, the four female participants were given the pseudonyms: Sofia1, Sofia2, Sofia3, Sofia4, and Sofia5, and the two male participants were Jose1 and Jose2.

The Spanish Language Assessment Experience

All of the participants were able to complete the Spanish Language Assessment which consisted of 5 questions in which the answers needed to be provided in writing and 5 questions in which the answers needed to be provided orally. The participants were made aware that the assessment is in the beginning stages of development and not yet standardized. They also knew that the assessment itself would not be scored by the researcher. The focus was more on obtaining feedback from those who participated in the assessment.

The first question of the interview asked what their experience was like taking the assessment and particularly, what they liked about the assessment. An overall theme in the participant responses indicated that they liked it because of how brief and straight forward it was. Most participants seemed to appreciate that. One participant, Sofia1, stated the following:

> I think it was great, just to be able to use Spanish. I think I like it because it is short and it is very representative. You really have to understand what is going on and to understand the language to get it.

Another participant, Sofia5, stated something similar:

> I like that it is pretty straight forward. I like that it is short and basic…..the simplicity was useful. I like that it was one page. It does not seem overwhelming. It is pretty straight forward. It is pretty simple. I like the simplicity.

Another theme noted in the responses to this question regarding what they liked about the assessment was that the oral questions required that they think critically and formally. The first five questions which were written questions seemed to be easier for the participants to answer as indicated by the time it took them to answer them. However, the oral questions required more time for most. As clinicians, it takes critical thinking to be able to conceptualize

each case that walks through our door. It is one thing to know the facts of a particular case, but it takes a special skill to gather that information and conceptualize it in a way that facilitates treatment planning and execution. One participant, Jose2, stated the following:

> This is the first time I have been asked to do something like this in Spanish. It's astonishing to me because when you were asking me the oral questions, I had to literally think in my brain in English and then translate it in Spanish and that is what made it challenging. I guess that is just how my brain works and so I was having to come up with things on the spot. It was challenging in that regard, but again, I have never been asked to conceptualize in Spanish which made it that much more difficult and so in my head, I was contemplating what I was doing. The processing time took a little bit longer for me and so for me it was eye opening and realizing that this is a skill that I really need to exercise. It is lacking a lot.

Another participant, Jose1, explained that he particularly liked the oral questions because it helped him articulate clinical thinking in Spanish:

> The first questions are pretty straight forward. The second set of questions, I like them because you can articulate in Spanish your clinical thinking and it gives you a further layer of how you can utilize the Spanish language in a clinical format. So as a way of formalizing how well clinicians are, or how competent they are clinically, I think it is spot on. I think it has all of the pieces, particularly because it really allows for the thinking to come through in Spanish.

The second question in the interview relates to what changes they would make to the assessment or if they would add anything to it. Ironically, given the fact that most participants liked how brief the assessment was, another theme was the suggestion of adding more questions at the end. One participant, Sofia1, stated:

> I think it is fine but if I had to suggest something, maybe, I don't know, add more questions. Maybe add a longer vignette and use a scale of Spanish language from 0 to 10 and the difficulty of the questions could be increasing. You can ask for more detail of the information. That is only if I had to add anything, but you also do not want a super long segment. I think this is great.

There might be some way to add more questions to the assessment while still keeping it brief. It would make sense for there to be more questions on the one vignette that is already part of the assessment. However, in order to add more questions, the vignette would have to be longer in order to add more elements to it. Another way to add more questions would be to add follow up questions to the responses that are given. One participant, Jose2, suggested the following:

> The only thing that I might add is that the last questions open up the possibility for more dialogue for the interviewer. The interviewer can use follow up questions, but I am not sure if that is part of the formula, you know, because not everybody will answer completely or some answers can elicit other questions so to speak. It lends itself for more conversation. I think follow up questions are a good way to see how a person reacts. You can see the questions, think about them, and answer them, but when someone throws you that curve ball follow up question, you're thinking on your feet a little more. You know what I mean? It adds another layer to how competent you are when thinking clinically in Spanish.

It is a great suggestion to add follow up questions to the questions that are already included in the assessment. However, this is something that would require a very astute interviewer that is also well versed clinically. Follow up questions would have to directly relate to the responses. Thus, the interviewer must have a keen ability to take in all of the responses and

see what can be dissected clinically to ask the respondent to further explain certain key points. Despite how good this suggestion might be, one would think that this would make the assessment even more difficult to standardize because follow up questions are dependent on responses and participant responses will inevitably vary.

Cultural Competence

Cultural competence is a concept often used in clinical settings, but it is uncertain how many clinicians actually know the meaning of it. As discussed earlier, cultural competence can be defined as a dynamic process of framing assumptions, knowledge, and meaning from a cultural perspective different than one's own (Dunaway et al., 2012; Stanhope et al., 2005). As part of the interview, one of the questions asked to participants was about their understanding of cultural competence and ways they thought this construct could be measured. Of all the questions that were asked in the interview, this appeared to be most challenging for participants. One of the themes in the data in terms of participants' understanding of cultural competence was that it essentially meant *not to assume* and that one must have an open mind and be willing to ask many questions. One of the participants, Jose2, stated the following:

> Cultural competence encompasses knowledge in that particular culture, in any culture really. It is your ability to gather information about that specific culture and to retain that knowledge, to be able to utilize it to appropriately address culturally specific issues. When I think of culture, like in this context, we are talking about Spanish speaking abilities, I am thinking there is tons of Latin American cultures and they are all distinct in their respective ways. I am familiar with certain Latin American cultures, but not all. In my experience, I have worked with people from all across Central America and they all have really distinct qualities. I have had to look some stuff up. The dialects can be different. The terminology can be different. Something what I might say can mean

> something totally different to them. What I have done is asked for clarification like “what do you mean by that?” or “what does this mean to you exactly?” and not making assumptions about what you are talking about and just really being curious. Whenever I am unsure, I always take a curious approach in order to clarify. I ask lots of questions.

The theme of not assuming was evident in most responses. Another participant, Sofia5, understands cultural competence as the following:

> Cultural competence is being able to be sensitive and being open, and respectful of the culture without making assumptions, but allowing the client or the patient to inform you, uhm, I am having a hard time with this one. It is not assuming that you know more than the client about his or her own culture. So not being based on assumptions.

Sofia3 also pointed out the importance of not assuming and understanding that a client’s behaviors and beliefs are shaped by his or her past experiences. She stated:

> So cultural competence is the ability to logically understand another person’s perspective or reactions, and not assuming that everyone thinks and reacts the same way that you do. Being able to incorporate or be open to thinking about how a client’s past experiences contributes or has shaped their behaviors, beliefs, reactions.

One of the participants, Sofia4, explained that cultural competence is not assuming, but also asking our clients from the start of treatment what their values are. Her response was very enlightening as she shared a personal experience that can be shared by other clinicians working with cultures different than our own. She acknowledges how crucial it is to have cultural competence and not assume in the following statement:

> I think the first step would be having cultural humility. I think assessing for those kind of things early on is very important. It means that you have to be really sensitive to people’s

> experiences and how they perceive the world. I think that would be step one, cultural humility. But that is the basic. I think that assessing for cultural differences is very important but very complicated and very layered. Culture is not just a one statement thing. Like intersectionality. There are kids who are bicultural. They are maybe not native to their country like their parents, you know I struggled with that. I was raised here with American values pursuing your education and career and some people in some cultures, this isn't something that they value. It is something that I had to struggle with but I understand why, you know, how it plays in therapy. That is why I think really assessing what your clients values are and goals are is one of the biggest things you have to do. You have to find a way to assess this from the beginning because I would hate to encourage or really explore certain areas that really do not mean anything for the client, you know, but it means a lot to me as American.

A general theme among all participants when asked how they think cultural competence could be assessed was that of using a vignette, which is not surprising as this was part of the Spanish language assessment that they were each given as part of this study. More specifically, participants recommended using a vignette to then ask culture specific questions. One participant, Sofia2, stated the following:

> Maybe using a vignette and including race. Aside from that, asking a clinician what they would do if they are unfamiliar with working with a specific culture. Asking them what they would ask a colleague of the same culture to know more. Asking if they would talk about that case with their supervisor. Just asking them, ethically what they would do.

Another suggestion given by one of the participants, Sofia5, was not only using a vignette, but also using role plays to assess cultural competence. The following are her ideas:

> I would ask the therapist to just briefly ask about you know, to define what is culture. I would provide a scenario about how would you respond to this family. Like just give an example. [Interviewer: Like a vignette?] Yes. Like give an example, if this would happen. Um, like what if the family wants to give you a gift? Like how would you respond? I would assess more like having the therapist in action. Maybe even a role play.

Linguistic Competence

Participants were also asked about their understanding of linguistic competence and how they believed this could be assessed in clinicians. A general theme among all participants was that linguistic competence was the ability to communicate clearly and effectively with our clients, in addition to the ability to understand and perceive accurately what the client is trying to communicate. In essence, it was described as the ability to engage in a dialogue with our clients in both an expressive and receptive capacity, both of which are equally important. Interesting, another theme in the responses to this question echoed aspects of how cultural competence was understood by the participants. For example, being competent linguistically was also having that cultural sensitivity of not assuming you know and therefore asking questions when you are unsure about something a client says. One participant, Sofia1, responded:

> I think it is the ability to ask, to make sure you are understanding. If there is a particular word for which you are not clear, then ask about it. I find that with Spanish speakers, they speak assuming that you are going to understand them very well. So not assuming and asking “what did you say?” So making sure that I am understanding them. Just because you understand them, they think that you are going to understand even beyond the language, even the thought. So slow down and asking a lot of questions.

Unlike the previous question on cultural competence, asking about linguistic competence was likely the easiest question to answer for some participants. It was easiest to answer in part

because it seems like it is easier to assess for linguistic competence than it is to assess for cultural competence. Looking for linguistic competence could be assessed by simply having a conversation with someone in Spanish. In fact, this was a theme in the answers provided by the participants. Many of them stated that in a clinical setting, a big part of the interview when hiring a Spanish speaking clinician should be in Spanish. Some of them who had interviewed for positions requiring use of the Spanish language reported that they were asked to speak Spanish for the interview. One of the participants, Jose1, shared the following:

> I think if you are going to have access to Spanish speaking clientele, you need to have a little bit of everything. A combination of the academic Spanish to be able to translate terms and you have to have the natural flow of being able to translate those words into conversational language. [Interviewer: Okay so how would you assess for that? Let's say you are an employer and you are trying to assess for Spanish language proficiency in a bilingual candidate?] I think this vignette and the subsequent questions really hit a lot of key points, but I would be more interested in having the entire interview in Spanish or opening more areas of embedding Spanish into the language. You know I have had interviews before for Spanish speaking positions as a therapist and the assessment for Spanish is a five minute conversation, where as long as I could keep it up in Spanish, I am good to go. Whereas my thinking is if my clientele will primarily be in Spanish, then ask me what are my goals as a clinician in Spanish to see if I could answer.

A very similar response was given by Sofia5 as illustrated here:

> If I am hiring someone as a bilingual therapist, half of my interview, or at least 20 minutes of it would be in Spanish. This is so that I could see the comfort level of the therapist. When I was interviewed at Pacific Clinics many years ago, half of the interview was in Spanish which was very, very appropriate. [Interviewer: So the half that is in

> Spanish would consist of basic interview questions?] Yes. Very basic interview questions. Maybe even just ask the therapist to share about her or himself. [Interviewer: Okay. Aside from that, is there any other way that you can think of?] Hmmm, let's see. I would just have a conversation about therapy. I don't know, like just talk about your training in graduate school but in Spanish so that I can see how familiar the therapist is with just basic Spanish. Even the word therapist, you know a lot of therapists get it wrong and they say "terapista" when it is "terapeuta." So just basic vocabulary.

Although having a basic conversation in Spanish may be an effective way of assessing linguistic competence in a clinician, it may be difficult to create a standardized assessment using this method as conversations vary in nature. Even if the topic of the conversation is narrowed down to clinical training experience as suggested by Sofia5, the most that can be determined is whether or not a clinician can hold a conversation in Spanish. However, one might argue that this is in essence the basic linguistic ability one wants to ensure in clinicians who will be working with Spanish-speaking clients.

Preparation for Working with Spanish-Speaking Clients

The final question in the interview was the one that provided the most valuable information in terms of ways to prepare and train clinicians. This last question asked whether or not the participants felt that their education and clinical training had prepared them for working with the Spanish-speaking population. They were asked to elaborate the reason for which it has or has not prepared them. When the answer was "no," this inevitably led to the question of what can be done to improve programs and training to better prepare bilingual clinicians for working with Spanish-speaking populations. All of the participants had great ideas of what can be done to improve programs to better prepare bilingual psychologists.

A little more than half of the participants did not believe that their graduate training, which includes both the education and the clinical training sites, has prepared them for working with the Spanish-Speaking population (see Table 3). In fact, those who did give their schools the benefit of the doubt and stated that they did believe they were trained to work with Spanish-speaking clients explained that the reason they felt this was because their program had done a good job at bringing multicultural and diversity issues to the forefront of their education and training. This was not only done by their schools through offering multicultural courses, but also because they believed that all of their courses encouraged inclusion of culture and diversity. One of them gave the example of having to incorporate cultural factors as part of her assessment class when writing a report or presenting on a case. Another participant explained that her program offered a “multicultural track” which placed more of an emphasis on multicultural issues, which she appreciated. The three participants that reported that their school has prepared them for working with Spanish speaking clients reported that their exposure to diversity in most of their classes has helped them in feeling more confident in terms of their cultural competence but not necessarily with their linguistic competence. However, for those that did feel their schools prepared them, the fact that culture and diversity was emphasized in their program was a foundation for them to feel more competent linguistically. Due to snowball sampling, the three participants that did feel that their school had prepared them for working with the Spanish-speaking population happen to all go to the same school and have received very similar training. The program that they all belonged to appears to be more effectively training their clinicians for working with Spanish-speaking clients, at least based on what this small sample of students are saying. Although the results of this study cannot be generalized, it may be worthwhile looking further into what this program may be doing correctly to better prepare their bilingual psychology students.

Table 3

Has your Program and Training Prepared you for Working with Spanish-speaking Clients?

No	4 (57%)
Yes	3 (43%)

All of the participants reported that their programs did not offer classes on the use of Spanish clinical terminology and none had classes that were taught in Spanish. Offering courses in Spanish was a general theme in responses when asked what programs could do to better prepare bilingual clinicians. One of the participants, Jose2, expressed the importance of learning therapeutic terminology in Spanish and having a class that covers this. His response to this question was as follows:

> I am trying to think of my personal experience and what has been challenging. You mention having knowledge of basic Spanish speaking skills. I have that because I grew up speaking Spanish. However, the terminology was never taught to us. Maybe perhaps incorporating a class that teaches not only cultural competence, but also has a linguistic component where we are able to exercise our Spanish clinical terminology. Am I making sense? [Interviewer: Yes. I love that idea. Having a class that is dedicated to Spanish terminology. Maybe even requiring us to buy the DSM in Spanish in order to understand the terminology. That would be great.] Yes and not even limited to the DSM. I am also thinking about therapeutic language. Like empathy. Some of the words that come to my head in English don't quite match in Spanish. I am not sure if I am making sense. [Interviewer: Yes. I remember when I first started seeing clients I wanted to use the word attachment to explain to a client and I was left wondering how to say this word in Spanish. I couldn't. I think it is apegamiento.] You see I wouldn't have said that. I would

> have said it is *relación entre mamá e hijo*, but you see that is not really capturing what attachment is either.

Another participant, Sofia3, also echoed the same sentiment of having classes that are taught in Spanish. She stated the following:

> In ideal land (laughs), well in LA, they should offer like a class for Spanish speakers. It would be an interventions class or a theories class. You would spend part of it in English and part of it in Spanish. Or my school does not do this, but some schools have a practicum class, you could have a teacher who speaks Spanish for the practicum class. Students can do case presentations that can be done in Spanish and discussed in Spanish. If they do not want to do a class because they do not have enough students or it is not feasible, they could offer an extra course on the weekends where you meet maybe once a month for the year. Like a Saturday for a few hours.

It may be challenging to find professors willing to teach full psychology courses in Spanish. One can imagine that Spanish-speaking psychologists are few and far between, but more so, Spanish-speaking psychologists that are also professors in doctoral programs. Perhaps entire courses do not have to be in Spanish, but as suggested by some participants, having Spanish speaking guest speakers or even allowing students to present case presentations in Spanish would be a great way to prepare clinicians for entering this field with the intention of working with Spanish-speaking clients. One participant, Sofia2, stated the following:

> Practicing what they are preaching. If they want us to be culturally diverse, they should allow us to present in that language. Um, and do whatever efforts. For example, for my master's program, they brought in someone to translate when we were presenting in Spanish. That would be great because it allows us to grow linguistically and just engage

> with the client. It is giving my Spanish speaking clients the same importance as the English speaking clients. They are worthy of being videotaped and worthy of being analyzed and critiqued- not them being critiqued, but us as Spanish speaking clinicians.

Sofia2 brings up a good point in that our Spanish-speaking clients are also worthy of being given attention in the academic and overall training realm. Having the opportunity to do case presentations in Spanish and even consulting about our cases in Spanish is a way of honoring our Spanish-speaking clients. This would give our Spanish speaking clients the same attention and the same analytical mind that is given to our English speaking clients. If clinicians are better able to conceptualize each unique case in the client's native language, how much more would this improve the quality of therapy? Just being able to formulate concepts effectively in Spanish will better prepare clinicians (and give them practice) for better explaining things to their clients in session.

Great suggestions on what could be incorporated into a graduate program were also given by Sofia5. She suggested the following:

> I would create a class that would allow students to role play. I would even require the students to buy the DSM in Spanish or to do different activities that would allow them to familiarize themselves with basic terms. I would actually have maybe some guest speakers in the class. Maybe ask therapists who have practiced in Spanish speaking countries to come and talk about their practices just for the students to familiarize themselves with it. Or even, for example, I would have guests who were born in other countries and came to the US at a later age. Knowing how their experience was growing up in another country and just sharing that, just to break a lot of assumptions. I would even create a workshop for the professors to have sensitivity on how to talk to the students about this topic. So I would start with the professors and giving them cultural

training, especially because we do not have a lot of professors that are Spanish-speaking.

Many of the suggestions given by the participants have already been considered but they are difficult to implement into reality. It may take a lot from people already in the field of psychology, both bilingual and not, to advocate for the importance of incorporating this kind of training for psychologists who will be working with Spanish-speaking clients. It does not have to start big with complete courses being taught, but perhaps it can start small with weekend workshops.

Discussion

The mental health field requires competent service providers who are trained and prepared to deal with the complexities that come with each client, including clients who are culturally diverse and may speak a different language. Graduate programs in psychology often pride themselves in the training they provide to their students preparing them to be psychologists. In fact, accredited programs are required to meet competency benchmarks when training their students. For example, psychology doctoral programs are expected to train their students in multicultural and diversity issues. While programs are required to address cultural diversity in their training, there appears to be limited training in the area of linguistic competence. Linguistic competence may naturally be related to cultural competence, but they are clearly two different constructs. This study focuses on these two areas, specifically through the use of a measure that was created to assess for these areas in bilingual clinicians. This qualitative study consisted of using the Spanish Language Assessment by Dr. Rogelio Serrano with seven doctoral level psychology students who identified as bilingual, Spanish-English speaking. In addition to administering the instrument to participants in order to obtain feedback on the measure, they were also interviewed and asked questions on their overall training experience in graduate school, specifically about how and if they believed they were being properly prepared for working with Spanish-speaking populations.

It is important to note that the Spanish Language Assessment that was used for this study is currently used to assess the proficiency of Master's level students in graduate school at the start of their program. Once the measure is standardized, it would be ideal to use both at the start *and* at the end of a student's program in order to assess growth and overall proficiency in the areas of linguistic and cultural competence. This would provide valuable feedback to the student in terms of areas that can be improved, and to the school in terms of areas they may need to focus on more in their training of Spanish-speaking clinicians. Ultimately, if the measure is proven to be accurate and valid, it would be ideal to use by employers to assess proficiency in

clinicians prior to clinicians working with Spanish-speaking clients. This would also constitute as an ethical practice that upholds the Spanish-speaking clientele to the same regard as the English-speaking clientele.

All the participants completed the Spanish Language Assessment and provided valuable feedback. A thematic analysis indicated that most participants liked the fact that the measure was brief. In addition, participants agreed that the oral questions were more challenging and likely a better indicator of Spanish language proficiency. These questions required more than a basic understanding of the Spanish language since it required critical thinking and the ability to conceptualize a case in Spanish, in addition to providing a comprehensive answer in Spanish. It was very easy to tell whether or not the participant knew Spanish via the written questions, but it did require a higher level of Spanish fluency to be able to discuss a treatment plan with specific interventions. A study that administered a Spanish oral and written proficiency test created for students in a classroom who learned Spanish as a second language demonstrated that some students were more proficient writers than speakers, while others were more proficient speakers than writers (Hubert, 2013). It would make sense to require a stronger oral proficiency being that the nature of work for psychologists is mostly verbal, albeit proficiency in both would be ideal. Furthermore, the assessment in this study may improve its ability to capture the degree of Spanish language proficiency by the addition of more oral questions.

Other suggestions for improving the measure included adding more questions specific to the vignette, adding more follow up questions for the oral part of the assessment based on responses given, and adding questions about psychological terminology and diagnosis (not necessarily related to the vignette). Adding more questions to the assessment may also prove helpful once the measure is tested to ensure it has construct validity (Gillem et al., 2016). It is important to note that the level of training for clinicians would moderate the ability to conceptualize each case regardless of which language is used as this is an analytical process. Research shows that academic training and experience are factors to be considered in

psychologists' ability to conceptualize cases (Brammer, 1997). Thus, a clinician may be limited in the ability of conceptualizing a case in Spanish by not having enough education and training and not necessarily because Spanish language skills may be lacking. All of the participants seemed to have a similar view of the concepts of cultural and linguistic competence. A theme in responses for the definition of cultural competence was that of "not assuming" that one knows what the client is experiencing, having the curiosity and humility to ask questions, and having the self-insight to know that one's biases and beliefs may play a role in treatment. In terms of assessing for cultural competence and linguistic competence, it seemed easier for the participants to come up with ways to assess for linguistic competence. The use of vignettes and role plays were suggested. Furthermore, the study demonstrated that although linguistic competence and cultural competence are two different constructs, both are equally as important when working with Spanish-speaking clients. This is because although one can communicate linguistically with a client, cultural competence is necessary to not assume one knows what is meant by what is said. Sometimes clinicians need to detect hidden meaning in what is said, in addition to noticing nuances in tone and body language. So much of the communication that happens in therapy goes beyond what is spoken. Research shows that even the tone one uses as a clinician often determines the direction of the therapeutic interaction between client and clinician (Weiste & Peräkylä, 2014). Some may even argue that verbal communication cannot be truly understood independent of non-verbal communication (Jones & LeBaron, 2002). Furthermore, the ability to demonstrate cultural and linguistic competence requires knowledge of not just language but also knowledge of the culture's history, beliefs, and values.

The results of this study also demonstrated that most Spanish-English bilingual doctoral psychology students do not believe that they have been sufficiently prepared for working with the Spanish-speaking population. This is unfortunate because they all had already provided therapy to monolingual Spanish speaking clients through their practicum experiences and were planning to continue providing services in Spanish upon graduating. The few that believed that

their doctoral programs have prepared them said that this was mostly because their program had done a great job at making them culturally competent, but not because of a linguistic focus in their programs. This is a reflection of the interwoven nature of language and culture. Another theme among participants was that doctoral programs who are training bilingual Spanish-English clinicians should teach classes in Spanish, particularly focusing on clinical terminology and theory in Spanish. Other suggestions were also given, which included that students should be encouraged to do client case presentations in Spanish, and professors should also be Spanish-speaking and ideally have some experience working with Spanish-speaking clients. Finally, the participants recommended having regular meetings with other Spanish-speaking students in the program where resources can be shared, cases can be consulted, and mentoring can occur with the most experienced and proficient Spanish-speakers coaching the least experienced. All of these ideas would not only make the programs better in preparing bilingual Spanish-English psychologists, but, as highlighted by a participant in the study, this would give the Spanish-speaking clients the same respect as the English speaking clients.

Strengths and Limitations

There is very little research on the assessment of linguistic and cultural competence for Spanish-speaking clinicians. This study used a measure that was intended to gauge bilingual students' linguistic and cultural competency, and obtain feedback on the measure from bilingual Spanish-English psychology students who are planning to work with Spanish-speaking clients. The feedback provided can be used to modify and improve the measure. This study also shed light on the participants' experience in their graduate training and whether or not they believed they were being prepared for working with Spanish speaking clients. It did not come as a surprise that most of them did not believe they were being prepared, especially because they were lacking the linguistic component in their training. Many valuable suggestions were given on ways to improve graduate level training for psychologists who will be working with Spanish speaking clients. The feedback provided will hopefully help improve the measure in order for it

to be used as a tool for assessing these very important competencies in clinicians. In addition, the feedback provided will hopefully broaden the discussion in the mental health field about what graduate schools can be doing to better train clinicians who will be working with Spanish-speaking populations.

There were some limitations of the study that must be considered. One limitation was the number of participants. Although the number was within the targeted amount of seven for the study, more participants would have rendered more data to analyze and different themes may have surfaced in the analysis. Also, due to snowball sampling the seven participants were only from a total of 3 different doctoral psychology programs, all within southern California. Participants in other programs or even other states may have had very different experiences and reactions to the assessment and given different answers for the interview. The interviews were all completed by phone and one may question whether or not the participants would have been more candid or open with the researcher had the interviews been in person. Also, the qualitative nature of the study allows for some subjectivity to take place particularly with the researcher gathering the data through the interview and then analyzing it for themes. Although the interview protocol was comprised of structured questions, the researcher solicited clarification from some of the answers, which may have unintentionally skewed the focus for some of the answers.

Although the Spanish Language Assessment was not scored, there was some insight gained through the administration of the measure. An observation that I made while administering the assessment was that because the “answer sheet” had the vignette on it, the participants had the opportunity to review the vignette for both the written answers and the oral answers. I am not sure if this was the intention when the assessment was developed. One of the participants did state that having the vignette printed on the answer sheet helped her to “remember” some of the basic facts in the vignette such as the age of the identified patient and how long ago the father had been deported. One of the oral questions is asking for a brief

summary of the case. It was noted that most of the participants appeared to be reviewing the printed vignette on the “answer sheet” as indicated by giving responses with almost identical wording as the vignette and in similar order. I am not sure if this was intended by the creator of the assessment since the assessment is likely administered in person. Perhaps this would not have happened if the assessment had been in person for this study. A concern I have is that this part of the assessment may be testing memory recall rather than linguistic comprehension, due to the number of facts that participants are asked to remember. It could be argued that an aspect of a clinician’s job is to remember facts, and this should be easier if the clinician is proficient in the language. Given that the vignette is read by the examiner, it may be better for the examiner to also read the first five questions and then allow for the participant to respond in writing without being able to look at the written vignette. This will tell the examiner if the participant is able to respond accurately solely based on what was heard and not what is in writing. This would also be a more accurate representation of what happens in a therapy session where communication is generally spoken and not read.

Recommendations for Future Research

Although this study can serve to help improve the Spanish language assessment that was used through the feedback that was provided, the study did not focus on standardizing the assessment. Recommendations that can come from this study would include research that would help in standardizing the measure once modifications have been made. Once the measure is standardized and sufficiently valid, it can be used by professionals in graduate schools and in the mental health field to screen for cultural and linguistic proficiency. More research can also be done on a broader scale that would encompass other mental health clinicians at a master’s level and not just doctoral level training. This may allow for a larger participant pool given that there are more masters level clinicians that are bilingual Spanish-English speaking than there are doctoral level clinicians (U.S. Department of Labor, Bureau of Labor Statistics, 2016).

Linguistic competence and cultural competence are two separate constructs and each warrant an in-depth understanding in the field of psychology, particularly for clinicians providing culturally-responsive services. Having competence in both will inevitably assist in providing quality care for Spanish-speaking clients. There should be more research in learning to assess these constructs more carefully in clinicians either through the use of vignettes, role plays, or direct questions. Having a more concrete understanding of these constructs will facilitate the development of measures to assess for them. Having a way to assess for these skills in a clinician will help guide each clinician by helping them identify their areas of strength and weaknesses. Indirectly, this will help the Spanish-speaking populations to which we provide mental health services.

Implications for Training and Clinical Practice

This study highlighted the great deficit there is in training bilingual Spanish-speaking psychologists. Based on the answers provided by the participants, there are ways in which they believed their graduate program was preparing them for working with the Spanish-speaking population. One way was that their program was intent in incorporating culture to all of its courses, such as assessment and theory classes among others. Some of the participants' suggestions were unique to individual participants, so they could not be included in the common themes presented in the results section. Nevertheless, these suggestions provided many valuable recommendations for graduate programs to improve the training to Spanish-English bilingual psychology students. They included:

- Having courses taught in Spanish (ideally by a psychologist who has had firsthand experience working with Spanish speaking clients).
- Having a course specific to learning psychological terms in Spanish.
- Having guest speakers who share about their culture, upbringing, and experience living in the US.

- Having individual and group supervision in Spanish at their respective practicum and internship sites.
- Doing presentations on case conceptualizations in Spanish and receiving feedback in Spanish.
- Having mentorship groups in which more proficient Spanish-speaking students mentor those not as proficient in Spanish.
- Having student support group meetings that meet regularly to discuss cases in Spanish and exchange resources in Spanish.
- Requiring students to buy the DSM-5 (Diagnostic and Statistical Manual Fifth Edition) in Spanish.

In summary, it is hoped that the findings in this study lead us not only to question the quality of mental health services provided to Spanish-speaking populations, but also to take steps necessary at both an individual and institutional level to better train bilingual Spanish-English clinicians for working with Spanish-speaking populations. As a bilingual Spanish-English speaking psychologist in training, it is frustrating to be expected to smoothly execute the wealth of knowledge and training we learn in English into our work with Spanish-speaking populations. The desire is there, but the academic support needed is not. Sure, there are moments when I get my hands on Spanish therapy handouts or when I happen to buy a therapy book in Spanish that I feel myself growing and becoming a more culturally and linguistically competent bilingual clinician. However, these moments are not formalized in any way by the entities molding me as a clinician. I have never been taught or tested for linguistic proficiency by my graduate program or practicum sites, yet I am expected to treat Spanish-speakers. There is an unspoken void in our training as bilingual Spanish-speaking psychologists that needs to be analyzed carefully. Our field needs to do much self-reflection in this regard and hopefully in doing so we can improve our graduate training experience and ultimately improve the quality of service provided

to our Spanish-speaking clientele. I am hopeful that the findings in this study and others like it will be a driving force to making positive changes in how we train and assess clinicians working with Spanish-speaking populations.

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APPENDIX A: Summary Table of Selected Literature

Study Authors & Year	Title	Major Findings
Aguirre, C., Bermúdez, J., Parra Cardona, J., Zamora, J., & Reyes, N. (2005).	The process of integrating language, context, and meaning.	The primary goal of the chapter was to illuminate some of the struggles in trying to explore how clinical training has influenced cultural and professional identities.
Ali, R.K. (2004).	Bilingualism and systemic psychotherapy: Some formulations and explorations.	A case is made for the exploration of meanings of difference including the lingua- cultural one. The author ends with a plea to start including more specific cultural issues such as bilingualism in systemic therapy practice.
Altarriba, J., & Santiago-Rivera, A.L. (1994).	Current perspectives on using linguistic and cultural factors in counseling the Hispanic client.	The review of the literature examined the role of language and culture in the mental health treatment of Hispanic clients. Several innovative approaches including the use of *dichos* and *cuento* therapy are described that incorporate linguistic and cultural traits in treatment. The article proposed that the assessment of such factors as language proficiency, level of acculturation, and the degree to which cultural expressions represent symptomatology should be considered in the development of an effective treatment plan. The process of acculturation is presented as a critical dimension influencing language, cultural beliefs, and mental health. Recommendations were made for future research on issues relating to the use of language switching and language mixing in therapy.
Altarriba, J., & Isurin, L. (2012).	Memory, language, and bilingualism: Theoretical and applied approaches.	This volume provided an integrated theoretical/real-world approach to second language learning, use and processing from a cognitive perspective. A strong international

		and interdisciplinary team of contributors presented the results of various explorations into bilingual language processing, from recent advances in studies on bilingual memory to studies on the role of the brain in language processing and language forgetting. This is a strong combination of theoretical/overview contributions and accounts of novel, original, empirical studies which will educate readers on the relationship between theory, cognitive experimentation and data and their role in understanding language learning and practice.
Arnett, J. J. (2008).	The neglected 95%: Why American psychology needs to become less American.	The result is an understanding of psychology that is incomplete and does not adequately represent humanity.
Arredondo, P. (1998).	Integrating multicultural counseling competencies and universal helping conditions in culture-specific contexts.	More articles on multiculturalism are being reported in journals.
Arredondo, P., & Toporek, R. (2004).	Multicultural Counseling Competencies = Ethical Practice.	The adoption of the Competencies is indicative of ethical and culturally responsive practices. Historical marginalization based on ethnic, racial, cultural, and socioeconomic differences and scientific racism have adversely affected the mental health professions and clients deserving of services. A rationale for the adoption of the Competencies is articulated based on existing research and examples of application of the Competencies. Rebuttals are made to criticisms about the Competencies by Weinrach and Thomas (2002). Viewing the Competencies as a living document indicates their future evolution as a set of culturally universal and culturally relative guidelines for the

		mental health professions.
Arredondo, P., Rosen, D. C., Rice, T., Perez, P., & Tovar-Gamero, Z. G. (2005).	Multicultural counseling: A 10-Year content analysis of the journal of counseling & development.	Findings indicate that there has been an increase of multicultural-focused publications since 1990 and that publications are more exploratory and developmental rather than pathology-oriented.
Arredondo, P., Gallardo-Cooper, M., Delgado-Romero, E. A., & Zapata, A. L. (2014).	Culturally responsive counseling with Latinas/os.	This book provides culture-centered assessment and intervention strategies for effective clinical practice with Latina/o individuals and families. Mental health professionals will gain new and expanded cultural competence as they learn to sensitively and ethically integrate Latino values into their work. Throughout the text, case scenarios illustrate ways to work successfully with clients of all ages. A sample culture-centered clinical interview is included, along with a listing of Latino-specific mental health resources. Topics discussed include roles, relationships, and expectations in Latino families; cultural and bicultural values; gender role socialization; generational differences; identity and acculturation issues; educational values and achievement; Latinas/os in the workforce; and religious beliefs and practices.
Barrera, M., & Castro, F. G. (2006).	A heuristic framework for the cultural adaptation interventions.	Lau's (2006) analysis brought considerable clarity to these questions. We place Lau's insights and those of others within an elaborated framework that proposes tests of three types of cultural equivalence to determine when evidence-based treatments might merit adaptations: equivalence of (a) engagement, (b) action theory, and (c) conceptual theory. Extrapolating from Lau's examples and

		recommendations of others, we describe a sequence for developing adaptations that consists of the following phases: (a) information gathering, (b) preliminary adaptation design, (c) preliminary adaptation tests, and (d) adaptation refinement.
Biever J. L., Castaño M. T., de las Fuentes C., González C., Servín-López S., Sprowls C., Tripp C. G. (2002).	The role of language in training psychologists to work with Hispanic clients.	Literature regarding the importance of the Spanish language in providing service to Hispanic clients was reviewed. It was argued that services to Spanish-speaking clients are frequently inadequate because of the lack of training in the use of Spanish in professional settings. A model for training psychologists to provide psychological services in Spanish was presented along with recommendations for practitioners who are struggling with the dilemma of providing services in a language other than that of their professional training.
Boroditsky, L. (2001).	Does Language Shape Thought?: Mandarin and English Speakers' Conceptions of Time.	This study looked to see if the language you speak affect how you think about the world. This question is taken up in three experiments. It concluded that language is a powerful tool in shaping thought about abstract domains and one's native language plays an important role in shaping habitual thought (e.g., how one tends to think about time) but does not entirely determine one's thinking in the strong Whorfian sense.
Brammer, R. (1997).	Case Conceptualization Strategies: The Relationship Between Psychologists' Experience Levels, Academic Training, and Mode of Clinical Inquiry.	This study provided a case vignette of a rape victim to 138 participants (some were psychologists and others were psychology students). Clinical experience was unrelated to confidence level, perceived expertise, and ability to generate

		questions. However, experience and academic training did influence the type/mode of questions that were asked-which were questions reflecting life experience. Thus, the types of questions asked in a therapeutic setting are influenced by training and experience.
Braun, V., & Clarke, V. (2006).	Using thematic analysis in psychology.	Thematic analysis is a poorly demarcated, rarely acknowledged, yet widely used qualitative analytic method within psychology. This paper argued that TA offers an accessible and theoretically flexible approach to analyzing qualitative data. Clear guidelines where provided to those wanting to start thematic analysis, or conduct it in a more deliberate and rigorous way, and consider potential pitfalls in conducting thematic analysis.
Braun, V., & Clarke, V. (2013).	Successful qualitative research: A practical guide for beginners.	This practical guide demystifies the qualitative research process. It is the kind of guide that not only *says* how to do it but that actually *shows* how to do it, with a myriad of real, reproduced examples, useful tables, boxes, chapter summaries, questions for discussion, exercises and lists of resources including references to a companion website with even more guidance and examples.
Brecht, R. D. & Ingold, C. W. (1998).	Tapping a national resource: heritage languages in the United States.	This book discusses the various languages in the United Stated, how language develops and resources available.
Burck, C. (2004).	Living in several languages: Implications for therapy.	This research was based on qualitative analysis of subjective experiences of living in more than one language, using a combined grounded theory and discursive approach, which raises significant issues for therapy. The paper argues for the importance of taking into

		account the differences languages bring for individuals, particularly in the context of colonialism and racism. Asking about families' experiences of their languages is a fruitful way to explore cultural meanings. Multilingualism is a resource for mental flexibility and creativity, but there are challenges in enabling living with its multiplicities.
Castaño, M. T., Biever, J. L., González, C. G., & Anderson, K. B. (2007).	Challenges of providing mental health services in Spanish.	This study examined the service delivery experiences of Spanish-speaking mental health providers by exploring their perceptions regarding their competence and training. Data showed that more than half of the participants reported that they had concerns. Implications for training were highlighted.
Chambless, D.L. & Ollendick T.H. (2001).	Empirically supported psychological interventions: Controversies and evidence.	Efforts to increase the practice of evidence-based psychotherapy in the United States have led to the formation of task forces to define, identify, and disseminate information about empirically supported psychological interventions. The work of several such task forces and other groups reviewing empirically supported treatments (ESTs) in the United States, United Kingdom, and elsewhere is summarized here, along with the lists of treatments that have been identified as ESTs. Also reviewed is the controversy surrounding EST identification and dissemination, including concerns about research methodology, external validity, and utility of EST research, as well as the reliability and transparency of the EST review process.
Comas-Díaz, L., & American Psychological	Multicultural care: A clinician's guide to cultural competence.	A comprehensive, practical approach for enhancing one’s understanding of clients' contexts, developing a

Association. (2012).		multicultural therapeutic relationship, and adapting your healing approach to your clients' needs. Each chapter demonstrates the application of cultural competence to a different aspect of clinical practice: self-awareness, assessment, engagement, treatment, psychopharmacology and testing, folk healing, and general multicultural consciousness.
Connolly, A. (2002).	To speak in tongues: Language, diversity and psychoanalysis.	The author examined the problem of 'analytical listening,' and turned to the problem of bilingualism and its role in analysis. In her view, bilingual analysts are facilitated in their task of listening and of translation, because bilingualism facilitates the rapidity and fluidity of the analyst's associations, and at the same time sharpens his or her awareness of how the sound of a word can subtly change its meaning. The study ends with a clinical vignette which illustrates the role that language can play in hysteria.
Costantino, G., Malgady, R. G., & Primavera, L. H. (2009).	Congruence between culturally competent treatment and cultural needs of older Latinos.	Results indicated that cultural congruence predicted treatment outcomes independent of treatment and evidenced moderator effects with respect to depression, suicidality, anxiety and physical health criteria.
Creswell J. W. (2007).	Qualitative inquiry and research design: Choosing among five traditions.	This book explores the philosophical underpinnings, history and key elements of five qualitative inquiry traditions: biography, phenomenology, grounded theory, ethnography and case study.
Crowe, M., Inder, M., & Porter, R. (2015).	Conducting qualitative research in mental health: Thematic analysis and content analyses.	The objective of this paper is to describe two methods of qualitative analysis - thematic analysis and content analysis - and to examine their use in a mental health context.

		The illustration of the processes highlights the different outcomes from the same set of data. Thematic and content analyses are qualitative methods that serve different research purposes. Thematic analysis provides an interpretation of participants' meanings, while content analysis is a direct representation of participants' responses. These methods provide two ways of understanding meanings and experiences and provide important knowledge in a mental health context.
Cummins, J. (1984).	Bilingualism and special education: Issues in assessment and pedagogy.	This book focuses on alternatives to traditional assessments, specifically as it relates to bilingual education. The author proposes that IQ test that are normed on the dominant population are culturally biased. He also talks about underachievement in minority students and how this may be related to low abilities in primary/first language. He states that when development of both languages is supported, there is evidence of greater linguistic and cognitive growth. He also talks about his well-known framework of BICS and CALP and how conversational language is much more different than academic language.
Cummins, J. (2000)	Putting language proficiency in its place: Responding to critiques of the conversational/academic language distinction.	This article highlighted how language proficiency relates to academic achievement and stressed its importance in educational development of bilingual and trilingual children. It turned to the differences between BICS and CALP.
Daly, E. J. I. I. I., Doll,	The Competencies Initiative in	The purpose of this article is to

B., Schulte, A. C., & Fenning, P. (2011).	American Professional Psychology: Implications for School Psychology Preparation.	explain the current competency initiative in professional psychology and examine its implications and potential impact on graduate training in school psychology. A brief overview of competency-based training and the current competencies initiative in psychology is presented. Specifically, the empirical and consequential bases for existing assessment methods are examined. In spite of current pressure by accrediting agencies to implement a competency-based training model, based on the challenges examined in this article, significant work remains if school psychology trainers want to assure that competency-based training is done well.
D'Andrea, M., Daniels, J., & Heck, R. (1991).	Evaluating the impact of multicultural counseling training.	This article reports on the results of a series of investigations designed to assess the impact of a comprehensive multicultural training model among different groups of graduate students.
Dickson, G.L. & Jepsen, D.A. (2007).	Multicultural training experiences as predictors of multicultural competencies	The authors surveyed a national sample of master's-level counseling students regarding their multicultural training experiences and their multicultural counseling competencies. A series of hierarchical regression models tested the prediction of inventoried competencies from measures of selected training experiences: (a) program cultural ambience or learning environment, (b) multicultural instructional strategies, and (c) multicultural clinical experiences. Perceptions of program cultural ambience or learning environment predicted all multicultural competencies:

		knowledge, skills, awareness, and relationship. Additional findings support the importance of clinical training experiences in the context of effective multicultural training.
DiCicco-Bloom, B., & Crabtree, B.F. (2006).	The qualitative research interview.	The article reviewed the more common qualitative interview methods and then focused on the widely used individual face-to-face in depth interview. Authors discuss methods for conducting in depth interviews and consider relevant ethical issues with particular regard to the rights and protection of the participants.
Doutrich, D., & Storey, M. (2004)	Education and practice: dynamic partners for improving cultural competence in public health.	This article reports on a collaborative project linking Washington State University College of Nursing Vancouver and Southwest Washington Health District. Designed to improve the cultural competence and public health skills of registered nurses who are baccalaureate student nurses, quantitative and qualitative evaluative analyses were used to document and describe themes and strategies.
Dunaway, K.E., Morrow, J.A., & Porter, B.E. (2012).	Development of Validation of the Cultural Competence of Program Evaluators (CCPE) Self-Report Scale.	The authors were attempting to validate a self-report scale they developed named the Cultural Competence of Program Evaluators (CCPE) self-report scale, and also to assess differences in cultural competence among program evaluators based on various demographic variables. The data analysis revealed the following: three factors of the CCPE which were cultural knowledge, cultural skills, and cultural awareness. The CCPE alpha was .88, and convergent validity was established based on significant positive correlations between the CCPE and the

		Multicultural Counseling Inventory. Results indicated that cultural competency training was related to higher scores on the CCPE, and cultural competency training was a significant predictor of scores on the CCPE.
Eva, K. & Regehr, G. (2011).	Exploring the divergence between self-assessment and self-monitoring.	This paper reports on a pair of studies that examine the relationship between self-assessment (a global judgment of one's ability in a particular domain) and self-monitoring (a moment-by-moment awareness of the likelihood that one maintains the skill/knowledge to act in a particular situation). These studies reveal that, despite poor correlations between performance and "self-assessments" (consistent with what is typically seen in the self-assessment literature), participant performance was strongly related to several measures of "self-monitoring" including: the decision to answer or defer responding to a question, the amount of time required to make that decision to answer or defer, and the confidence expressed in an answer when provided. This apparent divergence between poor overall self-assessment and effective self-monitoring is considered in terms of how the findings might inform our understanding of the cognitive mechanisms yielding both self-monitoring judgments and self-assessments and how that understanding might be used to better direct education and learning efforts.
Everett, D. L. (2012).	Language: The cultural tool.	This book discusses language and culture. It proposes that language is an essential tool unique to each culture

		worldwide and not necessarily an innate component of the brain as most linguists believe. The author, Daniel Everett, shows how language is influenced by human experience and social interactions. He uses specific cultures to support his point.
Falender, C. A., Shafranske, E. P., Falicov, C. J., & American Psychological Association. (2014).	Multiculturalism and Diversity in Clinical Supervision: A Competency-Based Approach.	This book provides enhancement of the clinical training literature by describing key elements involved in attending to multicultural and sociopolitical differences between supervisors and supervisees, and between supervisees and their clients.
Falicov, C. J., & Regeser, L. S. (2000).	Latino Families in Therapy: A Guide to Multicultural Practice.	This book chapter specifically touches on methods for culturally appropriate clinical services for Latino families.
Fossey, E., Harvery, C., McDermott, F. & Daviidson, L. (2002).	Understanding and evaluating qualitative research.	This paper provides beginning researchers with an orientation to the principles that inform the evaluation of the design, conduct, findings and interpretation of qualitative research.
Foud, N.A., Grus, C.L., Hatcher, R.L., Kaslow, N.J., Hutchings, P.S., Madson, M.B., Collins Jr., F.L. & Crossman R.E. (2009)	Competency benchmarks: a model for understanding and measuring competence in professional psychology across training levels.	The Competency Benchmarks document outlines core foundational and functional competencies in professional psychology across three levels of professional development: readiness for practicum, readiness for internship, and readiness for entry to practice. Within each level, the document lists the essential components that comprise the core competencies and behavioral indicators that provide operational descriptions of the essential elements. This document builds on previous initiatives within professional psychology related to defining and assessing competence. It is intended as a resource for those charged with training and assessing for competence

Fouad, N.A. & Arredondo, P. (2007).	Becoming culturally oriented: practical advice for psychologists and educators	This book provides a comprehensive framework for helping psychologists to increase and improve culturally responsive practice, research, and education.
Fowers, B.J. & Davidov, B.J. (2006)	The virtue of multiculturalism.	The authors place the cultural competence literature in dialogue with virtue ethics to develop a way for psychologists to understand and embody the personal self-examination, commitment, and transformation required for learning and practicing in a culturally competent manner. According to virtue ethics, multiculturalism can be seen as the pursuit of worthwhile goals that require personal strengths or virtues, knowledge, consistent actions, proper motivation, and practical wisdom. The authors term the virtue of multiculturalism openness to the other and conclude by describing how attention to cultural matters also transforms virtue ethics in important and necessary ways.
Fuertes, J. N. (2004).	Supervision in Bilingual Counseling: Service Delivery, Training, and Research Considerations.	This article reviews selected literature on the topics of bilingual and multicultural counseling and supervision and provides a framework for understanding salient issues in the delivery of bilingual services. It also presents practical interventions and ideas for future empirical work in this area.
Fuertes, J. N., Bartolomeo, M., & Nichols, C. M. (2001).	Future research directions in the study of counselor multicultural competency.	This article focuses on the study role of multicultural counseling competencies in counseling and psychotherapy in the United States. The researchers say that in their review of the literature, they found that the relationship between counselor multicultural competence and process and outcome variables in psychotherapy has not been studied. Thus, the role of

		multicultural competence in counseling needs further study. Future service delivery, counselor training programs, and research endeavors in the area of multicultural counseling and competence will be galvanized by data that demonstrate how multicultural competence relates to or explains important events in counseling. Research may be directed at studying how counselor multicultural competence facilitates the development of rapport in counseling, counselor and client involvement in therapy, client trust in counseling, client affective experiencing and insight, client satisfaction with therapy, and other variables. Studies that examine the relationship between multicultural competencies and culture-dependent or culturally relevant process and outcome indexes seem especially needed and useful.
Gallardo, M.E., Johnson, J., Parham, T.A., Carter, J.A. (2009).	Ethics and Multiculturalism: Advancing Cultural and Clinical Responsiveness.	APA's ethics code mandates that clients with diverse cultural backgrounds receive ethical and responsive treatment. The authors discuss challenges related to attempts to meet this mandate, such as the use of outdated theoretical constructs and training models that aren't culturally responsive, which can present as harmful rather than helpful to diverse clients. They further discuss that more culturally responsive views of client's needs, boundaries, and multiples relationships are needed.
Gamst, G., Dana, R.H., Der-Karabetian, A., Aragon, M., Arellano, L., Morrow, G. & Martenson, L.	Cultural competency revised: the California brief multicultural Competence Scale	The authors describe the development of the California Brief Multicultural Competence Scale (CBMCS). The 21-item CBMCS was derived from principal component

(2004).		analysis, item content validated by a panel of experts, and confirmatory factor analyses. Several studies provided internal consistency, subscale intercorrelations, criterion-related validation, and assessment of possible social desirability contamination.
Gillem, A. R., Bartoli, E., Bertsch, K. N., McCarthy, M. A., Constant, K., Marrero-Meisky, S., & ... Bellamy, S. (2016).	Validation of a Standardized Multiple-Choice Multicultural Competence Test: Implications for Training, Assessment, and Practice.	This study covers the validation of a test assessing for multicultural counseling, the Multicultural Counseling and Psychotherapy Test (MCPT). The validation process started out with having 451 test items that were administered to 32 multicultural experts and 30 nonexperts. The authors identified the top 50 discriminative test items which were then administered to 227 mental health professionals. The test demonstrated evidence to have construct validity.
Gillham, B. (2005).	Research Interviewing: The range of techniques: A practical guide.	This book emphasizes on methods of clinical interviewing.
Hall, J.K. (2007)	Redressing the roles of correction and repair in research on second and foreign language learning.	The author argued that conflating the conversation analytic practice and the instructional components misconstrues the former and, in so doing, conceals the important role that each set of practices plays in language classrooms. To make her case, the author reviewed research on correction and repair from both CA and second language acquisition perspectives, laying out their distinctive features, and then use these understandings to examine the treatment of repair and correction in studies using CA to study SLA.
Hall, R.E. & Brenland-Nable, A. (2011)	Spirituality vis-a-vis Islam as prerequisite to Arab American well being: The implications of eurocentrism for mainstream	Due to the historical preponderance of racial and/or intellectual homogeneity in the field of psychology, Eurocentrism set the

	psychology.	"gold standard" for its method of intervention. As such, it might be argued that psychology remains a bastion of Eurocentric thought despite the globalization of knowledge and the influx of racially and ethnically diverse scientists into the research endeavor. At the same time and the significant increase in the immigrant Arab population, Arab Americans remain a less familiar component of society. Among the various Arab populations, spirituality through Islam is fundamental. Thus, psychologists would be remiss to exclude a critical aspect of Arab American life from intervention when it is essential to well-being.
Hays, P.A. (2001).	Addressing cultural complexities in practice: a framework for clinicians and counselor.	This book offers a framework for recognizing and working with cultural influences.
Hays, D.G. (2008).	Assessing multicultural competencies in counselor trainees: A review of instrumentation and future directions.	The article discusses various tools available for evaluating counselors' awareness, knowledge and skills for working with culturally diverse clients.
Heredia, R.R., & Altarriba, J. (2001).	Bilingual Language Mixing: Why Do Bilingual Code-Switch?	Article explored potential theoretical explanations for code switching, the costs and benefits, and the role of language dominance in the direction of the switch. The findings suggested that language accessibility may be the key factor in code switching, and that bilingual individuals switch languages when a word in a base language is not currently accessible. They discussed that in therapy, language switching becomes a defense mechanism for clients attempting to distance themselves from emotional events. They conclude that more research is needed to evaluate the cognitive

		mechanisms underlying the ability to integrate and separate two languages during communication.
Hornberger, N.H. (2005).	Opening and filling up implenentational and ideological spaces in heritage language education.	The author discusses the work of Jim Cummings on heritage languages. She highlights his main points with particular attention to international, indigenous and policy perspectives.
Hwang, W. & Wood, J.J. (2007).	Being culturally sensitive is not the same as being culturally competent.	This case study highlighted the importance of cultural competency and cultural adaptation of empirically supported treatments when working with clients from diverse backgrounds.
Hubert, M. D. (2013).	The Development of Speaking and Writing Proficiencies in the Spanish Language Classroom: A Case Study.	The study focuses on whether the acquisition of a foreign language develops differently as it relates to speaking versus writing proficiencies. Proficiency tests were given to foreign language learners (learning Spanish) and it was determined that, although there was a strong correlation between speaking and writing, some students were more proficient writers than speakers and others were more proficient speakers than writers.
Ingram, B.L. (2006).	Clinical case formulation: Matching the integrative treatment plan to the client.	This book discusses in depth various methods of conceptualizing cases while taking into account various cultural factors.
Innaco, G. (2009).	Wor(l)ds in translation – Mother tongue and foreign language in psychodynamic practice	In this study explored some of the processes involved in the act of communication for the multilingual individual. The author described a ‘continuous inner translation process’ open to defects of symbolization, and suggested that the psychodynamic counselor attends to this inner translation process and contains its inherent difficulties. The author illustrated this process by drawing parallels with the actual translation practice, and by relating it to certain

		linguistic and psychoanalytic concepts.
Javier, R.A. (1989).	Linguistic considerations in the treatment of bilinguals	This study examined research and clinical data regarding the language independence phenomenon as it relates to treatment of bilingual patients. It illustrates how linguistic shifting may further reinforce defenses.
Johannessen, B.G.G., & Bustamante-Lopez, I. (2002).	Bilingual Academic Spanish Proficiency Tests: Assessment of Bilingual Cross-Cultural and Language and Academic Development Teacher Candidates	The authors discuss how essential it is to understand the complexity of the language abilities required of bilingual teacher candidates when designing valid and reliable assessment instruments of academic language proficiency tests. They note the utilization of language tests as helpful in developing courses to enhance the Spanish language abilities of the teacher candidates. The authors also emphasize that sharing the same ethno-cultural background and similar social language skills with students can be valuable resources for the educational system. They discuss the need for teacher candidates with cultural knowledge and sensitivity and high-intermediate Spanish proficiency.
Jones, E.A., Voorhees, R.A., & Paulson, K. (2002).	Defining and assessing learning: Exploring competency-based initiatives.	This document examines the use of competency-based initiatives across postsecondary education in the United States and presents principles that underlie successful implementation drawn from selected case studies. Conducted under the auspices of the National Postsecondary Education Cooperative, this project was informed by a Working Group of individuals selected for their expertise in utilizing competencies in a variety of settings. This project

		began in September 1998 and concluded in October 2000.
Jones, S. E., & LeBaron, C. D. (2002).	Research on the Relationship Between Verbal and Nonverbal Communication: Emerging Integrations.	The authors discuss the importance of looking at verbal and nonverbal communication as an inseparable process that takes place. They talk about assumptions made in the research when looking into these two constructs.
Kaslow, N.J. (2004).	Competencies in professional psychology.	After defining professional competence, the author focuses on the identification and delineation of foundation, core, and specialty competencies within profes sional psychology. Attention is then paid to developmentally informed and innovative approaches to training in these competencies. Finally, consideration is given to state-of-the-art approaches to the assessment of these competencies for educational and credentialing purposes.
Kaslow, N. J., Grus, C. L., Campbell, L. F., Fouad, N. A., Hatcher, R. L., & Rodolfa, E. R. (2009).	Competency assessment toolkit for professional psychology	A 'toolkit' for professional psychology to assess student and practitioner competence is presented. This toolkit builds on a growing and long history of competency initiatives in professional psychology, as well as those in other health care disciplines. Each tool is a specific method to assess competence, appropriate to professional psychology. The implications of professional psychology's current shift to a 'culture of competency,' including the challenges to implementing ongoing competency assessment, are discussed.
Kim, B.S., Cartwright, B.Y., Asay, P.A. & D'Andrea M.J. (2003).	A revision of the multicultural awareness, knowledge, and skills survey-counselor.	Authors discussed the development and revision made to this scale which evaluates multicultural competence in several areas.

Knipscheer, J.W. & Kleber, R.J. (2004).	A need for ethnic similarity in the therapist-patient interaction? Mediterranean migrants in Dutch mental health care.	This study examined the importance of the ethnic similarity in mental health care in the Netherlands. Findings suggested that he majority of respondents did not value ethnic matching.
Kokaliari, E. & Catanzarite, G. (2011).	Understanding the role of language in bilingual psychotherapy: Clinical implications.	This qualitative study explored therapists' understanding of the role of language in psychotherapy with bilingual clients. Among the findings were language switching.
Lewelling, V.W., & Peyton, J.K. (1999).	Spanish for native speakers: Developing dual language proficiency.	This digest focuses on teaching Spanish to native or Hispanic heritage language students in the United States. Heritage language students are students who speak another language (in this case Spanish) as their first language either because they were born in another country or because their families speak another language at home. The entrance of these heritage language students into Spanish foreign language classes places huge demands on teachers, particularly at the secondary and postsecondary levels. As a result, a number of secondary schools, colleges, and universities in states with large Hispanic populations are offering Spanish courses tailored to the needs of Spanish speaking students. These courses offer Spanish as an academic subject to students who have some level of exposure to Spanish from their home environment. The digest discusses the need for these special courses; the characteristics of students who participate in Spanish for native speakers (SNS) courses; the goals of SNS instruction, including language maintenance, expansion of the bilingual range, acquisition of the

		prestige variety, and transfer of literacy skills; evaluation of the goals of SNS instruction; and resources for SNS professionals.
Mattar, S. (2011)	Educating and Training the Next Generations of Traumatologists: Development of Cultural Competencies	Little attention has been paid to the training of trauma psychologists and cultural competency. Three key factors are proposed to help with the education and training of these psychologists, they include: 1. The development of a trauma psychology curriculum and training which thoroughly discusses cultural factors; 2. Inclusion of cultural context in trauma psychology research; and 3. Promotion of organizational structures and culture that provide support for cultural competence within the field of psychology.
Neufeldt, S. A., Pinterits, E. J., Moleiro, C. M., Lee, T. E., Yang, P. H., Brodie, R. E., & Orliss, M. J. (2006)	How do graduate student therapists incorporate diversity factors in case conceptualization?	The authors sought to understand how student therapists incorporate diversity factors in conceptualizing cases, including the positive and negative impacts of their own cultural characteristics in the relationship with the client and treatment course. This was based on the concept that multicultural training increases a therapist's ability to better conceptualize a minority client's issues. The study found that while therapist trainees integrated an awareness of cultural issues with client participants, they varied widely in competently integrating multicultural knowledge and skills. They stated it has implications for training programs so as to have them enact and infuse the multicultural competency guidelines for more effective and ethical training and practices.
Noy, C. (2008).	The Hermeneutics of Snowball Sampling in Qualitative	The article discusses snowball sampling via constructivist and

	Research.	feminist hermeneutics, suggesting that when viewed critically, this type of sampling can generate a unique type of social knowledge that is emergent, political, and interactional. The results informed on interrelations between sampling and interviewing facets, leading to a reconceptualization of the method of snowball sampling with regard to power relations, social networks, and social capital.
Oller, J. (1979).	Language tests at school: A pragmatic approach.	This book focused on how to make, give, and evaluate valid and reliable language tests of a pragmatic sort. Theoretical and empirical reasons were discussed to establish the practical foundation and show why teachers and educators can confidently use the recommended testing procedures without a great deal of prerequisite technical training. It tries to provide practical information without presupposing technical expertise. Practical examples of testing procedures were given. The aim of the book was to fill an important gap in the resources available to language teachers and educators in multilingual and in monolingual training and use.
Paniagua, F.A., & Yamada, A.M. (2013)	Handbook of multicultural mental health: Assessment and treatment of diverse populations, Second Edition.	This book reviews the impact of cultural, ethnic, and racial factors for the assessment, diagnosis, treatment, service delivery, and development of skills for working with culturally diverse populations. It discusses diversity going beyond race and ethnicity as characteristics or experiences related to gender, age, religion, disability, and socioeconomic status. The authors provided suggestions for multicultural

		curriculum and training.
Peters, M. L., Sawyer, C. B., & Guzman, M. (2014).	Supporting the development of Latino bilingual mental health professionals.	Article discusses the struggle for Spanish speaking Latinos to receive competent bilingual service providers within the mental health field. The findings suggest this issue can be addressed by having Spanish-speaking mental health students attend higher education programs that assist with financial support, and provide cultural and linguistic competency training, as well as mentoring from peers and faculty.
Pezalla, A. E., Pettigrew, J., & Miller-Day, M. (2012).	Researching the researcher-as-instrument: an exercise in interviewer self-reflexivity.	The authors inform the importance of recognizing the unique researcher characteristics that have the potential to influence the collection of empirical data. This discussion is based on the concept of the researcher as the instrument in semi-structured or unstructured qualitative interviews. The study evaluated the interviewer characteristics of three different interviewers, with results suggesting that certain interviewer characteristics may be more effective than others in eliciting detailed narratives from respondents depending on the perceived sensitivity of the topics. They noted that these variances may benefit the goals of team-based qualitative inquiry. The article highlights training implications by encouraging enhanced self-reflexivity in interviewer training and development activities.
Pieterse, A. L., Evans, S. A., Risner-Butner, A., Collins, N. M., & Mason, L. B. (2009).	Multicultural competence and social justice training in counseling psychology and counselor education: A review and analysis of a sample of multicultural course syllabi.	The article's findings are based on a descriptive content analysis of 54 multicultural and diversity-related course syllabi as part of counseling and counseling psychology programs accredited by the American

		Psycholgoical Association and the Accreditation of Counseling and Related Programs. The overview of findings suggested that most courses adhere to knowledge, awareness, and skills paradigm of multicultural competence. Common content in multicultural courses included social justice information, however, they identified a need to more clearly outline the fundamental points of distinction and overlap between multicultural competence and social justice advocacy in counselor and counseling psychology training.
Platt, J. (2012).	A Mexico City–based immersion education program: Training mental health clinicians for practice with Latino communities.	Findings provided training recommendations for U.S. graduate students in mental health programs to better serve Latino clients. The authors discuss findings based on themes observed from a training program in Mexico that can serve as a model to help graduate students develop multicultural and international competencies, increase their Spanish language abilities, engage in an understanding of themselves as therapist, and expand their understanding of historical and cultural influences that shape the mental health care needs of Latin American clients.
Polit-O'Hara, D., & Beck, C. T. (2006).	Essentials of nursing research: Methods, appraisal, and utilization (Vol. 1).	A book providing guidance for finding, reading, and critically evaluating published nursing research. Book also discussed considerations for putting this research into practice.
Ponterotto, J. G., Gretchen, D., Utsey, S. O., Rieger, B. P., & Austin, R. (2002).	A revision of the multicultural counseling awareness scale.	The article reported results of two studies aiming to test and revise the Multicultural Counseling Awareness Scale. The authors results' indicated that knowledge and awareness as the best fit model and provide initial

		validity and internal consistency for the Multicultural Counseling Knowledge and Awareness Scale.
Pope-Davis, D.B., Reynolds, A.L., Dings J.G., & Nielson, D. (1995).	Examining cultural counseling competencies of graduate students in psychology.	Results indicated that counseling psychology students related themselves as more multiculturally competent that clinical psychology students in three of the four multicultural competency areas. Different educational and clinical variables were predictive of multicultural counseling competencies for the two groups.
Pope-Davis, D.B., Liu, W.M., Toporek, R.L., Brittain-Powell, C.S. (2001).	What's Missing From Multicultural Competency Research: Review, Introspection, and Recommendations.	Important to understand client's subjective experience of counseling when being served by multiculturally competent counselors through the examination of client's preferences, expectations, context, and adequacy of current empirical data. They propose that qualitative methods with clients is the best way to examine this. Also with regard to training and teaching, they find that capacity of the student to become multiculturally competent is related to the multiculturally competent instructors.
Pope-Davis, D. B. (2003).	Handbook of multicultural competencies in counseling & psychology.	This book provides a guide for practitioners and scholars to provide multicultural competent services by discussing various competencies within psychology and for counseling. Discussions include topics such as limitations in various models, instruments, among other topics and highlight helpful skills and models for mental health professionals.
Reboul,A. (2012)	Language: Between cognition, communication and culture.	This article challenges the Sapir-Whorf hypothesis and Everett's Hypothesis by suggesting that language and languages, rather than being "cultural tools" are instead collection of tools used in different language contexts, some cultural,

		social, and some cognitive.
Robb, M. (2014).	National survey assessing perceived multicultural competence in art therapy graduate students.	The authors evaluated the effects of multicultural competence training in art therapy programs by focusing on three aspects of training: Awareness, knowledge, and skills. Findings suggested that students' own perceptions of their multicultural knowledge and skills significantly increased after taking a multicultural course. However, their self-perceptions of multicultural awareness did not significantly increase. The article provides recommendations for addressing multicultural competence in graduate curriculums.
Roberts, M. C., Borden, K. A., Christiansen, M. D., & Lopez, S. J. (2005).	Fostering a culture shift: Assessment of competence in the education and careers of professional psychologists.	This authors were part of the Assessment of Competence Workgroup which identified principles in professional competence as well as discussed considerations for the development of methods to assess competence. Among the principles identified were discussions of maintaining a developmental perspective, practicing multicultural sensitivity, and conducting formative and summative, career-long assessment. They suggested a "culture shift" occur that went from the current ways in which competence is assessed to a more continual assessment of professional knowledge and skills across the life span.
Santiago-Rivera, A. L., Arredondo, P., & Gallardo-Cooper, M. (2002).	Counseling Latinos and la familia: A practical guide.	Book is an integrated approach to assist the understanding of Latino families and increasing competence for mental health professionals who work with Latinos and their families. It discusses information regarding Latinos and their families, the diversity of various Spanish-speaking

		groups, socio-political issues, and changes in family forms. The books also provides recommendations for counseling strategies based on a multicultural approach.
Sawyer, C., Nelson, J., Marquez, J., & Weaver, L. (2013).	Elements of a bilingual school counselor training program for Spanish speakers.	The article discussed contributing barriers related to the shortage of bilingual school counselors such as financial barriers, retention barriers, and linguistic and cultural barriers. The authors summarized elements that were found to be essential for the training of bilingual school counselors such as: recruiting and preparing school counselors to meet the needs of English Language Learners (ELL), provide intensive support and mentoring for bilingual counselors in-training, provide free counseling and support services to ELL public school students and families as part of the counselor training process, and facilitate employment placement assistance and monitoring post-training for one year.
Schon, J., Shaftel, J., & Markham, P. (2008).	Contemporary issues in the assessment of culturally and linguistically diverse learners.	The authors discuss the difficulties faced by school psychologists when assessing students from culturally and linguistically diverse backgrounds such as limited examiners who are appropriately trained, and challenges of finding and using appropriate assessment tools. They discuss issues associated with referral and assessment procedures and explain essential knowledge for examiners that include second language acquisition using basic interpersonal communication skills (BICS) and cognitive-academic language proficiency (CALP).
Schulte, A. C., & Daly,	Operationalizing and	The authors address two areas

E. (2009).	evaluating professional competencies in psychology: Out with the old, in with the new?	where further work needs to expand in order to ensure that a final process of competency evaluation is helpful to the field, our clients, and our constituents. They discuss making the improvement of competency assessment a priority, especially with regard to examining the psychometric adequacy of decisions based on competency assessments. They also outline emerging regulatory context for the field to assist with the development and implementation of competency assessments, as well as provide future recommendations in the area of competencies.
Schwartz, S. J. & Unger, J. B. (2010).	Biculturalism and context: What is Biculturalism, and when is it adaptive?	The authors discuss the concept of biculturalism and navigating across worlds. The article further explains conditions that can facilitate biculturalism and conditions that can make it more adaptive. The authors evaluate what it is, how it comes into being, its functions, and factors that can make it most adaptive.
Seijo, R., Gomez, H., & Freidenberg, J. (1991).	Language as a communication barrier in medical care for Hispanic patients.	The authors address differences language differences between Hispanic patients seen by bilingual physicians and Hispanic patients seen by monolingual (English-speaking) physicians, which can impact doctor-patient encounters and patient recall. The results suggested that when physician and patient communicate in the same language and have similar cultures, the information is better understood by the patient and engages more actively in the interaction; resulting in important implication regarding the utilization of health care services by Hispanics when language and culture awareness are incorporated.

Sherry, A., Whilde, M. R., & Patton, J. (2005).	Gay, Lesbian, and Bisexual Training Competencies in American Psychological Association Accredited Graduate Programs.	The study looked at how the American Psychological Association accredited clinical and counseling doctoral programs incorporate training issues relevant to gay, lesbian, and bisexual (GLB) clients. The findings suggested that doctoral programs are incorporating GLB in multicultural classes and practicum. Of note, counseling programs versus clinical programs were more inclusionary of discussions of GLB issues by requiring multicultural courses and mentoring students in GLB research.
Snow, C.E., Cancino, H., De Temple, J., & Schley, S. (1991).	Giving formal definitions: A linguistic or metalinguistic skill? In E. Bialystok (ed.) Language processing in bilingual children.	The book is a review of papers that explore the ways in which bilingual children manage two language systems.
Sodowsky, G. R., Taffe, R. C., Gutkin, T. B., & Wise, S. L. (1994).	Development of the Multicultural Counseling Inventory: A self-report measure of multicultural competencies.	The article presents the Multicultural Counseling Inventory (MCI), which is a self-report instrument measuring multicultural counseling competencies. The findings indicated that the MCI is comprised of four factors: Multicultural Counseling Skills, Multicultural Awareness, Multicultural Counseling Relationship, and Multicultural Counseling Knowledge.
Stanhope, V., Solomon, P., Pernell-Arnold, A., Sands, R. G., & Bourjolly, J. N. (2005).	Evaluating cultural competence among behavioral health professionals.	The authors discuss the philosophical and practical issues related to measuring cultural competence, based on the evaluation of statewide cultural competence trainings for behavioral health professionals. The challenges noted included the operationalizing of cultural competence, balancing the needs of program implementers and evaluators, and issues in the development of a robust and feasible evaluation design, which assess

		outcomes for persons in recovery and providers.
Stern, D. (1985).	The Interpersonal World of the Infant.	The author engaged in a discussion proposing four interrelated sense of self, which develop over the life spans. He contends that attachment, trust, and dependency are clinical issues throughout life versus viewing it as a gradual process of separation and individuation.
Sturges, J. E., & Hanrahan, K. J. (2004).	Comparing Telephone and Face-to-Face Qualitative Interviewing: A Research Note.	The results of this research are based on a comparison of face-to-face interviewing with telephone interviewing in a qualitative study. They concluded that telephone interviews can be used as a productive method in qualitative research and found no significant differences among both forms (e.g. face-to-face or telephone) of interviewing.
Sue, D.W., Arredondo, P., & McDavis, R. (1992).	Multicultural counseling competencies and standards: A call to the profession.	The article discussed how the Association for Multicultural Counseling and Development (AMCD) approved a document that outlined the need and rational for multicultural perspective in counseling. The Professional Standards committee proposed 31 multicultural counseling competencies and encouraged the AMCD and the field of counseling to adopt these competences when considering criteria for accreditation. The aim was to have competencies eventually become a standard to change curriculum and training of helping professionals.
Sue, S. (1998).	In search of cultural competence in psychotherapy and counseling.	The findings of this article suggest that therapist's scientific mindedness, dynamic-sizing skills, and culture-specific expertise are important and orthogonal ingredients in cultural competency. They review literature

		related to this which suggest that ethnic match between therapist and client's is important in psychotherapy.
Sue, D., & Sue, D. W. (2003).	Counseling the culturally diverse: Theory and practice.	The book includes current research in multicultural counseling, cultural and scientific theoretical formations, and expanded exploration of internalized racism. The book also provides specific techniques and advice for leading forthright and productive discussions. Additionally, the course-centric focus of the book facilitates instructor and students' needs.
Sue, D. W., & Sue, D. (2012).	Counseling the culturally diverse: Theory and practice.	The book reviews research in multicultural counseling to provide preparation for students and it also serves as an influential guide for professionals. It reviews the following main components: Multicultural counseling competence for minority mental health professionals, multicultural evidence-based practice, culturally competence assessment, and poverty and counseling.
Sweet, L. (2002).	Telephone interviewing: is it compatible with interpretive phenomenological research?	The authors' findings described how telephone interviewing is a methodologically and economically valuable data collection technique in qualitative research. They argue that qualitative researchers should not rely exclusively on the face-to-face interview since telephone interviewing can be seen as a valuable data collection approach.
Tervalon, M., & Murray-García, J. (1998).	Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in medical education.	The authors propose that cultural humility is an important aspect of multicultural medical education, as it incorporates a lifelong commitment to self-evaluation, self-critique, address the power imbalances in the patient-physician dynamic, and

		develops mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities.
Timmins, C. L. (2002).	The impact of language barriers on the health care of Latinos in the United States.	The overall intention of the article was to provide information for providers and institutions for effective strategies for bridging language barriers for Latinos in the health care system. The main findings of this article included solid evidence in demonstrating that language barriers can adversely affect quality of health care for Latino populations. Recommendations included for health care practitioners to devise effective strategies to bridge language barriers in their setting. The authors also provide guidelines and resources for access to appropriate language services in health care. Additionally, applicable laws and policies are discussed.
Trimble, J. E., & Mohatt, G. V. (2002).	The virtuous and responsible researcher in another culture. In J. E. Trimble & C. B. Fisher (Eds.), The handbook of ethical research with ethnocultural populations and communities.	This chapter in this book raises racial and cultural concerns for White researchers to consider when engaging in research involving African Americans, Latino/Latina Americans, Asian/ Pacific Islander Americans, and Native or Indigenous Americans (ALANA) . The authors discuss that a primary concern is that White researchers lack credibility in many ALANA and immigrant communities. They discussed recommendations to enhance credibility such as immersing themselves in the cultural context of participants based on the conditions under which the immersion should take place. The highlight that White psychologist should take special care to respect the racial and cultural knowledge, skills and life

		experiences of members of these groups, which can be essential for all psychologists.
Toporek, R. L., & Reza, J. V. (2001).	Context as a critical dimension of multicultural counseling: Articulating personal, professional, and institutional competence.	The authors discuss a model that addresses the complexity of multicultural competence. The Multicultural Counseling Competency Assessment and Planning Model (MCCAP) enhances the D.W. Sue et al. model through the inclusion of personal, professional, and institutional contexts as critical elements in multicultural competence. They also discuss this change occurs across three domains: affective, cognitive, and behavioral learning and competence.
U.S. Census Bureau. (2014).	Population and Housing Unit Estimates	Provides information regarding population and housing in the United States, and indicates that Hispanics are the largest ethnic minority in the United States.
U.S. Department of Labor, Bureau of Labor Statistics. (2016).	Occupational outlook handbook, 2016-17	Provides information on jobs in the U.S., specifically how many jobs there are for each field of study, what degree is required, and approx. salary.
Vargas, L. A., Porter, N., & Falender, C. A. (2008).	Supervision, culture, and context.	The authors discuss the role of supervision in training therapists as one that needs to culturally responsive to the real life issues faced by clients and that the establishment of diversity should be a core clinical and supervisory principle. The authors further note that biases, belief systems, values, and specific realities should be addressed as they impact the conceptualization and interventions of supervisors.
Vasquez, V. M. (2014).	Negotiating critical literacies with young children.	The book discusses the idea that children can co-construct knowledge with teachers and challenges older education models and previous ideas

		of teacher's role. The book has implications for social justice discussions in educational communities and in society.
Verdinelli, S. & Biever, J.L. (2009).	Spanish-English bilingual psychotherapists: Personal and professional language development and use.	This study highlighted, using phenomenological analysis, the complexities of living in two worlds and providing psychological services in two languages. Among those complexities included discussion of Spanish-English bilingual therapists feeling isolated and disconnected when struggling to use the two languages in their personal and professional lives. These participants discussed limitations given lack of training working bilingually, with specific stressors (i.e. using technical vocabulary, translating their own thoughts during sessions, etc.) noted for heritage speakers.
Verdinelli, S., & Biever, J.L. (2013).	Therapists' experiences of cross-ethnic therapy with Spanish-speaking Latina/o clients.	The findings pertained to a qualitative study exploring the experiences of bilingual therapists who are not Latino and whose first language is English in conducting therapy to Spanish speaking clients. The results indicated that colleague support, Spanish language proficiency, desire to learn about other cultures were factors that fostered their development as bilingual therapists. The acquisition of their therapeutic skills came from the feedback given by clients and through practice. The authors highlight that sharing Latino cultural values and demonstrating interest in client life experiences strengthened the connection with their Latino clients.
Weiste, E., & Peräkylä, A. (2014).	Prosody and empathic communication in psychotherapy interaction.	This study looked at the effects of prosody (intonation) of the therapist and the direction of therapy. Seventy

		audio recorded sessions of CBT and psychoanalysis were analyzed. Results showed that prosody influenced the session by the interpretation of the clients of the therapists. The interpretation was either one of being challenged or one of being validated –depending on the prosody of the therapist.
Whiting, L. S. (2008).	Semi-structured interviews: guidance for novice researchers.	The author's findings provide helpful information for conducing semi-structured research interviews using nursing literature as this field is increasingly involved in qualitative research.
Witkin, S. (Ed.). (2011).	Social construction and social work practice: Interpretations and innovations.	The book discusses how a social constructionlist and postmodern approach to social work practice can enhance the work of social work that can go beyond general evidence based practice approaches in social work.
Whorf, B. L. (1956).	Language, Thought and Reality.	Discusses the hypothesis of "linguistic relativity" which includes the idea that the structure of a human being's language influences the manner in which a person understands reality and impacts the way they behave with respect to this reality.

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APPENDIX B: Recruitment Flyer

RESEARCH PARTICIPANTS NEEDED

PURPOSE: Measuring the degree of cultural and linguistic competence of bilingual clinicians through the use of a proposed assessment tool.

ELIGIBILITY: Doctoral level psychology students who are training to be clinical psychologists and who identify as bilingual Spanish-English.

BENEFITS: Helping to improve qualifications for bilingual (Spanish-English) psychologists and assisting in the development of an assessment tool to measure cultural and linguistic competence. Ultimately the research aims to benefit the Spanish speaking community receiving mental health services by better training bilingual mental health providers.

COMPENSATION: Participants in the study will receive a $10 gift card to Starbucks.

CONTACT: Gloria Lainez

APPENDIX C: Spanish Language Assessment

Spanish Language Assessment

Aliento, The Center for Latina/o Communities

Dr. Rogelio Serrano

Master of Arts in Clinical Psychology with an Emphasis in Marriage and Family Therapy with Latinas/os.

ADMINISTRATION INSTRUCTIONS: This assessment is to be utilized in conjunction with a graduate level program of study in clinical psychology. It is designed to evaluate a student's current level of language aptitude in Spanish as it pertains to clinical data and information processing for clinical evaluation of Spanish dominant clients.

The administration of this measure should last approximately 30 minutes. The measure requires reading of clinical case vignette and 10 responses (5 written, 5 oral) to questions following the presentation of the case material. Assurances should be made that the student understands the purpose of this assessment and is afforded time to clarify any misinterpretation of instructions. The "Clinical Case Vignette" should be read no more than two (2) times in order to ensure material has been heard and understood to the students capacity.

Read the instructions as provided and record responses.

"***The purpose of this brief assessment is to help us identify your written and oral understanding of the Spanish language. While it does involve clinical material, our main purpose is to understand your language capacity and not clinical knowledge or expertise. You will be prompted to respond to some questions in writing and others in oral form. Please give the information your full attention and be sure to answer all the questions to the best of your ability. Do you understand***? Student answer

I will now read you a brief clinical case vignette in Spanish. If you need me to read it one more time I will do so. Following the reading(s), I will give you a series of questions on an answer sheet. In the first series of questions you will provide written responses. The second series of questions I will read to you one at a time and you will provide me with oral responses as best you can. Remember that it is important for you to provide me with answers in Spanish. Do you understand these instructions?" Student answer

Let's begin; here is the case vignette… "

Initiate administration by reading the case vignette and then provide student with "***Answer Sheet"*** for completion of the first series of questions (1-5). Following student's written responses begin reading the second series of questions (6-10) one at a time and listen to his/her responses. Note the student's responses and provide score on the **"Scoring Sheet"**.

SCORING: Scores should be recorded on the **"Scoring Sheet"**. Individual questions have a range of difficulty from 1-5 depending on the level of fluency [Distinguished =5, Superior= 4, Advanced= 3, Intermediate= 2, Novice= 1]. Contingent upon the answers provided, the administrator should rate each individual score. If answer is correct it should be provided full credit. Partial or null responses should be given credit in .5 increments (e.g. 0, .5, 2.5).

Answer Sheet

Trabaja como consejero/a en una clínica familiar. Le han entregado un nuevo paciente para servicios de consejería. El paciente es un niño de 10 años que tiene problemas de conducta en

la escuela. El niño vive con su mama y dos hermanas en un apartamento local. Su maestra le ha indicado a la mama que el niño requiere atención psicológica para controlar su coraje y deficiencia de atención. La familia es de bajos recursos y tiene cinco años en su vivienda. Son originarios de México y la mama trabaja como cajera en una tienda de abarrotes. El padre del niño sufre de alcoholismo y fue deportado hace dos años. El niño no tiene problemas de salud y su desarrollo ha sido libre de complicaciones.

Favor de responder a las siguientes preguntas sobre el párrafo anterior:

1. ¿Cuantas hermanas tiene el niño?_____
2. ¿Aproximadamente cuantos años tenía el niño cuando su padre fue separado de la familia?_____
3. ¿Indique los síntomas que presenta este niño?
   _____
   _____
   _____
4. ¿En cuál etapa de desarrollo se encuentra este niño? (circule su respuesta)

   Infancia Niñez Adolescencia Adultez

5. ¿Indique cual persona de esta familia debe de firmar el "Consentimiento Para Tratamiento" en este caso?
   _____

Las siguientes preguntas tendrán que contestar oralmente durante su entrevista:

6. Por favor de un breve resumen de este caso:
7. ¿Los síntomas del niño indican un tratamiento de urgencia o tratamiento general? (Favor de explicar su respuesta)
8. Formalice y provee dos preguntas que usted tendría para la maestra del niño:
9. ¿En el tratamiento de este niño es indicado hablar con el pediatra del niño? (Favor de explicar su respuesta)
10. ¿Qué teoría psicológica usara para iniciar el tratamiento de este caso? (explique su respuesta)

Scoring Sheet

Trabaja como consejero/a en una clínica familiar. Le han entregado un nuevo paciente para servicios de consejería. El paciente es un niño de 10 años que tiene problemas de conducta en la escuela. El niño vive con su mama y dos hermanas en un apartamento local. Su maestra le ha indicado a la mama que el niño requiere atención psicológica para controlar su coraje y deficiencia de atención. La familia es de bajos recursos y tiene cinco años en su vivienda. Son originarios de México y la mama trabaja como cajera en una tienda de abarrotes. El padre del

ACTFL Proficiency Guidelines: D=5; S=4; A=3; I=2; N=1

niño sufre de alcoholismo y fue deportado hace dos años. El niño no tiene problemas de salud y su desarrollo ha sido libre de complicaciones.

Favor de responder a las siguientes preguntas sobre el párrafo anterior:

1. ¿Cuantas hermanas tiene el niño?_____ **1/**
2. ¿Aproximadamente cuantos años tenía el niño cuando su padre fue separado de la familia?_____ **1/**
3. ¿Indique los síntomas que presenta este niño?
   _____
   _____
   _____ **2/**
4. ¿En cuál etapa de desarrollo se encuentra este niño? (circule su respuesta)

   Infancia Niñez Adolescencia Juventud Adultez **2/**

5. ¿Indique cual persona de la familia debe de firmar el "Consentimiento Para Tratami **3/**
   en este caso?
   _____

Las siguientes preguntas tendrán que contestar oralmente durante su entrevista:

6. Por favor de un breve resumen de este caso. **5/**
7. ¿Los síntomas del niño indican un tratamiento de urgencia o tratamiento general? (Favor de explicar su respuesta) **4/**
8. Formalice y provea dos preguntas que usted tendría para la maestra del niño: **3/**
9. ¿En el tratamiento de este niño es indicado hablar con el pediatra del niño? (Favor explicar su respuesta) **4/**
10. ¿Qué teoría psicológica usara para iniciar el tratamiento de este caso? (explique su respuesta) **5/**

*Levels of ACTFL Proficiency: **D**=Distinguished, **S**= Superior, **A**=Advanced, **I**=Intermediate **N**=Novice

___ **30/**

Score respondents points on right side and record. Max. 30 possible

APPENDIX D: Informed Consent

PEPPERDINE UNIVERSITY

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

Title of Project: Assessing Linguistic and Cultural Competencies in Doctoral Clinical Psychology Students

You are invited to participate in a research study conducted by Gloria Lainez, M.A. who is under the supervision of Carrie Castañeda-Sound, Ph.D., Associate Professor of Psychology at Pepperdine University, because you are a bilingual (Spanish-English) psychology doctoral-level trainee**.** Your participation is voluntary. You should read the information below, and ask questions about anything that you do not understand, before deciding whether to participate. Please take as much time as you need to read the consent form. You may also decide to discuss participation with your family or friends. You will also be given a copy of this form for your records.

PURPOSE OF THE STUDY

The purpose of the study is to review the training and assessment of linguistic and cultural competence in bilingual (Spanish-English) psychology doctoral-level trainees. The study intends to improve ways in which bilingual (Spanish-English) clinicians are trained and assessed in the areas of linguistic and cultural competence.

STUDY PROCEDURES

If you volunteer to participate in this study, you will be asked to provide basic demographic information (e.g. age, education, doctoral school/program, etc.), take a brief assessment measure consisting of a vignette that assesses linguistic and cultural competence, and participate in a brief interview to discuss your opinion and experience of cultural and linguistic training of doctoral level bilingual psychology students. Volunteers are required to be audio recorded in order for accuracy of data being collected. The study will last between 30-45 minutes. The interview will be conducted via telephone, a video call, or in person. Furthermore, participants will receive a $10 gift card to a coffee shop for participating in the research study. If participants choose to participate in the study via telephone or a video call, the researcher will mail the gift card.

POTENTIAL RISKS AND DISCOMFORTS

The potential and foreseeable risks associated with participation in this study are minimal, and may include discomfort with discussing the topic, fatigue and/or boredom. If feelings of discomfort or distress are triggered by participating in the study, a referral list of community mental health resources will be provided.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

While there are no direct benefits to the study for participants, there are several anticipated benefits to the field of psychology which include: gaining a greater understanding of the training and assessment of cultural and linguistic competence for bilingual (Spanish-English) psychology doctoral level clinicians.

PAYMENT/COMPENSATION FOR PARTICIPATION

Participants will receive a $10 gift card to a coffee shop for their participation in the research study. If participants choose to prematurely withdrawal from the study prior to both the assessment and interview being completed, the $10 gift card will be forfeited.

CONFIDENTIALITY

The records collected for this study will be confidential as far as permitted by law. However, if required to do so by law, it may be necessary to disclose information collected about you. Examples of the types of issues that would require me to break confidentiality are if disclosed any instances of child abuse and elder abuse. Pepperdine's University's Human Subjects Protection Program (HSPP) may also access the data collected. The HSPP occasionally reviews and monitors research studies to protect the rights and welfare of research subjects.

The data will be stored on a password protected computer in the principal investigator's place of residence. The data will be stored for a minimum of three years. The data collected will be coded, de-identified, and transcribed. The data collected will be de-identified by giving each subject a pseudonym. If there are exchanges of documents via email, these will be encrypted for added protection. The audio will only be heard by the researcher and one external auditor. The transcript may be reviewed by the dissertation chair supervising the study if necessary.

SUSPECTED NEGLECT OR ABUSE OF CHILDREN

Under California law, the researcher(s) who may also be a mandated reporter will not maintain as confidential, information about known or reasonably suspected incidents of abuse or neglect of a child, dependent adult or elder, including, but not limited to, physical, sexual, emotional, and financial abuse or neglect. If any researcher has or is given such information, he or she is required to report this abuse to the proper authorities.

PARTICIPATION AND WITHDRAWAL

Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty. However, the gift card will only be provided upon you completing the assessment and interview that is part of the study. Furthermore, you are not waiving any legal claims, rights or remedies because of your participation in this research study.

ALTERNATIVES TO FULL PARTICIPATION

The alternative to participation in the study is not participating or only completing the items for which you feel comfortable.

INVESTIGATOR'S CONTACT INFORMATION

You understand that the investigator is willing to answer any inquiries you may have concerning the research herein described. You understand that you may contact Gloria Lainez, M.A., who is under the supervision of Carrie Castañeda-Sound, Ph.D. if you have any other questions or concerns about this research. Gloria Lainez, M.A. can be reached by email or by phone. Carrie Castañeda-Sound, Ph.D. can be reached by email or by phone.

EMERGENCY CONTACT INFORMATION: In the event of a research-related emergency, you may contact: Research Chair Carrie Castañeda-Sound, Ph.D. by email or by phone. You may also contact IRB Chair Judy Ho, Ph.D. by email or by phone.

RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Dr. Judy Ho, Chairperson of the Graduate & Professional Schools Institutional Review Board at Pepperdine University 6100 Center Drive Suite 500 Los Angeles, CA 90045, 310-568-5753 and gpsirb@pepperdine.edu.

I understand to my satisfaction the information regarding participation in the research study. All my questions have been answered to my satisfaction. I have received a copy of this informed consent form which I have read and understand. I hereby consent to participate in the research described above.

_____ _____

Participant's Signature Date

I have explained and defined in detail the research procedure in which the subject has consented to participate. Having explained this and answered any questions, I am cosigning this form and accepting this person's consent.

_____ _____

Gloria Lainez, M.A. Date
Principal Investigator

APPENDIX E: Interview Questions

1. What was your experience taking the Spanish Language Assessment? What did you like about it?
2. What changes would you make to the Spanish Language Assessment? What would you add to it?
3. What is your understanding of cultural competence and what would be an accurate way of assessing it in clinicians?
4. What is your understanding of linguistic competence and what would be an accurate way of assessing it in clinicians?
5. Do you believe your graduate training (schooling and clinical practice) has prepared you for working with the Spanish-speaking population? Why or why not?

APPENDIX F: Community Referrals

Mental Health Clinics

Clinic	Phone number	Location
Airport Marina Counseling Service	(310) 670-1410	LAX
Assistance League Family Services	(323) 469-5893	Hollywood
Center for Individual & Family Counseling	(818) 761-2227	North Hollywood
Department of Mental Health	(800) 854-7771	various
Didi Hirsch Mental Health Center	(323) 778-9593	various
Gay & Lesbian Mental Health Services	(323) 993-7640	Hollywood
Families In New Directions	(323) 296-3781	Windsor Hills
Family Services	(818) 845-7671	Burbank
Foothill Family Services	(866) 304-4337	Pasadena
Fuller Psychological & Family Services	(626) 584-5555	Pasadena
Hollywood Mental Health Center	(323) 769-6100	Hollywood
Hollywood-Sunset Free Clinic	(323) 661-0718	Hollywood
Insight Teens & Families	(800) 599-8820	Pasadena
Jewish Family Services	(323) 761-8800	Miracle Mile
Kedren Community Mental Health	(323) 233-0425	South Downtown
La Vie Counseling Center	(626) 351-9616	Pasadena
Maple Counseling Center	(310) 277-2796	Beverly Hills
Mental Health America of Los Angeles	(213) 413-1130	Westlake
NAMI Los Angeles	(323) 294-7814	various
Open Paths Counseling Center	(310) 398-7877	Culver City
Pacific Asian Counseling Resources	(310) 337-1550	Inglewood
Pasadena Mental Health Center	(626) 798-0907	Pasadena
Saban Free Clinic	(323) 653-1990	various
Santa Anita Family Service	(626) 359-9358	Monrovia, Covina
Saturday Center for Psychotherapy	(310) 829-7997	Santa Monica
Southern California Counseling Center	(323) 937-1344	Mid-city
Sunrise Community Counseling Center	(213) 207-2770	Westlake
Valley Community Clinic	(818) 763-2084	San Fernando Valley
West Central Family Mental Health Services	(323) 298-3680	Windsor Hills
Westwood Counseling Center	(310) 208-3120	Westwood
Wright Institute	(310) 277-2796	Century City
LA CARE	(800) 854-7771	
Los Angeles County Services	211	

APPENDIX G: Brief Demographic Questionnaire

Age:

Gender:

Ethnicity:

Acquisition of the Spanish language (i.e. native speaker vs heritage speaker):

Graduate school and degree (Psy.D. or Ph.D.):

Year in the program:

Comfort level using Spanish in therapy sessions (on a scare from 1-10):

APPENDIX H: IRB Notice of Approval for Human Research

PEPPERDINE

Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: February 23, 2018

Protocol Investigator Name: Gloria Lainez

Protocol #: 17-06-572

Project Title: Assessing Cultural and Linguistic Competencies in Doctoral Clinical Psychology Students

School: Graduate School of Education and Psychology

Dear Gloria Lainez:

Thank you for submitting your application for exempt review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations 45 CFR 46.101 that govern the protections of human subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Since your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair

PEPPERDINE

Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives

Mr. Brett Leach, Regulatory Affairs Specialist