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Cultural Responsiveness in Psychology Training and Practice

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"Ancora Imparo: I am still learning"

Valerie B. Jordan, PhD

Michelangelo allegedly wrote this self-disclosure in 1562 at the age of 87, and it still rings true for me (and I hope other readers) as we progress through our life and career. This issue's theme of training psychologists to be culturally competent and responsive implicitly assumes that this is a life-long process. I propose that 'still learning' is a prerequisite for competency in any arena of practice.

Fortunately there is a wealth of excellent resources in our profession for information on cultural competence and diversity training, so one challenge besides staying current with the literature is incorporating this knowledge into practice. Another challenge is the personal self-awareness and growth that must accompany this evolving knowledge-base, and I think most of us realize the challenge of that self-growth, especially when issues are often very personal and poignant.

The feature articles address this theme from a variety of practice perspectives. First, Drs. Anastasia Kim and Alicia del Prado provide us with an overview of the demographic shifts that are rapidly occurring in California and nationally, and some thoughtful issues we should consider to remain knowledgeable about our diverse students and clients. Next, Drs. Charles Chege and Michi Fu describe an innovative tool they have designed, a worldview genogram, that promotes a deeper appreciation of diversity issues for both supervisors and supervisees. I interviewed deans from three APA accredited programs about their unique perspectives in training culturally competent doctoral students. Finally, Dr. Melodie Schaefer summarizes interviews with numerous doctoral students and alumni about their perspectives of the diversity training they experienced in their doctoral programs and training sites.

Finally, as this issue went to press, we learned of the death of our esteemed colleague Dr. Hedda Bolgar. I want to add my personal tribute with the many others who had the good fortune to know her as a supervisor, mentor and colleague. She truly was a model of life-long learning, being and doing good. Thanks and farewell dear Hedda.

Valerie B. Jordan, PhD *(editor@cpapsych.org) is Emerita Professor of Psychology at the University of La Verne from which she retired in 2012 after 30 years of graduate level teaching, program administration and clinical supervision. She also maintained an independent clinical practice working with college age and adult clients. She recently completed a six-year term on the CPA Ethics Committee, served on the CPA MCEP committee, is secretary for CPA's Division VII (Diversity and Social Justice) and serves on the CAPIC Board of Directors.*

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Diversity – Making CPA Relevant for Everyone

Mark D. Kamena, PhD, ABPP
2013 CPA President

Members of the CPA Executive Committee met the first weekend of March to revisit our Strategic Plan and decide on the direction of our organization for the next three years. The retreat was facilitated by our Chief Executive Officer, Dr. Jo Linder Crow who led us through a process of identifying what we were hearing and thinking about CPA, what people were saying about CPA, and ultimately what we worry about when we think about CPA.

We grouped the ideas, categorized them into seven main issues, brainstormed some "what if's," and finally identified four domains that should be our focus for the next few years:

(1) Support for the business of practice;
(2) Protection of the discipline of psychology;
(3) Communication, engagement, and recruitment; and
(4) Preparation for the future.

One issue that dominated our discussion was "relevance." That is, how can we make CPA more relevant to its members and to all of the psychologists in California?

One concern expressed struck a chord with me: "Convention attendees don't look like me," and I wondered if this feeling was shared by other members of CPA. I continue to wonder about how we make CPA more inclusive for psychologists with diverse backgrounds? How can CPA assist in recruiting more diverse students into psychology? And, considering the constantly changing demographics of our State, how can we help psychologists develop the cultural awareness necessary to meet the needs of California consumers?

Dr. Michi Fu suggested that we re-create the multi-cultural conference that was developed by APA in 2000, and that is on our list of priorities. CPA has a long and consistent track record of supporting such issues.

For example, CPA is one of a handful of state psychological associations that fund a Diversity Delegate to the annual State Leadership Conference in Washington, DC. In 2004, Dr. Hildebrandt established the Diversity Task Force that ultimately was subsumed under our Division of Diversity and Social Justice (Division VII). The CPA Foundation has been actively supporting minority students through scholarships, and recently identified Immigration, LGBT concerns, and education for diverse students as major focus areas. CPA was an early supporter of same-sex marriage and strongly opposed California's Proposition 8. CPA also took the lead on supporting Sen. Lieu's bill to ban sexual orientation change therapy.

This issue of the CP is a continuation of our dialogue, with a focus on the critical role of training for our profession. I hope you enjoy it.

Mark D. Kamena, PhD, ABPP *(markkamena@comcast.net) is a licensed psychologist with a private practice in Marin County. He is board certified in police and public safety psychology and conducts adult psychotherapy focusing on trauma, depression, and anxiety. He is the Director of Research for the First Responders Support Network, which includes the West Coast Post-trauma Retreat and Significant Others & Spouse programs and is Treasurer for the CPA Foundation.*

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Why Do We Keep Talking About Diversity?

Jo Linder-Crow, PhD

Josh Whedon is a writer, director, and Executive Producer who is best known for his creation of *Buffy the Vampire Slayer*, *Angel*, and *Firefly*. In an interview a few years ago, a reporter asked him "Why do you always write about strong female characters?" His answer was "because you keep asking me that question." I was reminded of his answer when I sat down to write my column. I was struck by the fact that we are doing another issue specifically focused on diversity, even though here at CPA we do really try to maintain a focus on diversity and cultural responsiveness in all the work that we do. The idea is to have diverse ideas and talent at play in the association that come from a diverse group of members and leaders. All of us want to prepare our students so that they are equipped to provide culturally appropriate services to the variety of individuals, communities and organizations they will serve when they launch their careers. We want to have an association and association leaders that represent our highly diverse state. We want these things because we believe it will make us all stronger.

We can be proud of our track record. We have "walked the walk and talked the talk" by dedicating resources and energy toward programs, projects, and positions that demonstrate our commitment to diversity in the broadest sense. We have strategies in place to identify individuals who bring diverse perspectives to our efforts, and to bring them into leadership positions. We continue to watch for opportunities to engage our members in conversations that help us understand each other better, and we have more projects in the wings just waiting for the necessary volunteers and resources to make them happen.

So why do we keep talking about diversity? Because we should keep talking about it until we're not asking that question.

Jo Linder-Crow, PhD (jlindercrow@cpapsych.org) is the Chief Executive Officer of the California Psychological Association. You can follow her on Twitter at http://twitter.com/jlccpa. You can "like" CPA on Facebook at www.facebook.com/cpapsych.


California is Changing: Training "California-Competent" Clinicians

Anatasia S. Kim, PhD and Alicia del Prado, PhD

Diversity of California

It is now a well-established and widely accepted reality that the U.S. landscape is becoming more and more racially and ethnically diverse. In fact, as of July 2011, national estimates indicate that 50.4% of children under the age of one are ethnic minorities (U.S. Census Bureau, 2012). In some parts of the country, ethnic minorities are already the numerical majority. As of 2010, this was true in Texas, Hawaii, New Mexico, District of Columbia, and California (U.S. Census Bureau, 2012).

Currently, California has the largest number of ethnic minority residents at 22.9 million representing 60.3% of the state population (US Census, 2013). Additionally, the most recent U.S. Census Bureau's State and County QuickFacts (2013) indicated that California residents are comprised of 27.2% foreign born persons and 43.2% who speak a language other than English at home. California is also the leading state of residence for undocumented immigrants at an estimated 2.8 million (Hoefer, Rytina & Baker, 2012). The diversity observed today will only become greater as state projections compiled recently by the California Department of Finance Demographic Research Unit (2010) indicated that between 2010 and 2060, there will be a 119% increase among California residents who identify as multiracial, 80% increase among Latinos, 61% increase among Pacific Islanders, 47% increase among Asians, 14% increase among American Indians, 4% increase among Blacks, and 4% increase among Whites. This means that by the year 2060, approximately 70% of California residents will be persons of color.

Given the undeniable and rapidly changing demographics in California, it is imperative that we find ways to best meet the needs of all residents. In so doing, clinicians must have high quality training and tools with which to offer the very best services. To this end, we must focus on multicultural competencies including knowledge, self-awareness, and appropriate skills (Sue & Sue, 2008) necessary to provide the best culturally affirming services possible. This will require personal commitment in our development as multiculturally competent psychologists.

Teaching Multicultural Competencies

Not surprisingly, translating these statistics into the psychology classroom and ultimately into clinical services is challenging. However, it is imperative that doctoral training programs in applied psychology promptly and responsibly take up this challenge, and establish student learning outcomes in which their graduates will be able to competently respond to the health needs of our changing society. Epstein and Hundert (2002) defined professional competency to be the "habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (p. 277).

Multiculturally competent teaching and training needs to be integrated at multiple levels of the programs, and especially so in the curriculum. Most graduate programs have accepted at least one course that specifically focuses on multicultural issues (Metzger, Nadkarni, & Cornish, 2010). However, coverage of all cultural groups in a traditional semester or quarter system is nearly impossible. In fact, Metzger et al. pointed out that, "practitioners and researchers alike recognize gaps in therapists' awareness and experience in effectively meeting the

It is not enough to merely adhere to a checklist of competencies and skills. . . . we must adopt values that embrace a willingness to be transformed personally and professionally by others.

needs of clients whose multicultural identities fall outside of the syllabi of most three-credit graduate 'diversity' courses" (p. 3). Therefore, it stands to reason that students may not be learning about and discussing the histories and clinical needs of groups that are increasing in California, such as undocumented persons and multiracial individuals. While there is no easy solution to this gap in training, supplemental reading lists and options for students to engage in readings centered on specific populations in their local communities can help students gain additional training in these areas. To this end, Cornish, Schreirer, Nadkarni, and Rodolfa's *Handbook of Multicultural Counseling Competencies* (2010) focused on target groups and topics that they describe as being commonly overlooked in multicultural competency education including classism, immigrant communities, linguistically diverse populations, people of mixed ancestry, and transgender and intersex persons.

Importance has also been given to integrating multicultural competency throughout the traditional curriculum, and not just in the specific classes dedicated to these issues. In other words, instructors need to integrate how courses, such as life span development, research methods, ethics, and supervision (to name just a few), relate to being a multiculturally competent psychologist. For example, what constitutes "ethical" standards when working with undocumented clients? What is the "normal" identity development for someone of multiracial identity comprised of three or more racial categories? What are culturally affirming research methodologies, such as participatory action, that help to empower instead of further oppress historically marginalized communities? What is lost in the translation of Spanish services in order to conduct supervision in English? What are the ethics involved in providing services to clients for whom there are no existing norms for assessment and intervention tools?

Faculty can set the tone for a multiculturally affirmative learning environment with the construction of their syllabus, the choice of their reading list, and the topics of their lectures/discussions. Instructors can ask themselves: Am I effectively communicating to my students how the goals and student learning outcomes of the course contribute to training multiculturally competent psychologists? To what extent are the perspectives of marginalized communities represented by my choices in journal articles and textbooks? How do I integrate multicultural issues in each class meeting? In addition to content, the process of classroom dynamics is also paramount to modeling how students can engage in courageous conversations (Singleton & Linton, 2005) in the classroom on difficult but necessary issues such as racism, xenophobia, homophobia, and sexism.

In this article, we have focused on knowledge – just one component of multicultural competency – and also have narrowed in on the

professional development stage of graduate education. Needless to say, working toward multicultural competency also includes self-awareness and skills development and must continue throughout each psychologist's professional trajectory.

More than Just Competencies

Ultimately, in order for any efforts in multicultural competency to be effective in training high quality psychologists, we need to invest more fully and systematically in cultivating a *multiculturally affirmative learning environment* in both our educational institutions and training agencies. It is not enough to merely adhere to a checklist of competencies and skills. If we are truly invested in understanding and helping the needs of culturally diverse Californians, then we must adopt values that embrace a willingness to be transformed personally and professionally by others. Beyond the traditional educational context, what this requires is the constant seeking of, creating, and participating in direct exchanges with one another, and in particular with cultural others.

Moving beyond the classroom and supervision, we must help students develop opportunities for *intimate engagement*, an exchange of thoughts and feelings through direct and personal experiences. Involved in this process are: personal relationships in professional contexts with diverse persons; personal relationships in personal contexts with diverse persons; participation in student and community groups that champion multiculturalism; direct exchanges with faculty and administrators on topics of multicultural issues and conflicts; active involvement in institutional committees; leadership in organizing and participating in community meetings; and active participation in local, state, and/or federal advocacy and policy efforts. Ideally, such engagement would yield not only courageous conversations, but as well, relationships and alliance building, cultural shifts in beliefs and values, and even systemic changes to our society at large. Ultimately, intimate engagement requires tremendous energy, passion, and the unwavering commitment for social justice.

Since it is not a matter of if, but a matter of when, a student/trainee and psychologist come into contact with culturally diverse clients in California, the goal of multicultural competence cannot be aspirational, but rather a professional and personal mandate. It cannot be casual or happenstance, but must be serious and urgent. The diversity of California is not in the future, it is here and now.

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Walking the Talk: Clinical Supervisors Modeling Diversity Competency

Charles Chege, PsyD and Michi Fu, PhD

Licensed psychologists serving as primary supervisors have the exciting challenge of fostering interns' development so that they will achieve intermediate to advanced levels of expertise in each of the training program's eight competency areas. The internship at Pacific Clinics has been APA accredited since 1988 and is a member of the Association of Psychology Postdoctoral and Internship Centers (APPIC). This article describes how to implement one integral training tool to examine diversity issues among the psychologists-in-training.

Why Diversity?

The changing demographics of California indicate that we are becoming a minority-majority state, whereby non-Caucasians currently make up over 50% of the state's population. Therefore, it's imperative that clinicians know how to work with clients of diverse backgrounds.

APA (1993) published a comprehensive statement outlining the ethical obligations of working with ethnic minorities and underserved populations. Sue and Sue (2013) offer a widely accepted notion that cultural competence needs to include all three components of awareness, knowledge *and* skills. One could say that knowledge can be acquired through readings or didactic teachings. One might also say that skills can be developed through observation or practical training. However, how might one go about acquiring *awareness* as a cultural being? The Worldview Genogram offers an effective way of helping the supervisor and supervisee develop of awareness of who we are as cultural beings and how this impacts us as psychologists.

Culturally Sensitive Supervision

The second author has been supervising trainees for over a dozen years. Over the years, she developed an awareness that appropriate self-disclosure can have different meanings depending on context. A few years ago, my colleague and co-author offered his cross-cultural training tool of the Worldview Genogram as a means to gain an awareness of how to approach culturally sensitive treatment.

Rationale for a Diversity Training Tool

Supervision literature is replete with calls for diversity competency (Bernard & Goodyear, 2008; Falendar & Shafranske, 2012, Pedersen et al., 2008). The centrality of diversity competency in sound clinical training cannot be overemphasized. Many authors are devoting significant efforts on this matter and it is fair to say that currently it is not whether to, but how to have a safe and effective way to inculcate this into the practice of clinical supervision. I can hear many trainees saying in frustration, "just show me how to do it." Supervisors have expressed frustration with not having a mechanism to help them do this effectively, if at all. You can call it the most recognized and urgent need in clinical supervision today, for which there is minimal, if any practical guidance and tools.

Introducing the Worldview Genogram

We have found the Worldview Genogram (Jenks et al., 2013) effective. Put simply, it is a tool to enhance awareness building and application to various aspects of our identities or functions. One of its hallmarks is de-emphasizing pathology (often a common focus of the family-of-origin genogram process) and emphasizing strengths, adaptation and resiliency. The idea of a worldview genogram was born out

of struggles – akin to the ones articulated above – by the first author and several fellow supervisors working at Pacific Clinics, a large community mental health agency based in Los Angeles that serves diverse populations in the southern California area in 1999. Other authors have used the concept of cultural genograms (Hardy & Laszloffy, 1997; Shellenberger et al., 2007) in an attempt to stress the need to examine the influence of culture in training. We coined the phrase 'worldview genogram' with the idea of transcending limitations imposed by other genograms and definitions of culture, and as a more encompassing concept in regard to self and other constructs (C. Amenson, J. Hao, G. Masuda & P. Pannel, personal communication, 1999).

Since 1999, Dr. Chege has operationalized the concept in graduate school diversity courses, dyadic and group supervisory contexts, and workshops (Jenks et al, 2013). A central aspect of this process is that the supervisor goes first, truly "practicing what we preach". Supervisees and other participants consistently report that this profoundly empowers them. As a result of this modeling, the author's experience is that without exception, students and trainees gain such comfort that they disclose (without coercion and to the betterment of the supervisory relationship) more than they would have imagined.

The first of three steps is to exhaustively examine one's background in order to gather as much and as diverse information as possible. Go beyond family history. Examine cultural, generational, cohort, historical etc., influences, and derive themes. Ask yourself as many worldview driven and deep questions as possible. Hays (2008) ADDRESSING framework is one way to guide this step. Examine worldview related pride and shame issues as well, for often they significantly motivate role performance. Second, synthesize the information, again keying on supervision related themes. Critically examine how these impact and influence how you function as a supervision and why. Look at possible worldview related blind spots. Look at strengths. When done exhaustively, the process is often bigger and better than the product, which is the content gathered for the next step. Third, present in your chosen format with supervisor presenting first. Engage in a dialog, maintaining a non-pathologizing and strengths-based focus. Conclude this step by talking about how you might now understand or know each other better. Extend this to how your current supervisory relationship is better informed by the insights and awareness gained from this process. In groups, supervisees present and their peers interact with them over the presentation with the supervisor serving as moderator of the process.

Applying the Worldview Genogram

"Lily" (a pseudonym) was the first intern to tell me (Dr. Fu) that she wished I had attended her Worldview Genogram presentation to the rest of her intern class. Every week, the interns have a supervision of supervision group consultation with Dr. Chege. During this meeting, interns take turns presenting their Worldview Genogram to one another. I invited Lily to present her Worldview Genogram to me during individual supervision and I learned rich information about her family history, values transmitted from her culture, etc. For example, I could easily see the pattern of how she developed her excellent work ethic. During our termination supervision session, she shared that she wished I had reciprocated and also presented my worldview genogram to her and I took this feedback into my next supervisory relationship.

The following year, I offered to my supervisee "Alyssa" the option of having me attend her worldview genogram presentation during their supervision of supervision session, presenting to me during individual supervision, or opting out of including this in our supervisory relationship (although I secretly hoped she wouldn't choose this option). In return, I also offered to share my worldview genogram. This was a big decision for me since I didn't want supervision to turn into inappropriate self-disclosure, but I also wanted to role model how effective self-awareness can aid our work as mental health professionals. Attending Alyssa's presentation to her intern cohort helped me to develop insight regarding potentially powerful countertransference issues. When she left our debriefing session during individual supervision tearful, she reported feeling vulnerable but having learned lots about the power of countertransference. She seemed grateful when I reciprocated by sharing my worldview genogram, thus creating a restored sense of safety developed by the level of self-disclosure. I saw how sharing about my family of origin's immigration history helped my supervisee to see both our within-group similarities and differences since our families had both originated from the same part of Asia.

Recent supervisees usually opt for me to attend their Worldview Genogram presentations during their supervision of supervision to their intern cohort. They have yet to decline my offer to present my own Worldview Genogram to them individually. Some have walked out of supervision stating that they understand my supervisory philosophy better as a result of my sharing. Others are grateful that I share freely during the "sources of shame" as much as I share during the "sources of pride" sections.

Next Steps

After experiencing successes in supervision with applying such a unique, I would highly encourage supervisors to utilize such methods. The worldview genogram offers an alternative to traditional supervision, which may or may not involve levels of self-disclosure. Supervisors may want to compare such available training tools and decide for themselves the potential value of attempting to use such a powerful culturally responsive training technique. We are very curious to hear of your personal experiences applying such methods and welcome your feedback.

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Doctoral Program Diversity Training: The Academic Dean's Perspective

Valerie B. Jordan, PhD

This article addresses the theme of diversity training at the doctoral program level from the academic administrator's perspective. The idea was to consult with various stakeholders of the doctoral programs to obtain snapshots of the ways in which their programs implement this goal. To this end, several deans of clinical psychology doctoral programs (and numerous students and alumni in the subsequent article) from various California-based doctoral programs were interviewed, to hear their perspectives about their program's experiences in diversity training. The author has prepared a list of all regionally accredited doctoral programs in California that is available from editor@cpapsych.org.

All APA accredited program adhere to APA's Commission on Accreditation's Guidelines and Principles (2009) that dedicates an entire domain (D) to a range of issues concerning program diversity. Doctoral program membership in the California Psychology Internship Council (CAPIC) requires six areas of training including cultural competency (www.capic.net/doctoral.html). In addition, 12% of the EPPP examination (ASPPB, 2013) addresses the domain of social and cultural bases of behavior. Clearly all of these doctoral programs adhere to numerous specific guidelines and outcomes concerning diversity. With this in mind, the interviews were focused on some innovative and program specific experiences and perspectives that might be models for others to consider.

While these were convenience samples with anecdotal responses, several criteria were used in recruiting these interviewees: they represented California academic institutions that are actively involved in CPA; they are APA accredited; they deliver PhD and/or PsyD doctoral programs; and they reflect a variety of geographical locations (southern, Northern and state-wide), campus/program size, and institutional missions. The deans were interviewed by phone for about 45 minutes in early May. The three deans were Dr. Tamara Anderson, Associate Dean of Graduate Students, Rosemead School of Psychology, Biola University; Dr. Morgan Sammons, Dean, California School of Professional Psychology at Alliant University; and Dr. Gilbert Newman, Dean, The Wright Institute. Here is a summary of the highlights of their comments to the following questions:

How does your program prepare students to become culturally knowledgeable and responsive to current state demographics?

All deans described system efforts starting with the admissions process, recruitment of diverse students, attention to diversity issues from "day 1" in new student orientations, first-year coursework that addresses diversity issues both in intensely experiential as well as didactic formats, and a range of diversity themed special events such as workshops, conferences, consultations and CE coursework for students, faculty and clinical supervisors. All deans described specifically how powerful experiential experiences were for students (and faculty) when they occur in a safe and supportive environment. All of these efforts can probably be best described as early, often, and infused throughout the curriculum. Interestingly, about half to two thirds of the enrolling students in these programs are from out-of-state (including a small proportion of international students), so California institutions train doctoral students from across the country. Some specific program examples include being a designated Hispanic-serving (CSPP/Alliant) or a faith-based (Biola) institution, and being a program known for its commitment to social justice (WI). One institution described an

institution-wide effort to redesign restrooms from gender-specific to gender-neutral where feasible. CSPP offers a range of immersion and English-language international programs in Mexico City, Japan, Jordan, Vietnam and Hong Kong which create opportunities for local students and faculty to experience immersion or study abroad programs. Finally, most program sponsor student-run interest groups reflecting specific areas of diversity and social justice.

How does your program prepare your faculty (full and adjunct) to be knowledgeable about cultural competency, regardless of their teaching specialty?

All programs reported ongoing training opportunities for faculty (special workshops, Continuing Education workshops), and some funding to support faculty attendance/participation at diversity-focused conferences. One program (WI) described annual visits with a nationally known consultant on diversity issues. Biola requires a signed statement of faith from all faculty but brings faculty from other faith traditions to campus for broader religious and spiritual perspectives.

How does the program select practicum sites and supervisors that provide students with culturally sensitive training experiences and reflect the diversity of your community?

All programs reported that they annually visit or review their network of practicum sites about a range of issues including diversity. One institution (WI) has its own affiliated network of training sites that are designed specifically to address diversity issues with a range of diverse clients for their program. Some examples of these sites are low-income community clinics, school-based programs and a county jail, all of which provide low-cost services to mostly underserved clientele. Students from Biola participate in secular practica and are known for their skill in addressing issues of religion and spirituality in proactive ways. With CSPP's geographic diversity, their programs are able to provide local training sites that work with locally diverse ethnic and cultural populations (for example, working with Hmong clientele in Fresno).

What changes would you like your program to make in the next 3-5 years, especially keeping in mind the future demographic shifts in California?

All of the deans mentioned efforts to redesign the curriculum to reflect the pending California demographic shift from a majority to multiple minority demographics; continue to expand concepts of diversity and multicultural competencies; allow more flexibility for students to attend international programs with fewer financial and logistical barriers; increase coursework addressing linguistic competencies through a variety of pathways such as on-line language modules, electives in non-English language competencies, specialties in mental health interpreters; shift to more experiential diversity-themed coursework in the first year of the program; addition of second-year case conferences focusing on diversity issues; recruiting and retaining more diverse faculty; and finally, increase special events related to diversity including workshops, lectures, local conferences, and interdisciplinary events.

In summary, the consistent theme that emerged from these interviews was to begin all diversity related initiatives from the admission process onward, engage students and faculty in didactic and experiential activities from the first week of classes forward, and provide pro-

gram specific opportunities as often as possible to sustain and innovate this commitment. Hopefully some of these ideas will inspire other programs to find ways to enhance and expand the diversity experiences within their institutions.

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Multicultural Education, Training and Competence: Voices from the Field

Melodie R. Schaefer, PsyD

Within our ranks are those, who with passion and dedication, develop and provide diversity education and training, via academic curricula or clinical training at practica and internship programs. Students and trainees are provided feedback on demonstrated assimilation of knowledge learned as well as its clinical applications. In an effort to invite conversation on the impact of doctoral program education and training on students' sense of multicultural competency, a convenience sample of eight individuals shared their experiences and insights to a set of interview questions.

Responses were elicited from doctoral clerkship, practicum and internship level students, as well as early career psychologists that included postdoctoral fellows and licensed psychologists. Academic institutions/programs represented through those interviewed include Alliant International University/CSPP, Fuller Graduate School of Psychology, University of Denver's Graduate School of Professional Psychology, University of Iowa, and University of La Verne.

Following are the responses to questions posed regarding the interviewees' assessment of the exposure to cultural diversity they experienced both academically and through their professional training.

What were the strengths/highlights of the training you received from your doctoral program concerning cultural diversity and competency?

All respondents identified formal diversity-specific coursework as a strength of their doctoral program. Among the course elements found to be most helpful were the following:

- A focus on the application of knowledge in cultural diversity to clinical interventions;
- Integration of a variety of means by which to facilitate knowledge acquisition including specific lectures on selected diversity issues, guest speakers, and review of relevant research;
- Small group discussion format found to create an intimate setting promoting open dialogues and sharing of students' diversity experiences;
- Introducing ways to encourage awareness and continued self-reflection of students' own cultural diversity, potential biases/prejudices and struggles, and what the psychologist may bring into the room when serving clients. Doing so may result in more fully integrating diversity awareness into conceptualization, and was found to positively impact practicum training experiences.
- Creating and maintaining a safe environment for students to share their perspectives;
- Promoting an understanding of the client and their presenting concern from a systemic perspective that includes multiple layers of their cultural context was found to enhance competence in the development of my treatment plans and interventions;
- Integration of cultural diversity and competence throughout academic courses which facilitates how a particular intervention, assessment, or case conceptualization might be impacted if one or more aspects of a client's socio-cultural makeup differed from the original demographic presented.
- Consideration of each individual's spiritual beliefs and worldview, and how those beliefs added meaning to the client's identity, experiences, and mental health.
- The opportunity to choose a diversity-focused learning track, coupled with their institution's strong commitment towards addressing the mental health needs of diverse populations, which included research as well as practice.

When you entered your practicum/internship/postdoctoral site, did you feel prepared to handle the cultural issues you actually encountered?

Most of the interviewees remarked that their academic training was effectively informative to the process of their practicum/internship work in terms of increasing cultural competence. However, most also indicated an awareness that no matter what amount or type of academic preparation may be offered, translation into real world experiences cannot be all-encompassing due to the breadth of client related diversity issues one encounters in practice. A few commented that the academic knowledge they acquired did not necessarily translate in an understandable way into practice, particularly in respect to the range of diversity issues presented by their clients served.

Among interviewee responses the following assessments were conveyed:

- It would be a misnomer to identify oneself as "prepared" as there is a sense of continual learning and discovery of new approaches by which to incorporate aspects of diversity into the clinical work. Academic preparation does not necessarily prepare the individual for how to address the issues in practice.

- Training sites emphasized multicultural competence resulting in increasing awareness, knowledge, skills and a sense of greater self-efficacy in working in a culturally sensitive manner. However, awareness remains as to how much more there is to learn due to the complexities of culture. This was exemplified by one interviewee who stated ". . . in fact, it seems the more I learn, the less I know. I was always told that there is not a magical point at which a person suddenly becomes culturally competent."
- Another stated, "My professors, mentors, and supervisors always stressed that lifelong learning is at the core of multicultural competencies."
- Receiving a number of multicultural trainings geared toward building and strengthening personal and professional awareness of multicultural identities and trainings that varied from population-focused to issues that cut across groups, such as privilege, oppression, and world-views, was found most helpful.

Although one interviewee is a native Spanish-speaker, they did not feel prepared at the time to conduct therapy in Spanish as translating clinical terms takes special preparation. They commented that it took significant self-studying and seeking outside supervision to eventually feel prepared to be fluent in conducting therapy and assessment in Spanish. Another person commented that some agencies suggest that if one's Spanish is rusty, they will have the opportunity to improve over the course of the training year. This caused the interviewee consternation as to the lack of concern for the impact this may have on the client due to what may be a poor quality of communication in therapy.

What else could your program do/have done to better prepare you for the clients and sites you encountered?

The majority of the respondents reported overall satisfaction with the preparation for clinical work provided by their academic program, with the following suggested improvements:

- Scheduling diversity coursework early in the academic program and prior to treating clients to maximize the course benefits throughout all levels of clinical placements;
- Better preparing students for issues related to race/ethnicity/culture and how that affects one's assessment and diagnosis of a client;
- More time dedicated towards discussing gender and religion as aspects of diversity;
- More exposure to the personal experiences of professionals and experts working with diverse populations;
- More training in linguistic competence; although cultural competence and linguistic competence are similar constructs, they are not identical.

What recommendations would you make for doctoral programs and agencies?

- Be intentional about creating space to discuss diversity and issues surrounding diversity with students beyond the required course;
- Encourage professors to include meaningful discussions about diversity in other courses and clinical directors to make diversity an ongoing aspect of didactic trainings and supervision;
- Consider developing informal learning moments where faculty and students interact to discuss issues of culture and diversity;
- Incorporate training on the intersect between multiculturalism and social justice, and how to advocate at the policy level as psychologists for services for underserved and underrepresented communities;
- Professors and supervisors at all sites could benefit from ongoing cultural competence training;
- Doctoral programs should provide more support for diversity-based research opportunities, grant seeking, and also team-based grant writing with mentors;
- Opportunities and mentorship in article writing, and accessing APA training opportunities such as the Minority Fellowship;
- Move from a superficial group differences approach to one that incorporates a lens that examines what may be at stake in one's local social world. Systematically incorporate diversity into all courses in a meaningful and empirically rigorous manner;
- Enhance the interaction between agencies and academic programs.

Miles Traveled – Miles to Go

Although significant emphasis and work has been accomplished related to the importance of the learning and doing aspects of multiculturally competent psychological service, efforts to improve the quality and impact of our endeavors are ongoing. Like the analogy of the onion, the more layers we peel back, the more we behold that of which we were not previously aware.

One of those interviewed noted that some trainees have a sense of being more up-to-date than their supervisors. Diversity training has

changed dramatically over the past several years, and it may be that some trainees have more recent cultural awareness/training than their supervisors may have been privy. Expertise may lie not solely within an individual nor institution in the particular arena of multicultural competence. Rather, it may best occur within a room without metaphoric doors and in conversations in which knowledge, experiences and perspectives flow generously between all who partake. The student becomes the professor in one moment, the client the professor, the professor the student.

In closing, one interviewee stated, "I don't know that any program could have completely prepared me for the unique cultural issues that have arisen over the years. However, I have felt comfortable engaging my clients in dialogue regarding those issues, in bringing up my areas of ignorance in supervision, and seeking additional consultation as needed. Our program encouraged us to collaboratively explore with our clients how their unique constellation of socio-cultural identity has informed their own narrative. That has been invaluable."

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Interviewees

Laura Bava, PsyD, University of La Verne graduate

Rachel Casas, PhD, University of Iowa graduate

Takisha (McNeill) Corbett, MA,
PhD Program at Fuller Graduate School of Psychology

Jime Saldeco, PsyD, University of La Verne graduate

Stephanie Salo, MA,
PhD Program at Fuller Graduate School of Psychology

Kevin Thomas, MA, PsyD Program at University of Denver

Shannen Vong, MA, PhD Program at CSPP-Alliant, Los Angeles

Geny Zapata, PsyD, University of La Verne graduate

Why Making a Sandwich Can be Hard.

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2. Place bread on counter
3. Open fridge
4. Look for cheese
5. Can't find cheese
6. Look for cheese
7. Can't find cold cuts
8. Find cold cuts
9. Close fridge
10. Forgot cheese
11. Place toppings on counter
12. Open fridge again
13. Grab mayo
14. Forget to close fridge
15. Place mayo on counter
16. Forgot cheese
17. Look in fridge again
18. Find cheese
19. Place cheese on bread
20. Place cold cuts on bread
21. Add mayo
22. Close sandwich
23. Eat sandwich

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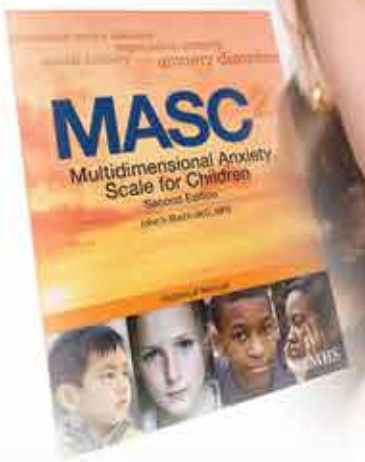

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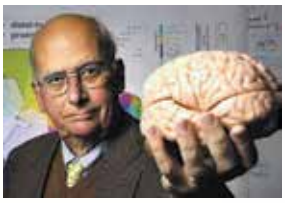

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The Case of Ramiro Gonzales: Supreme Court Sends Mixed Signals About the Psychotherapist-Patient Privilege

Jack P. Lipton, PhD, JD

The California Supreme Court, in the case of *People vs. Ramiro Gonzales* (2013), has issued a detailed published opinion which provides mixed signals regarding the protections afforded by the psychotherapist-patient privilege. On the one hand, the Court limited the scope of the "dangerous patient" exception to the psychotherapist-patient privilege, thus strengthening the overall applicability of the privilege. But on the other hand, the Court determined that even if confidential psychological communications are improperly revealed, that this is not necessarily "prejudicial error."

The Story of Ramiro Gonzales

Ramiro Gonzales, who is developmentally disabled, has had trouble with the law ever since he was a young man. He was convicted of his first sex offense at age 20 after he became sexually aroused when hugging a five-year-old girl and whispering obscenities in her ear. Two years later, Gonzales was convicted of another sex offense after he touched the buttocks and crotch area of a seven-year-old girl through her clothing. For this second offense, Gonzales served time in jail and became a registered sex offender.

Seventeen years later, Gonzales was caught rubbing the vaginal area of his four-year-old niece while she slept. He was convicted and sentenced to 11 years in prison. Prior to his scheduled release from prison though, the District Attorney filed a Petition seeking to have Gonzales civilly committed as a "Sexually Violent Predator" ("SVP") under the California Sexually Violent Predator Act. Under this statute, a court can order a convicted sex offender to be civilly committed if it finds that he or she is an SVP, meaning that the individual has been convicted of a sexually violent offense and has a mental disorder that makes the person "a danger to the health and safety of others in that it is likely that he or she will engage in sexually violent criminal behavior." At that time, however, the jury found that Gonzales was not an SVP and thus not subject to civil commitment.

Gonzales was released from prison, and one of the conditions of his parole was that he was to participate in outpatient psychological treatment. In this connection, Gonzales began psychotherapy at the Atkinson Assessment Center. Eventually, however, Gonzales was arrested for parole violations, namely, drinking alcohol and having close contact with children.

Prosecution of Gonzales as a Sexually Violent Predator ("SVP")

While in custody for his parole violations, Gonzales was evaluated as a potential SVP, and based on the testimony of two state psychologists, Gonzales was ordered to stand trial to determine whether he was an SVP.

In preparation for the SVP trial, the district attorney issued a subpoena to obtain Gonzales' psychological treatment records at the Atkinson Center. Gonzales' defense attorney objected to the subpoena, citing to the earlier case of *Gary Story vs. Superior Court*, arguing that any psychotherapy records related to sessions engaged in as a condition of probation were protected from disclosure by the psychotherapist–patient privilege under Section 1014 of the *California Evidence Code.*

Admissibility of Confidential Communications at SVP Trial

The Superior Court ruled that Gonzales' psychotherapy records at the Atkinson Center were ***not*** privileged, and moreover, that his psychotherapist even could testify at the trial to determine if he were an SVP, because of the "dangerous patient" exception to the psychotherapist-patient privilege, set forth in Section 1024 of the *California Evidence Code* which provides that there is no privilege if "the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger."

During the SVP trial, Gonzales' psychotherapist disclosed what Gonzales revealed during the therapy sessions: that he was sexually attracted to small children, especially when he was drinking, and that he had "an overwhelming desire" to touch children. The jury returned a unanimous verdict, finding that Gonzales was an SVP, and he was ordered civilly committed for an indefinite period of time.

Ruling of California Court of Appeal

Gonzales, through his attorney, appealed to the California Court of Appeal which ***reversed*** the finding that Gonzales was an SVP.

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According to the Court of Appeal, the Superior Court improperly allowed disclosure of Gonzales' psychotherapy records, and improperly allowed his psychotherapist to testify at the SVP trial. The Court of Appeal further determined that the error of the Superior Court constituted "prejudicial error" to Gonzales, and that the finding that he is an SVP needed to be reversed.

The case then came before the California Supreme Court.

Opinion of California Supreme Court

The Supreme Court began its analysis with a review of the history of the psychotherapist-patient privilege in California, noting that psychotherapy is "dependent upon the fullest revelation of the most intimate and embarrassing details of the patient's life," and that unless the patient "is assured that such information can and will be held in utmost confidence, he will be reluctant to make the full disclosure upon which diagnosis and treatment ... depends."

The Supreme Court agreed with the Court of Appeal that disclosure of Gonzales' psychotherapy records, and allowing his psychotherapist to testify, were not justified by the "dangerous patient" exception to the psychotherapist-patient privilege because the district attorney did not meet its burden of proof to show that Gonzales had ever revealed anything to his psychotherapist which indicated a danger to others, or that Gonzales' psychotherapist had ever needed to disclose Gonzales' confidential communications in order to prevent him from harming someone. Additionally, the Supreme Court noted that even if ***some*** confidential communications needed to be disclosed under the "dangerous patient" exception, that did not justify the disclosure of ***all*** privileged communications.

Finally, the Supreme Court considered the question of whether the error in improperly allowing disclosure of Ramirez's confidential communications necessitated a reversal of the jury's finding that Gonzales was an SVP. In reversing the finding that Gonzales was an SVP, the Court of Appeal applied the "federal constitutional" standard which required reversal unless the appeals court determines that the "error was harmless beyond a reasonable doubt."

The Supreme Court noted that a parolee, like Gonzales, has limited rights of privacy, pointing out that the government "has a strong and legitimate interest in authorizing a parolee's prior statements that occur in parole-mandated therapy." Thus, the Supreme Court ruled that the "federal constitutional" standard for determining whether an error in admitting evidence was "prejudicial" was inapplicable. Rather, the Supreme Court ruled that in determining whether the error in improperly allowing the disclosure of Gonzales' confidential psychological communications should be evaluated only in terms of "whether it is reasonably probable that result more favorable to defendant would have been reached in the absence of the error."

Applying this standard, originally articulated in the case of *People vs. Philip Watson*, the California Supreme Court ruled that even though it was legally improper for the Superior Court to allow the disclosure of Gonzales' confidential communications with his psychotherapist, this error did not constitute "prejudicial error." Thus, notwithstanding the improper disclosure of his psychotherapy records and the improper testimony of his psychotherapist, the jury verdict finding that Gonzales was an SVP was upheld.

Conclusions and Recommendations

The *Ramiro Gonzales* case is instructive to California psychologists and other mental health professionals for several reasons.

First, the case provides a stern reminder that a psychologist who is called as a witness at a deposition, hearing, or trial should not disclose confidential communications under the "dangerous patient" exception to the psychotherapist-patient privilege unless the psychologist actually has a reasonable basis to believe not only that the patient has a mental condition that makes him or her a danger to self or others, but also, that the disclosure of the confidential communication is necessary to prevent the threatened danger. In other words, if a psychologist is called to testify, the fact that the psychologist reasonably believes that the patient is a danger to self or others is insufficient in itself to justify disclosure of confidential information; the psychologist also must reasonably believe that the disclosure of the confidential information is necessary to prevent the threatened danger.

Second, based on the *Ramiro Gonzales* case, even if such confidential and privileged communications are improperly disclosed at a trial, this error may not necessarily be a "prejudicial error" requiring judicial reversal. Nevertheless, it still is best practice for psychologists to assert the psychotherapist-patient privilege whenever it may be applicable.

One interesting side note from the *Ramiro Gonzales* case, though, is that if a court orders a psychologist to disclose confidential communications during testimony, notwithstanding the psychologist's assertion of the psychotherapist-patient privilege, and then the court's ruling is overturned on appeal, the improper disclosure of confidential communications by the psychologist could be considered as simply a harmless, inconsequential error. But psychologists still have a legal and ethical duty to protect the confidentiality of their communications with patients.

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Ethical Dimensions of Cultural Competence in Supervision: Diversity, Equity, and Inclusion

Terry Patterson, EdD, ABPP, Candace Claiborne, MA, and Alana R. Russaw, MPH, MA

Nearly every psychologist has been oriented to the pitfalls of cultural blindness and the need to develop competence in order to be effective in various modalities of practice. What is less understood is the ethical basis for proficiency in working with diverse individuals and groups, particularly in the area of clinical supervision. On the one hand we can say that treating everyone alike is good, and yet on the other hand this view overlooks the fact that a key to understanding every individual is the context of her or his socialization in the many dimensions it may encompass. The lens through which psychologists, students, and supervisees view the comments and actions of others is a key to developing cultural competence.

The APA Ethics Code (Principle E) is unequivocal in stipulating that competence in cultural matters is essential. Standard 7.06 refers to *Assessing Student and Supervisee Performance*, and Standard 2.01 directly addresses understanding cultural factors as a basis for effectiveness. (APA, 2010).

It is therefore clear that awareness and skill regarding all aspects of culture and diversity are ethical matters, and that they apply directly to supervision. If we think back to our student or professional experiences in training and supervision, how do we remember culture and diversity being addressed? In classrooms and supervisory sessions, was there any concern for cultural implications of assessment, treatment planning, intervention, or to the reactions of those receiving services, or was there little attention to these matters except when problems arose? If the majority of students, clients, supervisees or consultees were white, were their backgrounds and particular world views brought to light? To guide in this process, a very useful set of techniques for introducing multicultural issues in supervision is listed in a workbook on supervision by Campbell (2000).

From a student perspective, the following issues have been highlighted by the co-authors of this column:

CC: Cultural experiences, biases, and assumptions can easily shift the direction of supervision and treatment, and are related to cultural transference and countertransference. Finding ways to safeguard against doing harm to the client, especially when the cultural fit might not have been the most appropriate, requires knowledge, skill, and sensitive perception.

Using culturally sensitive and/or culture-specific assessment tools with clients of color is a critical issue. It was noticeable in my experience that measures were culturally biased and rarely provided an accurate picture of the client's problems. The supervisor indicated that the selection of tests was left to the clinician's discretion and access to resources, but there was no guidance on how to match culturally appropriate measures with clients.

AR: The fact that I am black does not mean that African American clients will automatically be receptive to me. We cannot always assume that our skin color in itself will allow us to develop rapport. The best supervisors I have had were white, and they really loved the population we worked with and believed true change could be made by anyone. The parallel process at work in supervision has direct effects in supervisees' work with clients. I also believe that training sites need to provide assessment tools that are appropriate for all of the clients they serve, and whenever possible, conduct outreach in order to broaden the diversity of clientele for trainees to work with. In-service training should also be offered so that assessment and treatment is culturally relevant.

The ethics code, the professional literature and information from students can serve as useful guides for supervisors to develop cultural competence. The keys to greater effectiveness are in obtaining appropriate information, building rapport, and maintaining awareness and sensitivity to the perceptions of supervisees and their clients.

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"El Idioma sin Cultura no es Idioma"

LaTonya Wood, PhD

My first awareness of the complexity of language and its role in psychotherapy came about years ago in my clinical work with an adolescent Latina client and her mother. While the mother spoke English well enough to participate in collateral sessions, when it came time to discuss the experience of trauma and loss in the family that prompted her to seek services for her daughter, she had considerable difficulty conveying her emotions in English. Noticing her strained efforts to express herself, I turned to the mother and told her to just say it in Spanish. While I didn't have enough Spanish fluency to understand what the mother was saying, the depth of her emotion and pain filled the room. In that moment I realized that simply speaking Spanish would have not addressed the broader cultural and linguistic needs of the client. In fact there is some research to suggest that if I had attempted to speak Spanish with the client, my own need to transpose the information from English to Spanish and back to English could have interfered with the therapeutic process and inhibited my own clinical attunement with the client (Castaño, Biever, Gonzalez, & Anderson, 2007). Understanding the broader role of emotion, language acquisition and culture in bilingual services is crucial in providing culturally responsive services to clients (Santiago-Rivera & Altarriba, 2002).

Providing services in another language requires that a culturally responsive clinician considers how language informs what modes of interaction will successfully engage clients in treatment; cultural nuances within the language; the language preferences and proficiencies of the client; as well as their own level of comfort with the language and culture of the client (Castaño, et al. 2007). One often overlooked challenge of bilingual and bi-cultural clinicians is the amount of responsibility, burden and potential lack of confidence they have in providing services in a second language (Verdinelli & Biever, 2009). In a survey conducted by Castaño et al. (2007), bilingual therapists reported that top concerns in regards to providing services in Spanish were their ability to effectively and accurately translate technical language and theoretical concepts into Spanish for clinical practice. For many of these clinicians, whether they are native Spanish speakers or not, their formal training in psychology occurred in English so their acquisition of these concepts were in English. Therefore, transcribing this knowledge into another language places additional cognitive and linguistic demands on the therapist that may delay therapists' responses during sessions; limit their vocabulary in the language needed to discuss mental health issues with clients; and lessen the effectiveness of the intervention(Castaño, et al. 2007). Similarly, there is a need to assess and determine the language proficiency of the client so that assessment of symptoms and diagnosis is culturally and linguistically sensitive as well (Santiago-Rivera & Altarriba, 2002). Simply put, transposing vocabulary from English to another language may not capture the broader cultural values, needs, interests and preferences of the client.

If we aim to be truly culturally responsive in clinical practice we need to not only examine the provision of bilingual services, we have to honestly and accurately evaluate how we address issues of language in our academic and training programs. While there are efforts to increase presence of bilingual clinicians in our schools and programs, there remain concerns about what educational opportunities unique to being a bilingual therapist await them. Specific recommendations to expand the provision of quality bilingual services include encouraging clinicians to engage in professional activities that provide opportunities to write and speak in the language they are providing services; formal coursework in second languages; greater exposure to assessment tools and instruments in other languages; and when possible supervision in the language in which clinicians are providing therapy by a qualified and competent bilingual supervisor (Castaño, et al. 2007). Even more importantly, English speaking supervisors and practitioners have to be willing to advocate for and support the use of language based training for students and colleagues. Culture is a broad concept and we have to look at bilingual services in the same way. Enhancing services by simply translating the words is not being culturally responsive – language without culture is not language.

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CALL FOR PRESENTATIONS

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Proposals must be submitted online. Go to www.cpapsych.org to view the submission instructions.
If you have questions contact Sabrina Cullivan at CPA, at 916-286-7979 ext. 122 or via e-mail at scullivan@cpapsych.org.
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Presenters will be notified of the review committee's decision in late October 2013.

Firm Submission Deadline: August 26, 2013


Training and Supervision in Suicidality: Supporting and Empowering Student Trainees

Melodie R. Schaefer, PsyD and Alea Baron, MA

There are few clinical issues that trigger as an acute need for intervention as that pertaining to a suicidal patient. Patient self-harm behaviors and suicide are stressful for clinicians and trainees alike. Nearly half of psychologists will have contact with suicidal patients over the course of their professional careers, and clinical management of these events may be one of the most challenging of functions (Rosenberg, 1999). In a sample of 16 states across the US, 45% of those who completed suicide had a current mental health-related problem (CDC, 2009). Moreover, about one third (32%) of those who completed suicide were currently receiving mental health treatment.

40% of psychology trainees had a professional relationship with patients who had either made a suicide attempt or completed suicide while the psychologist was in training (Kleepsies et al. 1993). How a crisis is resolved will determine whether it personally or professionally increases or constricts development for those individuals affected (Kleepsies, Penk, & Forsyth, 1993).

Debski et al. (2007) investigated the level of preparedness and involvement of school psychology practitioners in suicide prevention and postvention. They found almost all respondents reported receiving some type of training in assessment of suicide risk, but less than half received their training as part of their graduate coursework. Internship and clinical sites seem to be doing more than graduate schools in orienting and helping students anticipate working with suicidal patients or patients who might actually commit suicide.

Kleepsies et al. (1993) found that most trainees felt supported and that case discussions with supervisors were well used and helpful. However, they found that for trainees, coping resources or ways of working through the event seemed underused. McNeil et al. (2008) exemplified the importance of risk assessment training which was associated with increased self-confidence in risk assessment skill, greater improvement in ability to identify risk and protective factors for suicide, and in ability to articulate better-organized reasoning about risk assessment and risk management strategies.

When considering elements to include in educating trainees, it may be helpful to acknowledge some of the concerns and fears trainees often encounter:

- How do I explore the issue of whether the patient has suicidal thinking in a manner that fosters a sense of safety and comfort? How do I deal with my own discomfort in asking direct questions of the patient related to suicide?
- Will I remember all the key elements for a full assessment in the moment when I am feeling anxious? Will my supervisor be readily available?
- How can I help instill hope in a patient who is struggling to find a reason to live?
- What if my patient is not honestly responding to my questions leading me to assess low risk? What if they then make a suicide attempt or complete a suicide? How will I emotionally handle this if it should happen? What will be my supervisor's reaction to how I assessed and intervened with my client?

Incorporating material and experiential training that addresses these and other issues into both formal coursework, training site didactics and throughout supervision may better prepare students and

support trainees when engaging with suicidal patients. This may include frank discussions of anxieties and fears surrounding issues of competence and outcomes related to patient behavior following interventions. The use of modeling and role-playing of scenarios related to engaging the patient, standard inquiry procedures, initiating interventions, communicating with response teams, family and others, as well as discussing their experiences with supervisors may facilitate a greater sense of self-efficacy in trainees. Ensuring adequate resource information is available as well as clear crisis-response procedures and contact information is also essential.

Finally, of great importance is the need to provide various ways to support the trainee during periods of active involvement as well as post-intervention with suicidal patients. This may include a de-briefing time with the supervisor providing the opportunity to examine what transpired as well as encouraging the trainee to share how they have been affected by their experience. This would also include discussing the importance of self-care and planning some self-support. Shared awareness by both supervisor and trainee on how the trainee may have ongoing or changing experiences related to working with a suicidal patient acknowledges an open-door for further processing and reaching out for support.

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In Memoriam

Helene West Feldman, PhD

1995 CPA President

Thank you for your service to the profession of psychology.

In Memoriam

Hedda Bolgar, PhD

Thank you for a lifetime of inspirational leadership.

Medication Non-adherence: The Make-it-or-Break-it of Psychopharmacology ~ Part One

John D. Preston, PsyD, ABPP

A large majority (85%) of prescriptions for the treatment of anxiety and depressive disorders are written by primary care physicians. Outcomes are poor owing to a number of factors, most notably a lack of appropriate follow-up. Topping the list of complications is non-adherence. Psychologists play a crucial role in monitoring treatment response as they are in the best position to note adherence, the emergence of side effects, and clinical response (Pomerantz, 2004).

Both in general medicine and psychiatry, the number one cause of treatment failure is not taking medications as prescribed. In numerous studies people with chronic illnesses often discontinue their medications or do not take them as prescribed (Shea, 2006). There are a number of reasons for non-adherence. Those commonly seen in patients treated with psychiatric drugs include the following:

• Many psychotropic medications require weeks of treatment before the first signs of clinical improvement are experienced. Most psychiatric disorders (especially depression) result in patients feeling pessimistic and hopeless. Even if they have been told about the need to wait in order to see improvement, after a few days frequently patients conclude that the drug is not working. They discontinue the medication and also may drop out of treatment all together. What makes this especially difficult to deal with is that they do not share their feelings and concerns with the treatment provider.

• Side effects often lead to medication discontinuation. At times side effects are intense and unpleasant, and may frighten patients. A common example is when the side effect *activation* (acute onset anxiety) occurs following the first dose of an antidepressant prescribed for a person suffering from an anxiety disorder. Intense anxiety not only may lead to medication discontinuation, but also may leave the patient traumatized by the experience to the point that they decide to never seek psychiatric treatment again. This decision (especially for those with chronic mental illnesses) can lead to life-long consequences (i.e. never again seeking treatment that could potentially greatly reduce their suffering). Often side effects such as weight gain or sexual dysfunction are the cause of patient-initiated discontinuation.

• Fears: Worries about adverse medication effects such as addiction are common. These fears exist for patients and also with parents who have their child in treatment. Another common and very understandable fear has to do with increases in suicidality in those taking antidepressants. Antidepressant advertisements on television always state that increased suicidality may occur with antidepressants. One of the biggest problems is when such fears go unexpressed; patients may, for various reasons, not tell their physician. If the concerns are brought to the prescriber's attention, it is generally addressed by providing information regarding risks and benefits. Providing this kind of information initially however is often not effective. What patients and parents first need is to really be heard. There is a time and place to provide information about these risks, but until our patients have had a chance to truly discuss their fears, such information may fall on deaf ears.

Treatment success can be significantly improved by two important proactive strategies (Shea, 2006). The first is to tell the patient that every person who is prescribed a medication will, at some point, evaluate the risks and the benefits of the medication (e.g. considering side effects, whether or not the drug is providing symptomatic relief, etc.). Often the patient will evaluate in a vague, non-systematic fashion and most of the time this assessment is not shared with the psychologist. Many patients conclude that the risks outweigh the benefits and then, on their own, discontinue the medication. To avoid this, the prescriber and psychologist should make a point to encourage the patient to discuss their concerns openly with the prescriber. Then the psychologist and patient can more carefully and systematically look at risks and benefits.

The second strategy is to address is the impact that friends and family have on our patients regarding medication treatment. It is not unusual for well intentioned family members to say, "You don't need that medication...you are strong enough...you can deal with this..." or "I heard that that drug is addictive." Such comments powerfully influence decisions to continue the treatment. The psychologist can anticipate this, and once again, proactively say, "Your friends and family are likely to have their own opinions about your decision to take this medication...when this happens please let me know what they say and what your own opinions are."

Medication non-compliance is also often in response to a number of psychological dynamics that must be addressed in therapy. This will be discussed in next month's issue of *The California Psychologist.*

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Mandatory Cultural Competence/Diversity Training: Time for a Serious Discussion?

Hengameh Maroufi, PhD

As psychologists we strive to understand the experience of our clients and feel empathy as we help them heal. But what happens when their experiences and their personal stories are vastly different from ours in terms of ethnicity, upbringing, socioeconomic status, gender, sexual identity or disability status? The stakes are high and it is crucial that we are able to help diverse clients. Should there be mandatory continuing education (CE) in diversity? The argument in favor of such a requirement is obvious – the population in California is especially diverse; psychologists should not work outside their areas of competence; many groups are grossly underserved and psychologists from similar cultures may not be available.

However, there are arguments to be made against mandatory topics for CE. CPA takes the position that psychologists themselves, not the legislature, should decide what kind of training they need. The Board of Psychology (BOP) currently requires psychologists to complete pre-licensure courses in Alcoholism, Child Abuse and Neglect, Human Sexuality, Spousal and Partner Abuse, and Aging and Long Term Care (California Board of Psychology, Article 3, section 1382) for licensure eligibility, and also requires continuing education in law and ethics and clinical supervision (for supervising psychologists) (Article 10, section 1397) for license renewal. The question then, is why not include diversity among these important mandated areas of training?

Cultural competence is an ethical issue (APA 2010, Standard 2.01 b). We simply cannot do our job ethically if we are not culturally responsive (we note that cultural competence cannot be achieved for each psychologist for every culture). Cultural competency may reduce the disparity gap that exists in healthcare. It is a way that patients and psychologists can collaborate on treatment in a way that allows for a respectful and responsive relationship where cultural differences enhance rather than interfere with treatment (Office of Minority Health, www.minorityhealth.hhh.gov).

I will never forget the first family therapy class I attended in graduate school. I walked away feeling alarmed that, based on Western views of family dynamics, my close-knit and loving Iranian family would be "pathologized" by a therapist who was not culturally competent. I feared for marginalized minority groups who find it hard to speak up for themselves if their perspective is not understood. The client sitting in front of us, needing our help and empathy may have a very different world view than us. As psychologists we need to listen to our client's stories and traditions. We also need to find out how problems are typically solved in their culture and families, and learn what it means to be seeking mental health treatment in their community.

It is my hope that we each take responsibility for our own professional and personal growth. My fear is that we may think that we are culturally competent when we are not. Diversity training would increase awareness of attitude towards individuals of diverse backgrounds, helping us know how much we don't know. According to the BOP website, discussions have begun on how to include diversity training as part our CE. There are already several examining boards that require mandatory training in this area. The New Mexico State Board of Psychological Examiners requires eight units within one year of licensure and four units during each renewal period (State of New Mexico, 2013). The Maryland Board of Examiners of Psychologists and The District of Columbia Department of Health requires three units every renewal period (Maryland Department of Health and Hygiene, 2013; District of Columbia Department of Health, 2013). On May 21, 2013, the Oregon legislature voted in support of cultural competency training for all licensed health care professionals (Oregonlive.com, 2013). The Oregon Examining Board appears to be headed toward changing their licensing requirements too. Is California merely to follow? Shouldn't we lead? The Board of Division VII strongly encourages our colleagues to communicate with us on this topic. We are very interested in your thoughts and ideas.

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Are You a Cost Increaser or a Cost Decreaser?

By Nancy Hoffman, PsyD

Here's a question for all neuropsychologists: Are you a cost increaser or a cost decreaser? Karen Postal, PhD, ABPP posed this very provocative question to the attendees of the West Coast Summit on Healthcare Reform sponsored by Division VIII and the Northern California Neuropsychology Forum. Most of us couldn't answer, but this is being asked about all specialists in healthcare reform.

One of the central mandates in healthcare reform is for physicians to decrease costs while increasing quality of care. Payment structures will be changing and although those changes have not been completely determined, we do know the fee for service payments will soon be a thing of the past. The most likely reimbursement model of the future will be global payments.

In this model, an annual or monthly lump sum is paid to a physician group for the care of each patient. This means any services that were previously billed to the insurance company will now be paid by the physician group in charge of that patient's care. If there is a savings at the end of the year, the group will collect a percentage of that savings if they have met quality measures. This model brings with it a built-in disincentive to refer for specialty services that increase the cost of care without adding measurable value. The key word here is "measurable."

Medicare has introduced the Physician Quality Reporting System (PQRS) and other insurance carriers are likely to roll out their own system for reporting change in patient health over time. The idea of "measurable results" in healthcare reform is very real and there are going to be consequences for not being able to prove that your services add value.

Payments to specialists are also going to be transparent. That is, the referring physician group will know how many hours you spent on an evaluation, how much you billed for the services, and how much your competitor has billed for similar services. The neuropsychologist whose reports add the most value for the least amount of money will be getting the referrals.

According to Dr. Postal, this requires a fundamental shift in our professional identity. The old ways of doing business are not likely to be viable in the brave new world of healthcare reform.

One of the ways neuropsychologists can add value is by using the cognitive and psychological data we collect from our testing to help our referral sources manage chronic conditions such as diabetes and high blood pressure, and to prevent costly hospitalizations.

We are accustomed to reporting on domains, making a diagnosis, adding in a few recommendations, and compiling all of this in a jargon-laden 15-page report that few people read. This has to change. The questions we need to be asking ourselves now are how can this data be used to improve this patient's health? And how can it be communicated in a brief, succinct manner that is free of jargon and is returned to the referral source quickly.

One of the most valuable aspects of a neuropsychological evaluation is the recommendations. A handful of forward-thinking neuropsychologists are now utilizing motivational interviewing techniques during the feedback session to help jumpstart the patients to make meaningful changes based on the test results. They work with the patient to develop a behavioral plan geared toward changing behaviors that interfere with compliance. This means that the feedback session may not be the last time you meet with the patient and you may find yourself collaborating with the treatment to develop a behavioral plan.

Neuropsychologists who work in rehab or with the schools already know how to write behavioral plans. Can you take the same idea and apply it to a diabetic patient who does not exercise or watch their diet? To the patient with sleep apnea who does not use the CPAP? To the patient with high blood pressure who does not take their medications on a regular basis? All of these patients have conditions that can be costly to treat if they are not well managed.

As Dr. Postal says, "Any specialist who is able to help physicians meet quality measures and avoid hospitalizations is going to be highly valued in the new system of healthcare delivery."

Nancy Hoffman, PsyD *(nah415@comcast.net) is a geriatric neuropsychologist in independent practice in San Rafael. She is the former President of the Northern California Neuropsychology Forum and currently serves as the Chair for the Committee for Geriatric Neuropsychology for CPA. In addition to her independent practice, she is also on staff at Kaiser Permanente, Union City and works as a consultant on the brain injury team at Kentfield Rehabilitation and Specialty Hospital in Kentfield.*

Division VIII Neuropsychology

Neuropsychologists and those interested in brain-related issues now have a place at the CPA governance table. We are committed to expanding appropriate continuing education opportunities for our Division members and we are evolving agendas for committees that represent some of the subspecialties within neuropsychology -- pediatric/developmental neuropsychology, geroneuropsychology, cultural neuropsychology, and forensic neuropsychology.

Toward the Way Forward in Disaster Mental Health: The Contribution of an Evidence Based Rapid Triage and Incident Management System: PsySTART

Merritt Schreiber, PhD and Rick Allen, PhD

Available research suggests there is a continuum of impact following disasters, terrorism and other large scale traumatic events such as mass violence. Currently, there is tremendous interest and focus on the concept of resilience in these events and ways to build community resilience. Research clearly supports the notion of resilience as a central aspect of the human response to traumatic events. This evidence (Galea et al., 2010; Norris& Galea, 2009) also suggests that resilience is not the only outcome. For some individuals exposure can result in the emergence of new incidence comorbid disorders that, left untreated, signal the beginning of a trajectory of chronic disorders and poly-situational impairment including PTSD. There are effective short term treatments for PTSD and even evidence that these treatments can be provided in internet interventions. Research on survivors of Katrina and other disasters found the best fitting measure for predicting DSM-IV anxiety disorder was physical illness, physical adversity and property loss. Galea et al. (2007) report that "A key to addressing the effects of trauma in a population following an incident is the effective and rapid identification of who is at risk." This is the basis for triage.

Triage. The PsySTART triage is based on a novel disaster mental health triage "tag" which includes a discrete measurement of severe and extreme event exposures, *and ongoing or evolving post event stressors* that may have evolved from the index event. PsySTART triage does not require a mental health professional to complete; school staff, health care workers, and individuals themselves can complete the tag.

The PsySTART triage "tag" includes the following elements:

- Impact of severe/extreme stressors or "severity of exposure" factors
- "What Happened" to the person (not their symptoms or mental health per se) based on objective features of :
  - Severe/Extreme Exposure such as being exposed to dead, dying, or mutilated bodies; hearing screams for help; delayed evacuation; trapped; separated from family; exposure to toxic agents/debris
  - Traumatic Loss (including missing family members)
  - Secondary Impacts (home loss, relocation, decreased social support, jobs)
  - Injury/Illness, such as acute injury/illness or extended health risks
- Expressed Peri-Traumatic Severe Panic (subjective risk)
- Practical human services case management foci (housing, unaccompanied children, etc.)
- Pre-existing mental health care
- Pre-existing disaster exposure

When individual PsySTART triage data is aggregated at the site, county, region or state level it provides an evidence based data metric to inform gap analysis in the preparedness/planning phases. In the response phase, the system guides near real time incident management using a floating triage algorithm which matches resources to needs in order of decreasing risk and other criteria such as "unaccompanied children," those with high exposure, and previous mental health or trauma history, etc.

In the last several years, several large disaster American Red Cross operations have used the PsySTART Disaster Mental Health Triage System to improve mental health recovery efforts. At a population level, risk surveillance can inform response leadership and rationally allocate limited professional mental health resources. At an individual level, PsySTART enables disaster workers to recognize risk factors in survivors and to use that information to guide immediate crisis focused interactions and clinical responses. The individual triage aspect of PsySTART informs Disaster Mental Health (DMH) workers of survivors who are in greater need of attention, particularly in operations with many thousands of survivors. Instead of "chasing tears" which may simply reflect distress with resilience, DMH workers can focus their training on those at higher likelihood for chronic outcomes but who do not display overt distress. Timely early triage using PsySTART followed by secondary assessment and referral for services has significant public mental health implications and holds the promise to improve resilience and clinical outcomes.

Please email the lead author for references.

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Rick Allen, PhD *(rallenphd@MangementContinuity.com) is the CPA Disaster Response Network Chair and has responded to numerous disasters and traumatic incidents. He conducts research on traumatic stress reactions; some of his previous articles can be found at: www.ManagementContinuity.com.*

Alameda County Psych Assn hosted a well-received day-long workshop in March beginning with Jessica Michaelson, PsyD on *Building a Smart Private Practice* followed by Fran Wickner, PhD giving a talk on *Everything You Need to Know about Getting on Insurance Panels*. The day ended with returning panelists, Michael Donner, PhD, Mary Jane Weatherbee, PsyD and Emily Morfin, MFT on *Becoming a Psychological Assistant*. The outstanding success of this day was due to the planning efforts of our Graduate Representatives, Kimberly Stanard and Barb Alperin. Membership Chair Dr. Greg Gayle and Early Career Chair Dr. Susan Guerrero also lent their support. ACPA continues to be committed to engaging our members through networking, continuing education, and advocacy opportunities.

Central Coast Psych Assn provided CE credit for a CLASP workshop presented by members of the CLASP committee, Drs. Victor Silva-Placios, Azarm Ghareman and Gary Lawson. CE credit was also provided for a *Suicide Prevention, Intervention, and Postvention* training taught by Rev. Naomi Paget, PhD and sponsored by the California Fire Chaplain Association Federation of Fire Chaplains. Dr. Monty Close, Disaster Response Chairperson, facilitated this cooperative effort. Dr. Halley Moore was appointed GAC Chair and Vatsa Shefali was appointed Student Representative. A Members Dine Out in Pismo Beach rounded out the Chapter's social calendar for the early summer.

Los Angeles County Psych Assn is presenting a Health Care reform event on September 21. Get up to date about healthcare reform at national and state levels with Cover California, our state's healthcare exchange. Elaine Miller-Karas, LCSW will present *Trauma Resiliency Model (TRM): A Mind-Body Approach to Treating Trauma* on September 28th. TRM is a comprehensive treatment that offers practical skills to restore resiliency coupled with education about the biology of trauma. Deemed a promising practice by the Department of Defense it is currently being researched by Walter Reed Medical Center. Future events include: October 19th for our 25th Convention; and November 23rd for *Mirrors of the Mind 2*, a gallery and performing arts by mental health professionals celebrating psychology, creativity and the power of art. For details: www.lapsych.org.

Santa Barbara County Psych Assn Mayor Schneider attended the board retreat and offered her perspective on local mental health issues. A successful fundraiser was held for the mayor in late June. The board's mission this year is to pursue cooperative relationships with other chapters of CPA and legislators. The GAC is training staff at Mayor Schneider's office to cope with distressed constituents. CPA's GAC will meet with our chapter to review the Health Care Reform Act. We are writing grants and establishing opportunities for practicum/ research opportunities. Dr. Gilbert Reyes presented *Recent Advances in Psychological Trauma* in June. Three student apprenticeships and two study groups have been established. SBCPA now has 140 members, the most ever.

Santa Clara County Psych Assn has an active calendar. Recent workshops include *What's New in DSM-5*, the *Myers-Briggs Type Indicator*, *Domestic Violence in the Affluent Community*, and *The Voice of the Child* in forensic issues. Upcoming workshops include *Relationships in Vivo* (July 20) and *Forensic Psychology 101* (September 28). Movie and book clubs continue (with CE), as do our popular networking get-togethers. For more information, go to www.sccpa.org and select "calendar." If you live or work in the area, join us for an event, or get involved! Contact us at admin@sccpa.org or 408-757-7720.

San Joaquin Valley Psych Assn and the Sullivan Center for Children hosted a two day conference with Thomas Shaffer, PhD, ABPP on *The Rorschach Performance Assessment System (R-PAS) in Clinical Settings* and Errol Leifer, PhD, ABPP on *Reflections on Expert Testimony in Administrative, Civil and Criminal Judicial Systems After 40 Years*. With Alliant-Fresno, SJVPA hosted the symposium *The Second Amendment and Mental Health: Implications for the Mental Health Practitioner*. In his never ending quest to increase awareness of the usefulness of Analytic Psychology, Ron Teague, PhD, ABPP, presented a two-day seminar titled *The Analytic Use of Dreams*. Claudia Cerda, PhD offered insight into her work as one of a handful of bilingual psychologists in the Fresno area.

The Division of Clinical and Professional Practice (Div I) promotes and advocates for the professional practice of psychology. Membership is provided with the following benefits: An exclusive copy of the 2012 Expertise Series (offered to non-members for $75) that explores a variety of issues/provides practical clinical practice tools; one hour per year of confidential attorney consultation regarding professional practice issues; opportunities for fellowship through specialty sections – Health, Forensics, Geriatrics, and Psychoanalysis. We continuously search to increase member involvement and to enhance communication to advocate on behalf of practitioners. Please consider joining us on this journey.

The Division of Clinical Psychopharmacology (Div V) has new and expanded web pages! Find them at the CPA Divisions link under *About CPA*. Look for: News clips on prescriptive authority; members of the Board and Chapter Liaisons; Tip Sheets and more. In addition, Division V is developing its second annual conference: *Addiction: Integrating Neurobiology, Psychopharmacology, and Psychotherapy* on February 21-22, 2014. Mark your calendars now for this important educational opportunity. We have a new mission statement: "To secure prescriptive authority, educate, and develop standards of professional competence in psychopharmacology for California psychologist." We welcome all members whether they have had post-graduate training in psychopharmacology or not.

The Division of Diversity and Social Justice (Div VII) held a well-attended town hall meeting at the CPA convention featuring Romana Norton, PhD who presented her research on the meaning of social support for racial stigmatization from a Black/White Biracial perspective. We were thrilled with the turnout at our social hour, meeting with both current and prospective members. We are planning some short CE presentations and are working on an Ethnic Leadership Minority Training day which hopefully we will partner with other divisions.

California Psychological Association

WELCOMES OUR NEWEST MEMBERS

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Joseph George, PhD, Sacramento, CA
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Martha Kahane, PhD, Santa Rosa, CA
Susanna Kanther, MS, PsyD, San Francisco, CA
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Eileen Lussier, PhD, Nipomo, CA
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Rajwinder Khurana, PsyD, Fremont, CA
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Jacob Schmidt, PsyD, Rodeo, CA
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Michiko Carey, PhD, Salinas, CA
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Meridee Runge, PsyD, Lodi, CA
Robin Sakakini, MS, PsyD, Calabasas, CA
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www.cpapsych.org

Please note: These members joined CPA between 4/6/2013 - 5/22/2013. As a CPA member, you may access other member's contact information online in our Member Directory under the Members Only section of our website or by contacting CPA's central office at (916) 286-7979, ext 122.

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Mission Viejo Office Corner of La Paz and Marguerite: Attractive psychotherapy office with view in prime location. Full/Part-time. Furnished and in turn key condition. Large group, referral source, sound-proofing, kitchen, call-lights, private restrooms, window, alarm, separate entrance/exit, elevator, waiting room, free WiFi/fax/copier. Call 949-215-4200, drrshulman@gmail.com.

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Addiction: Integrating Neurobiology, Psychopharmacology, and Psychotherapy

CPA Division V 2nd Annual Advances in Clinical Psychopharmacology Conference

February 21-22, 2014 ~ 14 CE credits

Topics will include:

- State of the Profession and New Directions; keynote speaker, Drew Pinsky, M.D.
- Neurobiology and Psychophysiology of Addiction
- Psychopharmacology of Addiction
- Pharmacological Management of Dual Diagnosis Patients
- Integrating Psychotherapy and Clinical Psychopharmacology
- Addiction, Psychopharmacology, and Psychotherapy in Forensic Settings
- Pipeline Drugs

The conference will be held at the Westin Hotel in Pasadena; CPA room rates are available. Speakers are medical and psychological experts in the field of addiction. Please save the date and plan ahead to attend this exciting, innovative, and informative conference. For more information, please contact Dr. Keith Valone, Conference Chair and Board Member of Division V, at valone@thearroyos.org.

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