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The Effects of Diversity Training on Mental Healthcare Professionals

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The Effects of Diversity Training on Mental Healthcare Professionals

Serving Hispanic Patients in Rural Oregon

by

Andrea E. Theye

Presented to the Faculty of the
Graduate Department of Clinical Psychology

George Fox University

in partial fulfillment

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in Clinical Psychology

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The Effects of Diversity Training on Mental Healthcare Professionals Serving Hispanic Patients
in Rural Oregon

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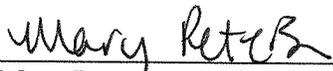
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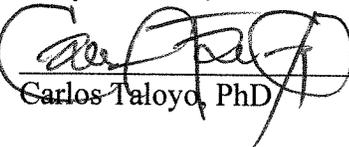


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Abstract

Previous research has indicated that the United States is experiencing a rapid growth in its racial and ethnic diversity. Although diversity trainings are common place, many of these trainings do not include outcome measurements to ensure that training goals are met and reactions are favorable. The current study expands the research by evaluating the change in attitude, self-reported culturally competent behavior, and knowledge as a result of the training as well as reactions to the training through the use of pre and post-training measures. Mental healthcare workers ($n = 47$) completed a pretest, received the diversity training, and then completed the posttest immediately following the training. Paired samples t -tests, and frequencies were used to analyze specific training outcomes. A statistically significant difference was found from the total scores of the pretest ($M = 60.31, SD = 10.23$) to post test ($M = 69.17, SD = 7.81$) on the measure, $t(47) = -7.86, p = .000$. Specifically, attitude, self-reported culturally competent behavior, and knowledge were all found to have statistically significant improvements, with attitude scores improving from pretest ($M = 24.99, SD = 4.07$) to post test ($M = 28.20, SD = 3.26$) $t(47) = -7.63, p = .000$, culturally competent behaviors scores improving from pretest ($M = 19.34, SD = 4.03$) to post test ($M = 22.06, SD = 3.16$), $t(47) = -6.85, p = .000$, and knowledge scores improving from pretest ($M = 15.98, SD = 3.05$) to post test ($M = 18.90, SD = 2.41$), $t(47) = -6.78, p = .000$ on the measure. These results indicate that diversity training can significantly improve participants understanding of diverse clients. This study highlights the importance of developing and objectively assessing diversity training to ensure its effectiveness and applicability to clinical work.

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Chapter 1

Introduction

The population in the United States is becoming increasingly culturally diverse. The 2011 census reported significant increases in the racial and ethnic minority populations and it is projected to continue to experience significant growth. It is projected that “by the year 2030 children from racial/ethnic minorities will account for more than one half of the Nation’s population under the age of eighteen” (Committee on Cultural Competence, 2008, p. 1). As a result of the ever increasing racial and ethnic diversity in the US, addressing diversity is becoming an increasingly important matter in mental healthcare. Of the various minority populations in the United States, Hispanics are now the largest minority group, constituting 17 percent of the total U.S. population (U.S. Census Bureau [U.S. Census], 2013). The term “Hispanic” can be broad; however the vast majority of Hispanics in the United States are of Mexican origin. Additionally, much of their booming growth is due to increasing immigration from Mexico and other South American countries (Diaz-Perez, Farley & Cabanis, 2004). The purpose of this study is to perform an outcome assessment of the shift in attitude, self-reported culturally competent behavior, and knowledge of mental healthcare workers who have completed diversity training specifically oriented towards Hispanic immigrants in rural Oregon. Diversity training is becoming increasingly important to mental health workers to maintain the highest quality of care possible in the wake of an increasing diverse nationwide populace.

In addition to the national trends, the population of Oregon is growing faster than the national average (Office of Economic Analysis, 2011); however within its growth lies unique patterns. Throughout its history, Oregon has traditionally had a lower percentage of ethnic and racial minorities than other states; however that fact is quickly changing. Minority groups as a whole in Oregon are growing at a faster pace than the corresponding rates at a national level (Office of Economic Analysis, 2011), resulting in an acceleration of diversity in Oregon's population. This rapid change is creating challenges for mental healthcare providers who may not be accustomed to working with minorities, and especially the rapidly increasing Hispanic population.

This study was conducted with mental health professionals who work with Hispanic patients in Polk and Yamhill Counties in Oregon. According to the U.S. Census Bureau, the terms Hispanic and Latino are often used interchangeably and they normally refer to individuals who have classified themselves as the specific Spanish, Hispanic, or Latino categories (U.S. Census, 2010). Although Mexican individuals are the largest Hispanic group nationwide, the term Hispanic may include individuals who are from Mexico, Puerto Rico, Cuba, other South American countries that speak Spanish, and others who indicate they are from Hispanic, Latino, or Spanish origins (U.S. Census, 2010). Although the terms Hispanic, Spanish, and Latino are often used interchangeably, they have slightly different connotations. For the purpose of this study the term Hispanic will be used. In regards to the race and diversity of Polk and Yamhill counties, according to the U.S. Census Bureau (2015a & 2015b), both of these counties report being composed of approximately 80.0% (79.9% and 78.5%, respectively) Caucasian, non-Hispanic individuals. In these counties, Hispanics have the highest minority percentage of the

population with 12.6% and 15.3% Hispanic, which are both higher than the statewide average of 12.2% (U.S. Census, 2013). Due to the high percentage of Hispanic individuals in these counties, mental health workers will likely provide care for a higher than average percentage of Hispanic clients.

This rapid growth of the minority populations in Oregon is especially seen in the Hispanic population; the growth tends to be mostly immigrants and is often associated with large families (Office of Economic Analysis, 2011). The Oregon population growth attributed to migration has fluctuated over the decades, however migration “is expected to contribute to nearly two-thirds of the population growth of Oregon in the next decade” (Office of Economic Analysis, 2011, p. 6). As noted in Diaz-Perez et al. (2004), at a national and statewide level, a significant portion of the growth of the Hispanic immigrant population has occurred in the rural counties that have not previously addressed the specific idiosyncrasies of caring for this group (Diaz-Perez et al., 2004). This booming growth is presenting a unique challenge to rural mental health workers who may not have been previously knowledgeable in working with this immigrant population.

Although the term rural can be broad, it generally addresses concepts such as overall population size of a county, population density of an area, measures of adjacency to a metropolitan area, measures of urbanization, commuting patterns, and socio-demographic characteristics (Keller, Murray & Hargrove, 1999). Although few universally accepted definitions exist, for the purpose of this study rural settings will be considered a geographic area that is located outside of a major city and town. The identification and definition of rural allows providers to focus attention on common issues in an underserved population that must be

addressed. In the context of this study, rural areas generally have a low population density and consist of mostly agricultural areas. The identification of the rural context also enables interested parties to target issues of common interest, allowing professionals to address common needs that may have at times been overlooked by mental health planners and policy makers at the state and federal levels.

Barriers to Immigrant Mental Healthcare in Rural Settings

Access to healthcare. Often immigrants in rural areas do not seek out and receive adequate medical and mental healthcare. Studies show that overall, Hispanic individuals continue to lag behind their Caucasian counterparts in access to healthcare (Morales, Lara, Kington, Valdez, & Escarce, 2002). There are several causal possibilities for this disparity, including the fact that Mexican immigrants are least likely of all immigrant groups to be covered by health insurance (Schmidley et al., 2001; Morales et al., 2002). Although there are many causal possibilities, this may be due to the fact that health insurance can be difficult to obtain; many immigrants do not receive health insurance from their employer and are unable to afford or obtain it independently. Although some of these trends may change in the near future with the implementation of the Affordable Care Act (ACA), without adequate health insurance, many immigrants face great hardship or are entirely unable to access necessary mental health services.

An additional barrier for immigrants to obtaining quality mental healthcare is a lack of working knowledge of the healthcare system. Studies show that immigrants tend to limit their use of public services, even for those that are fully eligible, for fear of possible demands for repayment, lack of a working knowledge of what programs are available, and concern over repercussions to their immigration status (Diaz-Perez et al., 2004). These barriers are mostly due

to a lack of knowledge of the medical system and resources available. Overall, these differences are found to be more pronounced in rural than urban areas (Diaz-Perez et al., 2004). Many rural residents are less likely to seek mental health treatment due to the weight placed on self-reliance, a diminished sense of confidentiality, and amplified pressure to conform (Hartley, Britain & Sulzbacher, 2002). Overall, many migrant Hispanic individuals do not have confidence in and awareness of the healthcare system that is available to them; this can be easily addressed with information on what aid is available and how to access services.

Additional challenges to attaining mental health services in rural areas include geographic isolation and lack of adequate mental healthcare facilities and workers in rural areas. As noted by Diaz- Perez et al. (2004), “in 2000, rural counties (as defined by Schmidley et al., 2000) with a majority Hispanic population averaged 5.3 physicians per 10,000 residents, versus an average of 8.7 physicians per 10, 000 persons across all rural counties” (Diaz-Perez et al., 2004, p. 260). This shortage of adequate mental health workers in rural environments has been noted for some time (Hartley et al., 2002) and has been a challenge to obtaining quality mental healthcare in rural areas. A study performed in 1997 found that “76% of the 518 designated Mental Health Professions Shortage Areas in the United States were located in nonmetropolitan areas with a population of over 30 million” (Hartley et al., 2002, p. 246). In addition, rural areas often have a lack of public transportation available. For many individuals who do not have dependable personal transportation, the lack of public transportation results in an inability to attend important appointments. Overall, in rural areas many minority individuals tend to underuse health services; this is partially due to fewer available facilities, and a lack of knowledge of the healthcare system.

Factors increasing stress. The immigrant population often experiences several factors that can greatly increase their stress level and cause additional barriers to accessing care. One of those factors may be a potential language barrier between patients and their mental health professional. Studies have found that nearly half of the US Immigrant population reported that they spoke English less than “very well” (U.S. Census, 2000). Limited English proficiency (LEP) with patients and their mental health professional can create miscommunications between the mental healthcare provider and the patient and can have “deleterious effects on navigating the healthcare system and on understanding health information and treatment” (Kim et al., 2011, p.1). Given the fact that mental health treatments often relies on direct verbal communication (rather than other more objective means), language barriers are especially important to address in mental health settings. Studies show that, when other factors were controlled for, non-English speaking individuals were less likely than their English proficient counterparts to receive their needed services. Therefore lower English proficiency is associated with lower use of mental health services (Sentell, Shumway, & Snowden, 2007). As a result, it is important for mental health professionals to have a heightened attention to individuals with limited English proficiency in both practice and policy and be aware of the challenges and how best to address them in their facility.

In addition to the other important barriers to care, it is imperative for clinicians to be aware of the impact of the high level of stress under which many of their minority patients will be operating. Although immigration presumably selects for a healthy population, stress significantly impacts activities of daily living for immigrant individuals and the community (Hiott, Grzywacz, Davis, Quandt, & Arcury, 2008). A study done by Hiott et al. (2008) found

that 38% of Hispanic immigrants reported significant levels of stress. The stressors with the greatest impact on immigrant mental health include social isolation and stressful work conditions, with each impacting their mental health status including anxiety and depression. In the study by Hiott et al. (2008), the social isolation experienced by many immigrants in rural areas “had the strongest potential effect on farmworker anxiety, whereas more stressful working conditions had the strongest potential effect on depressive symptoms” (p.37). Overall, immigrants working in a rural environment (farmworkers) experience additional stressors which can lead to an increase in mental health issues.

Rural mental health professionals. Working in a rural setting can also present challenges to mental health professionals, especially those who may not be adequately prepared for working with the unique rural population. The term *mental health professional* can be quite broad; however for the purpose of this research it will be individuals who are professionally trained to offer services to improve an individual’s mental health. It includes a variety of professionals including psychiatrists, psychologists, psychiatric nurse practitioners, clinical social workers, licensed professional counselors, and a variety of other professionals who have attained sufficient education and training to address specific mental health needs in the population (Duckworth, 2013). Mental health professionals who work in a rural setting are faced with the need to understand the social, life-style, organizational, and institutional factors that prevail in rural areas. With the rapid increase in the rural Hispanic population, the mental health systems as well as individual practitioners are often not adequately prepared to work most effectively with this population, creating an increased need for culturally sensitive or culturally competent mental health professionals. Current research in diversity training uses the phrase

culturally competent which generally refers to the idea of “the process in which the healthcare professional continually strives to achieve the ability and availability to effectively work within the cultural context of the client- family, individual, or community” (Campinha-Bacote & Campinha-Bacote, 2002, p. 181). To provide the best standard of care, mental health professionals who draw their client base from rural immigrant populations require a thorough understanding of the rural immigrant population where they work to provide the highest quality and most culturally competent care possible.

Additionally, mental healthcare providers must be aware of the impact of social isolation and stressful work environments prevalent in the immigrant community. They must also know how to address these matters in a culturally sensitive manner, and maintain awareness of specific culturally relevant practices and interventions. Being aware of specific mental health concerns is very important when working with specialized populations. For example, clinicians must be aware that screening for anxiety and depression is warranted in a rural immigrant population (Hiott et al., 2008). These specific issues that are relevant to the population served must be addressed in a specially tailored diversity training developed for providing culturally competent care.

Clinicians who are trained in providing culturally competent care have a stronger impact on their minority clients than clinicians who have not been trained in providing culturally competent care (Bezrukova, Jehn, & Spell, 2012). For the purpose of this study, diversity training is defined as a distinct program aimed at facilitating positive intergroup interactions, reducing prejudice and discriminatory practices, enhancing the skills, knowledge, and motivation of people to interact with diverse others (Pendry, Driscoll, & Field, 2007). Generally diversity

training is designed to address prejudice, stereotyping, and other damaging biases (Bezrukova, et al., 2012). It must address the specific needs of an underserved minority population that are imperative for culturally informed clinicians to be aware of in mental health settings.

Salient Cultural Factors

It is also of great importance for mental health workers to be aware of and sensitive to unique cultural factors of the population with whom they work. This is especially important if clinicians are required to work with a large portion of clients from a specific minority population. There are many unique attributes of the Hispanic, or Mexican-American, culture that are distinct from the Caucasian majority culture and are therefore imperative for mental-health workers to be aware of when working with this population. Several prominent aspects for clinicians to be aware of include specific Hispanic family dynamics, gender roles, and linguistic expression that may surface in therapy.

Several attributes of Hispanic family patterns and dynamics are important for clinicians who work with this population to understand. First, it is important to note that in many Hispanic families a high respect for elders and authority is expected. All members of the family are expected to maintain this esteem including children, their parents, and extended family members. Also important is the emphasis on the family, including the extended family and friends. Hispanic individuals (especially Mexican Americans) are typically described as being oriented to family well-being; this is more highly encouraged than individual well-being (Landale, Oropesa, Bradatan, 2006) and includes aspects such as attitude and behavioral components (Landale et al., 2006). This is important for clinicians to be aware of because the traditional western culture that psychology was founded on tends to encourage independence from the family and the health of

the individual. Contrarily, in the Hispanic culture, members of the family must be respectful to their elders, both in their attitude and their behaviors. For a younger individual to go against something that their elders requires of them would likely create great interpersonal stress in the entire family unit. Clinicians must be aware of and sensitive to aspects of the collectivistic culture, integrating it as a strength in therapy.

Another important dimension for clinicians to be aware of in the Hispanic culture is the existence of rigid gender roles found in many family units. This includes the male and female notions of Machismo and Marianismo, both of which have positive and negative aspects attributed to them. The term Machismo refers to values held for males; it can be characterized by positive traits such as “pride, honor, responsibility to be a good provider, and assertive behavior” (McAuliffe, 2008, p. 333). However it is also associated with challenging behavior such as aggression and restricted emotions (McAluiffe, 2008). Regarding women, the term Marianismo refers to positive characteristics such as dedication to family and being a keeper of tradition, as well as more negative terms such as being self-sacrificing and submissive (McAuliffe, 2008). It is imperative for clinicians to be aware of these attributes and find ways to use them in a positive manner when working with this population. These qualities are gross generalizations and, while not found in all Hispanic populations, remnants of these values may remain in the Hispanic culture and must be considered when working with this population.

Finally, linguistic concerns must be considered for mental health professionals working with Hispanic clients. Clinicians must be aware of the client’s language choice including the meaning behind the choice of language; the implications of a clinician choosing to address or not address language use, and the effect those factors have on a therapeutic relationship. Studies

have shown that multilingual clients switch languages depending on various subject matters and it is possible that “language switching is an effective mechanism for accessing all the intricacies of memory and emotion associated with the different languages” (Espin, 2013, p. 213). This is significant because clinicians should be aware of deeper meanings that could signal language switching, and the significance to the client of being able to speak in their first language.

Although it is preferable for the client and clinician to share common languages, oftentimes this is not the case and a clinician must rely on interpreters to relay meaning in the client’s first language. If a non-bilingual therapist is working with a client who is not fluent in English, it is important to have an interpreter available. This is crucial to culturally competent mental health treatment due to the fact that “Spanish-speaking clients are more positive about their treatment experience when a therapist is bilingual or when bilingual interpreters are available (Biever et al., 2002, p. 330). If a health worker has to utilize an interpreter in their sessions, it is important for the clinician to observe other factors such as emotional expression and body language while the client is speaking in their first language to further relay meaning that might have been lost through translation (Espin, 2013, p. 213). Therefore, it is helpful for clinicians to remain alert to language subtleties and any therapeutic relational dynamics that ensue from them. Another important aspect for mental health professionals to be aware of is the tendency for Hispanic patients to feel unable to disagree with the clinician’s medical decision or medication advice. Due to the power imbalance between the provider and the minority patient, Hispanic patients may feel a lack of control over their own healthcare; that they must take the advice of their provider without having the power to voice their concerns. Overall, aspects of family dynamics, gender roles, linguistic preference, and power differentials are important for clinicians who work

specifically with the Hispanic culture. As a result of assimilation into western culture, many of these aspects of their culture have been or are being eroded (Landale et al., 2006), causing inner conflict. This pressure to conform and choose between two cultures is often referred to as acculturative stress (Smart & Smart, 1995) and can be expressed through familial discord, intergenerational conflict, or other outlets (McAuliffe, 2008).

Health Disparities for the Hispanic Population

The aforementioned substantial barriers to care and important cultural dynamics that influence the type and quality of healthcare services Hispanics have access to and receive, constitute important factors that influence overall minority health. When combined, these factors compose what is commonly referred to as health disparities. Health disparities may be considered “the result of discrimination, differences in access to quality care, socioeconomic barriers, and cultural barriers” (US Commission on Civil Rights, 1999, p. 2). Health disparities are differences in access to and quality of care that generally lead to adverse overall health, these disparities are found to exist primarily in racial and ethnic minorities. They can rob individuals of good health and their sense of well-being and personal security. The research indicates that there is a high rate of healthcare disparities overall between Hispanic and non-Hispanic individuals that can negatively contribute to their health status, if not properly addressed (Livingston, Minushin, & Cohn, 2008; Askim-Loveseth & Aldana, 2010). More attention is needed to focus on persistent health disparities and access to care issues among diverse populations, especially in rural communities (Casey, Blewett, & Call, 2003). Studies have found that overall racial and ethnic minorities (including Hispanics) have an overall poorer health status, including having an overall higher prevalence of specific health problems. To address the

overall poorer health found in the Hispanic population, additional training must be provided to mental healthcare professionals to specifically address prevalent health disparities that strongly affect the population they work with.

Self-Reflection

Another important aspect of quality diversity training is encouraging participants to recognize the importance of their self-awareness when working with diverse clients. In the interest of ultimately having the maximum changing effect on participants' behaviors, attitudes, and knowledge, in regards to a diverse population, self-awareness is an important aspect to address in training. As a part of this self-reflection promoting self-awareness, quality diversity training must include concepts of racial identity theory (Murray-Garcia, Harrel, Garcia, Gizzi, & Simms-Mackey, 2005). True self-reflection can be considered giving participants an opportunity to cognitively and emotionally process the personal meanings of the training. Self-reflection in its truest form is likely not feasible in a time limited training, however, quality diversity training should include information on aspects of racial identity theory for participants to consider for themselves and their patients. Having this information included in diversity training encourages participants to reach the final stages of racial identity development which includes challenging themselves to the highest standard of equitable, culturally respectful, and effective care for their patients (Murray-Garcia et al., 2005). Studies have shown that metacognitive skills as well as awareness of self-reflection skills are highly important to successful training programs (Kraiger, Ford, & Salas, 1993). Overall, effective diversity training programs must encourage the importance of racial identity development and encourage participants to reflect on their own racial identity and that of their patients, as well as the effects both may make on treatment.

Training for Mental Healthcare Professionals

Despite continued importance placed on generalized diversity training, research indicates that healthcare professionals continue to be unsuccessful at understanding how to work with patients who are different from themselves and how to appropriately respond to patients' varied perspectives, values, beliefs, and behaviors in regards to their health and well-being (Williams, 2012, p. 5006). It is imperative to equip mental healthcare professionals with effective diversity training that is applicable to the population with whom they most often work. This training should focus on improving the communication between diverse clients and their mental health professionals, aiding the mental health professionals in understanding salient multicultural aspects, encouraging an appreciation of self-awareness, and teaching specific cultural knowledge that is helpful for working with the Hispanic population.

For the current study, in rural Oregon, this includes appropriately addressing the aforementioned significant healthcare disparities found in a rural setting. As a result, this training must address the unique needs of the Hispanic population in rural Oregon.

Statement of the Problem

Although mental health professionals often receive generalized multicultural or diversity training, many do not receive training that addresses the specific population with whom they work. As the population in the US overall, and in rural Oregon specifically, has become more ethnically diverse, mental health organizations must strive to make interventions and therapy more culturally aware and appropriate (Like, 2008). Through informal means, it was brought to the attention of local mental health organizations that the clinicians working in their practices did not feel adequately prepared to address the unique mental health needs of the growing Hispanic

immigrant population in rural Oregon. As a result of the significant increase in Hispanic immigrant workers, there is an expressed need for mental health professionals to be trained to address the specific needs and develop culturally sensitive practices that are recommended for this new demographic. This training must be empirically supported, effective, and mutually applicable to the three different mental health sites that have expressed a need and an interest in this specific training. Successful diversity training must also address the existence and impact of health disparities, including the various causes of health disparities and the culturally appropriate interventions to address them in therapy. It must also provide a thorough understanding of mental health needs and barriers to care faced by the Hispanic immigrant population (Diaz-Perez et al., 2004). Mental health professionals must also acquire the skills to effectively communicate and negotiate with this unique culture and language, including how best to utilize interpreters in the therapy session (Like, 2008). Understanding the existence and magnitude of health disparities, specific mental health needs, and learning effective communication are necessary skills for clinicians who work with the Hispanic immigrant population on a regular basis.

Research Question

The current study expands the research by examining distinct outcomes of diversity training that addresses a specific minority population, particularly the Hispanic immigrant population in rural Oregon. The purpose of this study was to conduct an evaluation of the changes in attitude, self-reported culturally competent behavior, and knowledge associated with diversity training outcomes. A quantitative approach was used to analyze the specific outcomes by using pre and post-measures (see Appendices B & C). These instruments measured the participant's knowledge, self-reported culturally competent behaviors, and skills in relation to

working with their Hispanic patients as well as their perception of increased understanding to treat their patients and understanding of their own cultural competence. The following hypotheses are proposed to occur as a result of the diversity training.

Hypothesis 1:

The mental health professionals' knowledge would improve the greatest, the self-reported culturally competent behavior would improve to a lesser degree, and the attitude would change the least or not at all.

Hypothesis 2:

Overall, there will be a statistically significant change in overall scores between the pre-training scores and the post-training scores.

Hypothesis 3:

On the post-training measure participants would score higher on question number 4, "my current stage of racial identity development has an effect on treatment" on the post-training measure.

Hypothesis 4:

Much of this information would be new and helpful for participants; that because they are not receiving this information elsewhere, they would feel they gained knowledge and strategies to better understand and treat their patients as would feel as if the training helped them to become more culturally competent.

Chapter 2

Methods

Participants

Participants were mental healthcare professionals who work on a regular basis with the Hispanic immigrant population in rural Oregon. They were recruited from the Willamette Family Medical Clinic, the George Fox Behavioral Health Clinic, and the Health Consultation Team at George Fox University to participate in mandatory diversity training for all mental health professionals at each site. There were 21 participants (44.7%) from Willamette Family Medical Clinic, 10 participants (21.3 %) from the Behavioral Health Clinic, and 16 participants (34%) from the Health Consultation Team at George Fox University. A total of 47 participants attended the training and completed both the pre and post measures (42.6% male, 57.4% female). Participants were Caucasian (64.4%), Hispanic American (17.8%), Asian American (8.9%), and Native American (2.2%). They noted their occupations as Mental Health Consultants (34.8%), other (including Medical Assistant) (28.3%), Psychologists (23.9%), Physicians (8.7%), and Social Worker (4.3%). Years working on the field varied from under 1 year to 20 years, with the majority having 3 years (34.4%), 2 years (25%), 4 years (12.5%), and 5 years (12.5%) of experience. Parametric participant demographics are detailed in Table 1.

Table 1

Mean, Standard Deviation, Minimum and Maximum values of Demographic Variables

<u>Demographic Variable</u>	<u>M</u>	<u>SD</u>	<u>Min</u>	<u>Max</u>
Age	33.43	12.84	22	65
Years in Field	4.31	3.94	1	20

Materials

Diversity training. The training was developed according to current standards in diversity education. The subject matter was empirically supported pertinent topics of cultural diversity that surround the Hispanic (primarily Mexican-American) migrant population in rural Oregon. It was targeted for mental health professionals who work with this population on a regular basis. Training took place on four different days, with two days of training at Willamette Family Medical Center (only one day was mandatory) and one day of training each at George Fox University and the George Fox Behavioral Health Center. The diversity training took approximately 50 minutes and the measure took approximately 5 minutes before and after the training to complete.

Measure. Pre and post-training measures (see Appendices B & C) assessed three domains of attitude, self-reported culturally competent behavior, and knowledge associated with diversity training. Within these three domains, five subject areas were measured. These subject areas are a collectivistic culture, acculturation/assimilation, mental health needs and treatments, barriers to mental health care, and models of cultural competence/racial identity development. Within the measure, items 1-3 apply to a collectivistic culture with item 1 pertaining to culturally

competent behavior, 2 to attitudes, and 3 to knowledge. Items 4-7 apply to acculturation/assimilation with item 4 and 5 pertaining to attitude, item 6 pertaining to culturally competent behavior, and item 7 pertaining to knowledge. Items 8-11 apply to mental health needs and treatments with item 8 pertaining to attitude, 9 and 10 pertaining to culturally competent behavior, and 11 pertaining to knowledge. Items 12-14 apply to barriers to care with item 12 pertaining to attitude, 13 to culturally competent behavior, and 14 to knowledge. Items 15-18 on the measures apply to models of cultural competence/racial identity development with item 15 pertaining to attitude, 16 and 17 pertaining culturally competent behavior, and 18 pertaining to knowledge. On the post measure (see Appendix C), questions 19 and 20 measured the participant's reactions to the training.

The measures were administered directly before and after the diversity training; each measure took the participants approximately 5 minutes per administration to complete. The pre-training measure (see Appendix B) consisted of 18 questions and the post-training measure (see Appendix C) consisted of 20 questions, with the 2 additional questions added to the post-training measure to assess the participant's perception of whether the training was helpful and relevant to their work with Hispanic individuals. Questions 1-19 ask participant to judge their learning on a 5-point Likert scale and question 20 asks the participants to evaluate their learning on a 10-point Likert scale.

Procedure

Diversity training and measure. Participants were recruited from three local healthcare organizations; two in Yamhill County, Oregon and one in Polk County, Oregon. Participants were mental healthcare professionals who are currently working with clients from rural counties

in Oregon. The diversity training was mandatory for all mental health professions on staff and took place during normal weekly training times in an assigned staff room. An informed consent (see Appendix A) was completed by each participant and then a measure was given to each participant at the beginning and the end of the training. All inclusive, the training and participation in the measures lasted approximately 60 minutes.

Proposed Analysis

The purpose of this study was to gauge the knowledge, self-reported culturally competent behavior, and attitudinal changes of mental health professionals that occurred as a result of diversity training specifically addressing Hispanic migrants in rural Oregon. A quantitative analysis was employed to assess each individual's self-reported attitude, culturally competent behavior, and knowledge in five areas: a collectivistic culture, assimilation/acculturation, mental health needs and treatment, barriers to mental health treatment, and models of cultural competence. Means, standard deviations, and descriptive frequencies were calculated for each area. Additionally, paired samples *t*-tests were used to determine changes from pre and post measures of the diversity training.

Chapter 3

Results

Outcome Evaluation of Training Event

The measures asked participants to rate attitude, culturally competent behavior, and knowledge regarding their work with Hispanic patients. A quantitative approach was used to analyze the outcomes through the use of pre and post-measures.

Hypothesis 1

The first hypothesis stated that the training would affect the mental health professionals' knowledge the greatest, the self-reported culturally competent behavior would improve to a lesser degree, and attitude would be most resistant to change, improving the least or not at all. To test this hypothesis, a paired samples *t*-test was completed with the pre and post-scores of the participants rating their attitude, self-reported culturally competent behavior, and knowledge independently. Surprisingly, all three domains improved at a similar rate, however as expected the total knowledge score improved the greatest. There was a significant improvement in the self-reported culturally competent behavior scores from pretest ($M = 19.34$, $SD = 4.03$) to post test ($M = 22.06$, $SD = 3.16$) on the measure, $t(47) = -6.85$, $p = .000$. Cohen's *d* is 0.75. There was a significant improvement in the knowledge scores from pretest ($M = 15.98$, $SD = 3.05$) to post test ($M = 18.90$, $SD = 2.41$) on the measure, $t(47) = -6.78$, $p = .000$. Cohen's *d* is 1.06. There was a significant improvement in the attitude scores from pretest ($M = 24.99$, $SD = 4.07$) to post test ($M = 28.20$, $SD = 3.26$) on the measure, $t(47) = -7.63$, $p = .000$. Cohen's *d* is 0.87.

Hypothesis 2

It was also hypothesized that overall, there will be a statistically significant change in overall scores between the pre-training scores and the post-training scores. To test this hypothesis a paired sample *t*-test was completed, comparing the total pre and post scores of the participants rating of their own attitudes, self-reported culturally competent behaviors, and knowledge. A statistically significant difference was found from the pretest ($M = 60.31, SD = 10.23$) to post test ($M = 69.17, SD = 7.81$) on the measure, $t(47) = -7.86, p = .000$. Cohen's *d* is 0.97.

Hypothesis 3

Additionally, it was hypothesized that on the post training measure (see Appendix C) participants would score higher on question number 4, "my current stage of racial identity development has an effect on treatment." A paired sampled *t*-test was conducted and a statistically significant difference was found from the pretest ($M = 3.57, SD = 1.03$) to post test ($M = 3.85, SD = .97$) on the measure, $t(47) = -2.55, p = .014$. Cohen's *d* is 0.27. Overall, the hypothesis was confirmed and participants were more aware that their current stage of ethnic identity affected their treatment of others.

Hypothesis 4

Finally, it was hypothesized that much of this information would be new and helpful for participants because they are not receiving this information elsewhere and feel they gained knowledge and strategies to better understand and treat their patients and would feel the training helped them to become more culturally competent. Frequencies were run for questions 19 and 20 on the post test, "overall I have gained knowledge and strategies to better understand and treat

my patients” and “overall, this training has helped me to become more culturally competent in my work with Hispanic patients.” First, the frequencies were ran to determine the mean score of question 19 which is 4.06 out of 5, the standard deviation is 0.77, the minimum is 2.0, and the maximum score 5.00. Next, frequencies were run for question 20 with the mean being 7.86 out of 10, the standard deviation is 1.48, the minimum score is 4.0, and the maximum score was 10.0.

These scores indicate that overall, the hypothesis was confirmed that most participants indicated they gained knowledge and strategies that they could utilize to better understand their patients. Additionally, overall participants felt that the training helped them to become more culturally competent in their work with Hispanic patients. Mean, standard deviation, minimum, maximum, and Cohen’s *d* are outlined in Table 2.

Table 2

Pre and Post-Test Means, Standard Deviations, t scores, Significance levels, and Cohen’s d values

Variables	Pre Test		Post Test		<i>t</i> -test		Cohen’s <i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>t</i>	Sig	Cohen’s <i>d</i>
Attitude Scores	24.99	4.07	28.20	3.26	-7.63	.00	0.87
Culturally Competent Behavior Scores	19.34	4.03	22.06	3.16	-6.85	.00	0.75
Knowledge Scores	15.98	3.05	18.90	2.41	-6.78	.00	1.06
Overall Scores	60.31	10.23	69.17	7.81	-7.86	.00	0.97
Question 4	3.57	1.03	3.85	0.97	-7.86	.014	0.27

Chapter 4

Discussion

This study showed that a diversity training program significantly improved mental healthcare professionals' self-reported knowledge, culturally competent behavior, and skills when providing care for that group. The findings demonstrate the importance of diversity training for mental healthcare workers who provide services for diverse individuals. It is evident from current and previous research that although the United States is experiencing a high influx of diverse individuals, healthcare disparities remain prevalent for many minority individuals (Casey et al., 2003). While an increasing number of entities are conducting diversity training, it is seldom measured objectively. Within these diversity training outcome evaluations, many focus largely on attitudinal change, with less emphasis placed on other outcomes (Kalinowski et al., 2013). However, research indicates that, to maximize training effectiveness, it must address multiple dimensions of learning including attitudinal, knowledge, and behavioral changes (Kraiger et al., 1993). Consistent with the research based on diversity training, this study evaluated all three primary areas of learning. In this study, change in knowledge was discovered to increase the most. However, a statistically significant increase was found in all three dimensions between the pre and post-measures. Similarly, overall scores were found to be increased between pre and post-measures. These findings indicate that the diversity training was found to be effective at imparting learning in various domains of the participants' understanding in regards to diversity.

An important part of understanding other cultures is the ability to practice self-reflection, including one's own identity markers and the effect they may have on treatment. Self-reflection is an integral aspect of multicultural training; when self-reflection is practiced there is an emphasis on awareness of one's own culture and biases, and ultimately it encourages more equitable care for diverse populations (Murray-Garcia et al., 2005). Although a thorough self-reflection of these attributes may not be fully attainable in a time limited diversity training program, it is important to emphasize the value of self-reflection and its effects when providing care for diverse individuals. Studies have shown that metacognitive skills as well as awareness of self-reflection skills are highly important to a successful training program (Kraiger et al., 1993). This study confirmed this finding. The trainees' awareness of the importance of their own ethnic identity increased between the pre and post-tests, with the participants reporting that they were more aware their current stage of ethnic identity affected their treatment of others. This finding is important because it confirms that this often forgotten aspect of diversity training, an appreciation for self-awareness, is an important aspect and must be considered when developing and evaluating diversity training programs.

Although diversity training is often considered mandatory, not all participant reactions are favorable. The trainees' reactions to the training are important to understand because often their reaction determines a large portion of their learning outcomes. Although anecdotal accounts of diversity training often indicate participants may view it negatively or as meaningless (Galen & Palmer, 1994), successful diversity training is generally rated favorably by participants (Law, 1998) and leaves them feeling as if the training was important and applicable to their work. The results found in this study indicate success. Most participants indicated they gained knowledge

and strategies that they could utilize to better understand their patients. Additionally, participants felt that the training helped them to become more culturally competent in their work with Hispanic patients. Some of this success may be attributed to the fact that this training was specifically designed to provide information for a population that the participants provide care for on a regular basis. Most of the participants did not have prior training on providing care for Hispanic individuals and much of the information provided was designed to be easily applicable to their work.

Implications for Practice

Overall, this study highlights the benefits specialized diversity training can offer to mental healthcare professionals, especially given the increasing diverse population. The United States of America is rapidly becoming increasingly culturally, ethnically, and racially diverse (Judy & D'Amico, 1997), thereby increasing the urgency for mental health workers to provide culturally responsive practices and services (Fouad, Arredondo, D'Andrea, & Ivey, 2012). To address barriers to care as well as persistent healthcare disparities found in the minority populations, appropriate diversity training is increasingly important for mental healthcare professionals (Dogra, Vostanis, & Frake, 2007). To address this need, the mental healthcare industry must properly train its professionals to effectively work with, and offer the highest quality care to the growing minority populations (Dogra et al., 2007). This study's findings suggest that providing relevant diversity training for mental health professionals can improve not only their attitude, self-reported culturally competent behavior, and knowledge regarding this population, but also increase their confidence in providing care for a diverse population. The field of mental healthcare must continue to respond to the professional calling of training mental

healthcare workers to recognize the importance of culturally sensitive care and to apply culturally sensitive clinical skills in their practice (Fouad et al., 2012).

Implications for Research

In addition to practice, this study has several important implications for research. Although diversity training is widely accepted as an important aspect to professional training, few studies are dedicated to outcome measurements to ensure the training is effective (Law, 1998). Including outcome measurement is an important aspect of quality diversity training to ensure it accomplishes its intended goals and its learning outcomes have been achieved (Kraiger et al., 1993). The outcome measurement must include a thorough evaluation of training outcomes, including measures of attitudinal, knowledge, and skill or behavioral change (Kalinowski et al., 2013). The findings of this study imply that when properly designed, diversity training can have a statistically significant impact on the participant's knowledge, skills, and behaviors in regards to working with diverse patients. To ensure efficacious diversity training, outcome measurement remains an integral aspect.

Often in diversity trainings, participants have been known to show resistance to training (Law, 1998; Murray-Garcia, 2005). Studies have sought to identify the source of this resistance, some suggesting it may be due to a resistance in the dominant race to sacrifice privilege (Dogra 2007) while others suggest it may be due to trainees being in different stages of racial identity development (Murray-Garcia, 2005). As part of the outcome measurement, this study sought to include a measure of participants' reaction to the training. Many participants indicated that they felt that they learned novel information, and that this information was relevant and helpful to their clinical work. In this study, possible explanations for the favorable reactions include

designing the training to be relevant to the specific minority population that the mental healthcare workers are exposed to the greatest, that the training specifically addressed racial identity development and stages of cultural competence, and that it was relatively brief and time limited. Additional research in these areas would be advantageous to determine the factors that are essential to positive participant reactions to training. Studies have not been able to predictably reduce resistance to training, however this study presents several explanations that would be advantageous for future research to continue to explore.

For future studies and training, there are several areas of additional statistical analysis as well as additional research that would provide valuable information. Additional research would be helpful to compare the overall scores between the doctoral students and the established professionals. This would provide insight into learning styles of the established professionals versus students, gauging which population may be more resistant to change. Once this can be understood, measures can be taken to ensure the training can have maximum effectiveness on both important populations. It would also be beneficial to conduct an item analysis of the items on the pre and the post-measures. This would provide greater insight into participants' responses to specific items, gauging the quality of those items as well as the measure as a whole. Item analysis would be particularly helpful if the measure is to be used again, to eliminate ambiguous or misleading items. It is also recommended that future research in outcome evaluation of diversity training continue to improve and refine the outcome evaluation process. As a part of this, it is recommended that future studies have an increased number of items related to reflective self-awareness, perhaps including a longitudinal post-test to gauge whether participants were able to retain the gains in learning. These additional analyses and research are important for

future studies to ensure the training has the maximum effectiveness for all participant populations and to ensure the items pre and post-training measures are relevant and effective for their intended use.

Limitations

There are several limitations to this study that are worth noting. The generalizability of this study is limited to mental healthcare professionals in rural Oregon who work with Hispanic patients. The majority of the respondents were either Mental Health Consultants or Psychologists; the slightly lower response rate of other occupations limits broad generalizations across career fields. Further research should attempt to gather responses from additional occupations who offer mental healthcare, such as social workers and physicians.

Further, the respondents were all from a Health Consultation team, a Behavioral Health Clinic, or a Medical Center. The inherent limitations are that the results may not be generalizable to other population or mental health facilities such as private practices, Veteran Administration Medical Centers, or college mental health centers. Future research is warranted to discover if the results may be replicated in these other mental health facilities.

Additionally, this study was completed with multicultural training for mental health workers interacting specifically with the Hispanic minority population. Due to this cultural specificity, the results may not be generalizable to trainings addressing other minority populations. Additional research would be advantageous to determine if such favorable results may be replicated with training geared towards other cultures.

Finally, this study was limited by the fact that the majority of the respondents were early career mental healthcare workers. The vast majority of respondents had less than 10 years of

experience working in their field. Further research would be helpful to discover if professionals with a greater amount of experience would experience a similar pattern of change in their attitudes, self-reported culturally competent behavior, and knowledge.

Conclusion

Overall, the findings of this study are important in supporting efficacious diversity training for mental health professionals. Although overall diversity training is prevalent in many organizations, it is often not objectively measured to ensure effectiveness based on research to ensure important diversity training outcomes. Additionally, diversity training for mental healthcare professionals must be relevant to the minority population they work with the most. When this is accomplished, the participants can improve not only their attitude, self-reported culturally competent behavior, and knowledge regarding this population, but also their confidence in working with this population. The findings of this study also carry important implications to research. For diversity training to remain both efficacious and relevant, quality diversity training must be objectively measured. This study is a call to not only develop relevant diversity training for professionals, but also to objectively measure the outcomes of that training to ensure its efficacy in communicating important cultural messages.

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Appendix A

Informed Consent for Research Participation

I, _____ voluntarily agree to participate in this study regarding training in cultural diversity for mental health professionals. I acknowledge that I am free to withdraw at any time without reprimand. I recognize the potential benefits of this study about mental health professionals and training in cultural diversity. I understand that there will be minimal risk to participating in this study. In the case of any emotionally upsetting situations, the researcher will ensure the issue is resolved appropriately, and refer if necessary. I understand that confidentiality is important to these researchers and that the measure does not contain identifiable information.

Printed Name

Signature

Date

Appendix B

Pre Training Measure

Please circle or write in the most applicable answer: Number of years working in the mental health field:

Age: _____ Gender: Male___ Female___ Training Site: GFU Health Consultation Team

GFU Behavioral Health Clinic

Willamette Family Medical Center

Race: White Hispanic American Asian American Occupation: Physician Mental Health Consultant Social
 African American Native American Worker

Other _____ Psychologist Other _____

Objectives	Strongly Disagree	Disagree	Somewhat	Agree	Strongly Agree
1. I feel comfortable offering culturally competent care to an individual who values their family well-being over their individual well-being:	1	2	3	4	5
2. I am aware of the positive effects that the collectivistic culture mindset can have in treatment:	1	2	3	4	5
3. I am aware of some of the differences between the collectivistic and individualistic cultures and how they can affect treatment:	1	2	3	4	5
4. My current stage of racial identity development has an effect on treatment:	1	2	3	4	5
5. My patient's stage of racial identity development has an effect on treatment:	1	2	3	4	5
6. I feel prepared to treat a patient who is in the beginning stages of acculturation:	1	2	3	4	5

7. I am aware of the different stages of assimilation and acculturation and how they affect treatment:	1	2	3	4	5
8. I am comfortable respectfully addressing potential culturally related resistance in treatment:	1	2	3	4	5
9. I feel prepared to provide culturally sensitive psycho education to my patient:	1	2	3	4	5

Objectives	Strongly Disagree	Disagree	Somewhat	Agree	Strongly Agree
10. I feel prepared to provide culturally sensitive referrals to mental health providers as needed:	1	2	3	4	5
11. I am aware of some forms of alternative medicine that my patient may feel more comfortable using:	1	2	3	4	5
12. I am aware of how the interaction between the patient and myself can shift when an interpreter is involved in treatment:	1	2	3	4	5
13. I feel comfortable addressing healthcare/mental health barriers and environmental barriers (e.g. legal status) with my patient:	1	2	3	4	5
14. I know some common barriers to healthcare/mental health for this population and how they can affect the patient:	1	2	3	4	5
15. I am aware of how my culture affects my ability to provide culturally sensitive treatment:	1	2	3	4	5
16. I am familiar with the models of cultural competence salient in treatment:	1	2	3	4	5

<p>17. I feel prepared to implement models of cultural competence in treatment:</p>	1	2	3	4	5
<p>18. Overall, I am aware of both how my cultural background and the patient's cultural background affect treatment:</p>	1	2	3	4	5

Appendix C

Post Training Measure

Objectives	Strongly Disagree	Disagree	Somewhat	Agree	Strongly Agree
1. I feel comfortable offering culturally competent care to an individual who values their family well-being over their individual well-being:	1	2	3	4	5
2. I am aware of the positive effects that the collectivistic culture mindset can have in treatment:	1	2	3	4	5
3. I am aware of some of the differences between the collectivistic and individualistic cultures and how they can affect treatment:	1	2	3	4	5
4. My current stage of racial identity development has an effect on treatment:	1	2	3	4	5
5. My patient’s stage of racial identity development has an effect on treatment:	1	2	3	4	5
6. I feel prepared to treat a patient who is in the beginning stages of acculturation:	1	2	3	4	5
7. I am aware of the different stages of assimilation and acculturation and how they affect treatment:	1	2	3	4	5
8. I am comfortable respectfully addressing potential culturally related resistance in treatment:	1	2	3	4	5
9. I feel prepared to provide culturally sensitive psycho education to my patient:	1	2	3	4	5
10. I feel prepared to provide culturally sensitive referrals to mental health providers as needed:	1	2	3	4	5

11. I am aware of some forms of alternative medicine that my patient may feel more comfortable using:	1	2	3	4	5
12. I am aware of how the interaction between the patient and myself can shift when an interpreter is involved in treatment:	1	2	3	4	5

Objectives	Strongly Disagree	Disagree	Somewhat	Agree	Strongly Agree						
13. I feel comfortable addressing healthcare/mental health barriers and environmental barriers (e.g. legal status) with my patient:	1	2	3	4	5						
14. I know some common barriers to healthcare/mental health for this population and how they can affect the patient:	1	2	3	4	5						
15. I am aware of how my culture affects my ability to provide culturally sensitive treatment:	1	2	3	4	5						
16. I am familiar with the models of cultural competence salient in treatment:	1	2	3	4	5						
17. I feel prepared to implement models of cultural competence in treatment:	1	2	3	4	5						
18. Overall, I am aware of both how my cultural background and the patient's cultural background affect treatment:	1	2	3	4	5						
19. Overall, I have gained knowledge and strategies to better understand and treat my patients:	1	2	3	4	5						
20. Overall, this training has helped me to become more culturally competent in my work with Hispanic patients:											
Disagree	1	2	3	4	5	6	7	8	9	10	Agree

Appendix D

Curriculum Vita

Andrea E. Theye

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Education

Present: Doctoral Student in Clinical Psychology, George Fox University, Graduate Department of Clinical Psychology (APA Accredited), Newberg, Oregon Expected Spring 2016

Dissertation Title: The Effects of Training on Competence, Attitudes, and Knowledge of Mental Health Professionals serving Hispanic Patients in Rural Oregon Final Defense May 2015

Master of Arts, Clinical Psychology: George Fox University, Graduate Department of Clinical Psychology (APA Accredited), Newberg, Oregon Spring 2013

Bachelors of Science, Elementary Education with Honors, New Mexico State University Summer 2006

Honors and Awards

Armed Forces Health Professions Scholarship Recipient 2013-current
Member of OPA Multicultural Committee, 2014-current
Multicultural Scholarship recipient 2011-2014
Crimson Scholar 2003-2006
New Mexico State University Full Tuition Scholarship
New Mexico Lottery Full Tuition Scholarship
Member of National Deans list
Member of National Honorary Collegiate Society
Member of Phi Theta Kappa Honorary Society

Supervised Clinical Experience

Practicum Pre-Intern

Ongoing Intervention and Assessment Hours

Doctoral Psychology Trainee
Willamette Valley Medical Center
McMinnville, Oregon

Populations: Senior inpatient, adult outpatient bariatric

Dates: August 2014-Present

Clinical Duties:

- Receive training in acute and longstanding psychiatric illness, inpatient care, senior behavioral psychiatric health, and bariatric care.
- Provide weekly Geropsychology psychotherapy groups.
- Researched and created evidence-based neuropsychology assessment battery with assessments appropriate for inpatient geriatric patients
- Neuropsychology assessments completed for geriatric patients to screen for dementia, serious mental health conditions, and other psychological factors that may affect their care.
- Implement monthly therapy groups for bariatric patients, preparing them for bariatric surgery as well as post- surgery follow-up.
- Utilize a manualized treatment protocol for monthly bariatric process groups.
- Complete individual psychotherapy for inpatient geriatric patients.
- Accomplished necessary research and created an empirically supported pre-surgical bariatric psychological evaluation
- Administer pre-surgical assessments and complete pre-surgical evaluations for potential bariatric surgery patients.
- Execute milieu therapy, working with multiple professionals including social workers, medical doctors, nurses, and program staff for the maximum benefit to each patient.
- Develop new treatment programs based on evidence based research in geropsychology and bariatric psychology. A unique and enriching experience as the pioneer student in this position.
- Review electronic medical charts, including medical and psychiatric history, to create a biopsychosocial framework for viewing each patient.
- Supervisors: Luann Foster, PsyD and Mary Peterson, PhD, ABPP/CL. Ongoing Intervention

Supplemental Practicum Doctoral Psychology Trainee Behavioral Health Center George Fox University Newberg, Oregon Population: Outpatient low income adults, racial and ethnically diverse, service referrals. Dates: August 2014-Present <i>Clinical Duties:</i>	Hours
<ul style="list-style-type: none"> • Conduct intake interviews. • Provide adult individual short term therapy using evidence-based practices and approaches. • Supervisors: Luann Foster, PsyD and Mary Peterson, PhD, ABPP/CL. 	
Practicum II Doctoral Psychology Trainee/ Psychometrician Northwest Family Psychology Vancouver, Washington Populations: Low income adults, Department of Human Services referrals, domestic violence survivors. Dates: August 2013-May 2014 <i>Clinical Duties:</i>	157 Assessment Hours
<ul style="list-style-type: none"> • Training in clinical, consulting, and forensic psychology. • Conducted intake interviews as well as comprehensive child, adolescent, and adult evaluations completed include ADHD/learning disability/autism evaluations, psychological evaluations, neuropsychological evaluations, and risk assessment evaluations. • Provided individual counseling for emotional and behavioral challenges. • Completed bi-lateral custody evaluations in dependency matters. • Performed various administrative responsibilities include writing assessment evaluations, treatment summaries, case notes. • Presented three clinical cases to supervisory clinical team. • Supervisor: Landon Poppleton, PhD and Jeff Lee, PhD once weekly individual supervision and once weekly group supervision. 	40 Intervention Hours

- Consultant: Winston Seegobin, PsyD.

Practicum I

Student Therapist

Archer Glen Elementary School

Sherwood, Oregon

254.5 Intervention Hours

Populations: Public schooled suburban elementary aged children.

Dates: August 2012-May 2013

Clinical Duties:

- Utilized behavioral therapy and behavioral training to target specific behavior change in and out of the school setting.
- Received weekly training in and utilization of play therapy.
- Served elementary students experiencing a wide range of clinical pathology, relational problems, and developmental problems.
- Provided individual psychotherapy, group psychotherapy, psycho-educational groups.
- Engaged in clinical interviewing, treatment planning, and report writing.
- Presented three clinical cases to supervisory clinical team.
- Supervisor: Hannah Stere, PsyD, twice weekly individual supervision.
- Consultant: Joel Gregor, PsyD and Heather Merrell, PsyD, weekly consultation and didactic supervision.

Prepracticum

Student Therapist Trainee

George Fox University

Populations: University Students

20 Intervention Hours

Dates: January 2012-May 2012

Clinical Duties:

- Provided outpatient services to undergraduate students including clinical interview, diagnosis, and individual psychotherapy.
- Conducted intake interviews.
- Performed various administrative responsibilities including report writing, weekly chart notes, case presentations, and consultation.

- Formulated diagnostic impressions, treatment plans, and case formulations.
- Presented two cases to a supervisory clinical team.
- Supervisor: Mary Peterson, PhD, ABPP/CL. weekly individual and group supervision.
- Consultant: Nancy Thurston, PsyD, ABPP and Mike Vogel, PsyD, weekly consultation.

National Presentations

Theye, A., Green, C., Holt, J., & Payne, T. (March 2014). *Child and Family Risk and Protective Factor Screener for Head Start of Yamhill County*. Poster presented at Oregon Psychological Association annual conference, Portland, OR. March 2014

Backstrand, S., Holt, J., Theye, A., Nelson, A. Seegobin, W., & Perez, J. (July 2013). *Ethnic/Racial Diversity in Graduate Programs at a Christian University*. Poster presented at the annual conference of the American Psychological Association, Honolulu, HI. August 2013

Seegobin, W., Holt, J., Theye, A., Backstrand, S., & Gleave, D. (April 2013). *Teaching integration as service: A model for psychologists*. Presentation completed at the Christian Association for Psychological Studies conference, Portland, OR. April 2013

Research Experience

Dissertation Title: The Effects of Training on Attitudes, Competence, and Knowledge of Mental Health Professionals toward Hispanic Minorities in Rural Oregon. Preliminary Defense: February 2014
Dissertation Chair: Winston Seegobin, PsyD
Committee Members: Mary Peterson, PhD, ABPP/CL, Carlos Taloyo, PhD

Abstract: Oregon is currently experiencing a rapid change in its ethnic and racial diversity. To address the rapid growth of the Hispanic population in rural Oregon specifically, a diversity training was conducted. It was designed for mental health professionals to address health disparities and barriers to care for this unique population. A pre and post-training measure was developed and administered, measuring the participant's attitudes, cultural Final Defense: May 2015

competence, and knowledge changes as a result of the training.

Research Team Member, George Fox University, Winston Seegobin, PhD, Chair 2011- Present

- Meet twice per month to discuss and evaluate progress, methodology, and design of group and individual research projects.
- Assist team members in research design, data collection, and analysis.
- Areas of team focus: International psychology, positive psychology, spirituality, trauma, human trafficking.

Research Assistant, George Fox University, Kathleen Gathercoal, PhD. June 2013

- Worked on a team to gather data, conducting and recording structured interviews with children for future analyzing.

Research Assistant, Los Alamos National Laboratory Assisted staff and customers at the Research Library June 2001-June 2003

- Assisted customers with the online catalog, with locating and retrieving library materials, assisted callers with their reference questions.
- Performed circulation desk functions, including: check in, check-out, and renewal services.

Relevant Teaching and Academic Appointments

Cognitive Behavioral Therapy Coach/Graduate Assistant- Doctoral Level Course: *Cognitive Behavioral Therapy*. George Fox University, Newberg, Oregon. Fall 2014

Professor: Mark McMinn, PhD, ABPP

Responsibilities:

- Role playing to demonstrate proper Cognitive Behavioral intervention techniques.
- Aiding students in learning and execution of various Cognitive Behavioral strategies.
- Occasional classroom teaching appointments, as needed.

Grading Assistant- Graduate Level Course: *Interpersonal
Neurobiology and Pharmacology*- Newberg, Oregon. March 2013
Professor: Amber Nelson, M.A.

Professional Development

Oregon Psychological Association Poster Review Committee, Student Subcommittee, Portland, Oregon March 2014

- Reviewed incoming poster abstracts for admittance into the poster session at the annual Oregon Psychological Association Conference in Portland, Oregon.

Convention Volunteer, American Psychological Association, Annual Convention, Honolulu, HI. August 2013

- Ensured all attendees completed registration in order to correctly assign CE credits upon completion of workshops.
- Monitored CE workshop and aided presenter as needed

Peer Mentor, George Fox University, Newberg, Oregon June 2012-June 2013

- Assisted first year PsyD student in transition to graduate school by providing academic and professional guidance and support.

Convention Volunteer, Christian Association for Psychological Studies, International Convention, Portland, OR April 2013

- Assisted multiple workshops and ran tables to ensure the attendees were properly registered and received the appropriate CE credits for their attendance.

Student Mentor, First Baptist Church, Los Alamos, New Mexico January 2010-August 2011

- Met with students weekly to support them through an ongoing mentor relationship on one-on-one and group settings.

- Helped students set appropriate goals and work towards accomplishing them.
- Built the relationship by planning and participating in activities together.

Volunteer Student Mentor, Baptist Student Union, Las Cruces, New Mexico

July 2005-June 2006

- Served in a leadership capacity, leading Bible studies and other events for the organization.
- Provided support, spiritual guidance, and friendship to students in a safe environment.
- Encouraged personal responsibility by helping them set attainable goals and then helping them work towards accomplishing.

Selected Professional Trainings

Clinical Team: Consultation group that meets weekly to present and discuss cases from various clinical perspectives.

January 2011- Present

Military Oriented:

Homelessness in the Military Population: Dr. Malinda Trujillo, Portland Veterans Administration.

April 2014

Evidence-Based Treatments for PTSD in Veteran Populations, Clinical and Integrative Perspectives: Dr. David Biel-Adaskin, Tucson Veterans Administration.

February 2014

American Psychological Association, Annual Convention, Honolulu, HI. With the presidential programming including three military oriented tracts, it included over five days of programming and sessions taught by many of the leading professionals in the field today.

August 2013

Assessment Oriented:

Using Tests of Effort in a Psychological Assessment. Paul Green, PhD.

May 2013

Assessing Mild Cognitive Impairment and Dementia, Mark Hondi, PhD, ABPP/CN, University of California.

Assessment and Treatment of Anger, Aggression, & Bullying in

June 2012

Children and Adults. Ray Diuseppe, PhD
 The Mini-Mental State Examination- 2nd Edition, Joel Gregor,
 PsyD, George Fox University. June 2012

Diversity Oriented:

Toward a New View of Intergenerational Trauma, Eduardo Duran, March 2013
 Ph.D. Psychological and educational implications of trauma. A
 workshop designed to examine the symptoms and effects of
 historical trauma and teach how the assessment and diagnoses
 process of psychological needs are understood from a indigenous
 perspective.

Sexual Identity: Erika Tan, PsyD, George Fox University. November 2012

Treating Gender Variant Clients: Christian Integration, Erika Tan,
 PsyD, George Fox University.

Mindfulness and Christian Integration, George Fox University
 Erica Tan, PsyD. March 2012

Related Training and Experience

Team Leader, Target Corporation January 2010-July 2011

- Regularly recognized, coached, and provided meaningful feedback to team members.
- Lead new process improvement initiatives and coached team through change.
- Regularly participated in the hiring and termination process.
- Full time position.

Lead Preschool Teacher, Little Forest Playschool May 2010-January 2011

- Provided a stable and safe classroom environment for multiple classes of 3-5 yr. olds, with 8-20 students per class.
- Regularly communicated information to students, colleagues, and parents regarding student progress and student needs.

Substitute Taught pre K-8th grade, Los Alamos Public September 2006-January

- School System 2011
- Worked in preschool classrooms providing specialized care to developmentally delayed students.
 - Prepared and delivered instructional activities that facilitate active and meaningful learning experiences.
- Training Specialist/Coordinator, Los Alamos National Laboratory January 2009-January 2010
- Designed, developed, and implemented training for Los Alamos National Laboratory workers.
 - Applied the Systematic Approach to Training (SAT) and Analysis, Design, Development, Implementation, Evaluation (ADDIE) in curriculum development according to Department of Energy standards.
 - Held a top Department of Energy Level security clearance, Q with HRP.
 - Full time position.
- Client Advocate, Hope Pregnancy Center August 2008- June 2010
- Provided individuals facing an unplanned pregnancy with compassion, accurate information, education, and resources to make informed decisions.
 - Provided crisis intervention counseling for each client in an atmosphere of warmth and compassion.
- U.S. Department of Energy Security Police Officer, Protection Forces Los Alamos March 2007- January 2009
- Held top Department of Energy Clearance (Q clearance with HRP certification) and all responsibilities therein.
 - Held federal arrest authority and was directly involved in protecting the site in accordance with U.S. Department of Energy security regulations and requirements without any security breaches or violations of policy.
 - Three months of intense tactical training as well as in depth site specific training on the appropriate tactical response to security breaches and other emergencies.
 - Full time position.

Affiliation/Memberships

Member of The Society of Federal Health Professionals, Military
 Medicine Division
 Student member of the American Psychological Association
 (APA)
 Member of Military Psychology Interest Group, George Fox
 University
 Member of the George Fox University Multicultural Committee
 Member of the Oregon Psychological Association’s Multicultural
 Committee
 Member of the Oregon Psychological Association
 Member of the American Psychological Association of Graduate
 Students (APAGS)
 Member of the Military Psychology Division
 Member of General Psychology Division
 Member of Division of the Psychology of Women

References

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Assessments Performed Under Supervision

16 Personality Factor Questionnaire
 Adaptive Behavior Assessment System
 Weschler Adult Intelligence Scale-IV
 Millon Clinical Multiaxial Inventory

Personality Assessment Inventory
 Minnesota Multiphasic Inventory-2
 Weschler Intelligence Scale for Children-IV
 Grooved Pegboard Test

Controlled Oral Words Association	Weschler Individual Achievement Test- III
Wide Range Assessment of Memory and Learning-2	Wide Range Achievement Test-4
Peabody Picture Vocabulary Test-4	Halstead-Reitan Neuropsychological Battery
Repeatable Battery for the Neuropsychological Status	Kaufman Assessment Battery for Children, Second Edition
Wechsler Abbreviated Scale of Intelligence	Arlin Test of Formal Reasoning
Trails A & B	Shipley-2
General Ability Measure for Adults	Weschler Memory Scale-IV
Tactual Performance Test	Booklet Category Test
Delis-Kaplan Executive Function System	Wisconsin Card Sorting Test
Boston Naming Test	Reitan-Indiana Aphasia Screening
Rey-Osterrieth Complex Figure	Benton Line Orientation
California Verbal Learning Test-2	Test of Memory Malingering
NEPSY- II	Weschler Memory Scale- III
Hopkins Verbal Learning Test- Revisited	Brief Visuospatial Memory Test- Revisited
Screeners and Checklists	
Adaptive Behavior Assessment System	Child Behavior Checklist
Saint Louis University Mental Status Examination	The Mini Mental State Examination
Suicide Prevention Scale	Lawton instrumental activities of daily living scale
Conner's parents scale	PHQ-9