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Los Angeles Community-Based Associate Social Workers' Understanding of Culture and Therapy

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Abstract

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Dissertation Submitted in Partial Fulfillment

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Abstract

Social workers have no clear professional guidelines about the application of culturally competent mental health service delivery. Without culturally competent mental health service delivery, clients from diverse cultures do not access needed mental health services and they experience less effective therapy treatment outcomes and overall disparity of service delivery throughout the therapeutic process. The purpose of this descriptive case study was to better understand how community-based social workers are delivering culturally competent services to clients. The theoretical framework for the study was multiculturalism and the primary research questions addressed how associate clinical social workers who provide in-home mental health services in Los Angeles deliver culturally competent services to their clients. Through 8 interviews with associate clinical social workers, this descriptive case study revealed that without clear direction on what culturally competent services are, or how to deliver them, social workers are using a combination of personal experience and personal culture, educational and practice knowledge, and in some cases no attention to culture, to meet the mental health needs of their clients. This study emphasized the need for an industry wide understanding of the term cultural competency, so it could serve as the frame of reference by which practice professional skill level could be assessed, practice protocols measured, and could lead to social change through greater access to counseling services for clients.

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MA, California State University 2004

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Dedication

Completion of a journey of this magnitude would not have been possible without a tribe. First, I thank all of the amazing clients of Conscious Living Counseling Center who have supported my efforts, asked about my studies, partnered with me in setting goals and working towards them, and encouraging me when times were tough. Your support has meant so much to me in this process and I look forward to continuing to celebrate your successes as you meet your goals. Second, I thank my mother who helped me work though Chapter 5 when I just could not find my words. I also thank my soulmate and best friend Janet for your unwavering support, especially at times when I needed your keen computer skills. Thank you for sitting next to me in 8th grade and for being by my side ever since. Finally, to my Dad- You always make me feel like I can accomplish anything. We did it!

Table of Contents

List of Tables

Chapter 1: Introduction to the Study

Introduction

The U.S. Census Bureau (2017) reported the population for Los Angeles County in 2016 was 10,137,915. Of that number, 34.7% reported being foreign born (U.S. Census Bureau, 2017) and 77% reported entering the county after 1980 (University of Southern California, 2015). In addition, 56.8% of individuals reported speaking more than one language in the home (U.S. Census Bureau, 2017), showing ethnic and cultural diversity. In addition to being ethnically and culturally diverse, Los Angeles County is racially diverse. According to the U.S. Census Bureau (2017), in 2016 Los Angeles County had 9.1% of individuals identified as African American, 1.5% of individuals who identified as American Indian or Native Alaskan, 15.1% of individuals identified as Asian, 48.5% identified as Hispanic or Latino, and 26.5% of individuals identified as Caucasian. For the rest of this study, I will use the word *culture* to represent ethnicity, culture, and race, although I recognize that they are separate constructs and that culture is also composed of other types of groups. My use of this definition comes from Merriam, Caffarella, and Baumgartner's (2007) definition of *culture* as "the shared behavior and symbolic meaning systems of a group of people" (p. 223).

Because of the diversity in Los Angeles, mental health practitioners experience unique challenges in delivering mental health care. One challenge mental health practitioners face is delivering culturally competent services to their diverse clientele

without instruction on how to do so. *Culturally competent services* are "a set of congruent behaviors, attitudes and policies that come together in a system or agency or among professionals that enable effective interactions in a cross-cultural framework" (Cross, Bazron, Dennis, & Isaacs, 1989, p. 13).

In this chapter, I overview current research on culturally competent mental health care and I explain the current gap in literature related to understanding how mental health professionals are delivering culturally attuned care to their clients. I also outline the problems experienced by clients seeking mental health care without the offer of culturally competent services. I conclude the chapter by describing the designed study and the theoretical framework that guided the research.

Problem Statement

The culturally diverse composition of Los Angeles County has posed, and continues to, pose challenges to mental health professionals working in Los Angeles County including differences in spoken language (Foster, Morris, & Sirojudin, 2013), differences in cultural values (Ward & Besson, 2013), cultural variations regarding views about mental health struggles (Hurley & Gerstein, 2012), distrust of mental health providers (Ward & Besson, 2013), and the stigma associated with receiving mental health services (Dadfar & Friedlander, 1982; Heggins & Jackson, 2003; Ibrahim & Ingram, 2007). To compound the issue, mental health professionals have the task of providing "culturally adapted services," or culturally competent services, which account for cultural

context and a client's value system (Griner & Smith, 2006, p. 3) without receiving adequate training (Chao, Okazaki, & Hong, 2011; Lee, Rosen, & McWhirter, 2013). The inability of mental health professionals to provide attuned mental health treatment to clients of varying cultures can lead to negative outcomes such as a lack of use of mental health services by people of varying cultures (Hurley & Gerstein, 2012), less effective therapy treatment outcomes (Lee, 2011), and an overall experience of disparity for service delivery throughout the therapeutic process from intake to discharge (Oaks, 2011). More individuals from diverse cultures are seeking mental health treatment. The California Endowment (2013) recommended that mental health professionals respond in culturally attuned ways to meet their client's needs, and according to Wang, Heppner, Wang, and Zhu (2015) the call to do so is urgent. The problem is that a professional mandate exists to deliver culturally competent mental health services, without a clear direction on how to comply (National Association of Social Work Code of Ethics, 2016) and mental health professionals may not be delivering culturally proper services, negatively affecting client care. By conducting this study I gained an understanding how mental health professionals are delivering culturally attuned services to their clients currently.

Purpose of the Study

My purpose in this qualitative, descriptive case study was to understand the ways in which community-based associate clinical social workers deliver culturally competent

mental health services to clients in the engagement phase of client treatment. My research found practices that mental health practitioners are currently using that call for further inquiry and named barriers to addressing culture in the mental health professional's work with clients. The results of my study contribute to the advancement of *best practices* in the field of therapy on culture. The increase of quality service delivery to culturally diverse clients could also lead to a larger number of clients having access to needed counseling services (National Alliance for Mental Illness [NAMI], 2012).

Research Question

To better understand how community-based mental health professionals deliver culturally competent services to clients during the engagement phase of treatment, the following research question framed the research:

> RQ1: How do associate clinical social workers who provide in-home mental health services in Los Angeles deliver culturally competent services to their clients?

Theoretical Framework for the Study

Multiculturalism refers to the way in which people use context, rooted in culture, to interpret their reality, and as such counseling treatment must also address the cultural origin of people's reported treatment issues (Comas-Diaz, 2012). Multicultural theory as it relates to counseling also suggests that all treatment interventions need tailoring to meet the needs of the individual while drawing upon the person's strengths (Hays, 2009).

Multiculturalism promotes the advancement of all individuals (NCSALL, 2007); however, many challenges exist with regard to true multiculturalism. Challenges included institutionalized racism and historical oppression of marginalized groups (Banks, 1997), separatism via racism (Howard, 1999), and white privilege (McIntosh, 1989).

I used the theory of multiculturalism to find themes of the study. Specifically, I tried to identify ways in which culture of the counselor has influenced service delivery, beliefs held by the counselor about the client's culture affect service delivery, and the ways in which the counselor believes the client's culture has influenced the client's response to service delivery. I will discuss the concept of multiculturalism further in chapter 2.

Nature of the Study

For the study, I pursued a qualitative method of inquiry and a descriptive case study design to understand how associate clinical social workers deliver culturally competent services in Los Angeles County. The choice to use a case study design was based on the following factors. First, I used a case study design to gain an understanding of the phenomenon related to its context (Baxter & Jack, 2008). For this study, I aimed to understand how associate clinical social workers in Los Angeles County who provide community-based mental health care deliver culturally competent services to their clients. I also used a case study as outlined by Stake (1995) and Yin (2003) to understand the creation of the meaning of culturally competent care through the participant's subjective

experiences. A case study design allowed for a close working relationship between the study participants and me, which allowed for a richer narrative from the participants when describing the study data (Baxter & Jack, 2008).

In my research, a case study was useful as a research design to make sense of how mental health professionals apply the concept of cultural competence to their work, which led to shared meanings of the concept of cultural competence as it relates to counseling. I chose to use a descriptive case study design for its ability to describe the phenomenon of culturally competent care within the real-life context in which it occurred, homes in Los Angeles (Yin, 2003). A case study design was necessary for this study due to the lack of clarity of boundaries between the phenomenon and the context (Baxter & Jack, 2008). In other words, the context of in-home settings was critical to study culturally competent service delivery in Los Angeles County.

Participants and Inquiry

In this study, I included interviews with eight participants of varying age, cultures, and race. I planned to increase the sample size if there was no saturation after the eight interviews, but this was not necessary. The participants consisted of license-waivered therapists trained in social work in the State of California. License waived therapists hold a master's degree in social work and for this study referred to as associate clinical social workers (Board of Behavioral Sciences, 2012). Homogeneity was the basis for choice of this pool of participants. Using a homogeneous population for the study

contributed to naming themes of behavior among the subgroup associate clinical social workers who provide in home mental health services, as related to culturally competent therapy delivery behaviors. Creswell and Plano-Clark (2011) recommend using this sampling strategy if a researcher is trying to find a group of individuals who are knowledgeable about a specific area of interest (Palinkas et al., 2015).

Site and Researcher Role

I drew upon this sample from a mental health agency in Los Angeles County that employs community-based associate clinical social workers practicing in-home therapy. I was formerly a corporate trainer for the agency and as such I did not have working relationships with the research participants at other company locations outside of the corporate office. My work relationship with this agency has since ended and they agreed to allow me to conduct interviews with their staff, none of whom I knew in a personal or professional capacity during my employment with them.

Sampling

I used a purposive sampling structure for this inquiry (Tongco, 2007). The specific type of sampling that I used will be typical case sampling (Tongco, 2007). The use of this strategy allowed for the collection of a diverse sample of associate clinical social workers who practice in-home therapy with diverse clients, and who are of varying ages, races, and cultures thus enriching the data. To address issues such as *sampling bias* and *sample distortion*, I requested participation from people unknown to me, who were

all referred by supervisors for their use of cultural practices, and who are all employed by various agency sites during the morning and afternoon shifts. The varying sample group led to greater transferability for those who also provide in-home therapy in Los Angeles County.

Analysis

Data collection processes allowed for the accurate collection of ample and accurate data. This included tape recording interviews for transcription later to ensure there was no loss of valuable data during the research process (Yin, 2011). Field notes taken during and after each interview also included observations and insights gained during the interview process (Patton, 2002). Coding of the gathered data uncovered themes. Codes are the assigned labels to address the descriptive or inferred meaning of the data (Miles, Huberman, & Saldana, 2014). The process used for coding was in vivo coding (Given, 2008). This means that I coded data using short phrases or key words used directly by the interview participants (Miles et al., 2014). I then interpreted the codes for meaning and generated preliminary findings written in a descriptive manner which allowed readers to draw similar conclusions to mine when reviewing the data. Prior to dissemination of the findings, I assessed the data for validity.

One type of validity that was used in this inquiry is face validity. Face validity indicates that readers who review the study will draw similar conclusions to mine based on the data (Yin, 2013). In addition to face validity I also attended to credibility,

authenticity, criticality, and integrity. To determine credibility, I used member checking to ensure that the interpretation of the data was accurate and I also disclosed my professional background and qualifications to conduct this research to study participants (Shenton, 2004). To establish authenticity, I ensured that there was variation of interviews among people from differing ages, educational institutions, races, and ethnicities. When addressing criticality, I allowed for and described the process used to reveal themes in the data rather than attempting to locate data which supported previously published data or hypotheses (Patton, 2002). Finally, to maintain integrity, I ensured that I disclosed all potential bias to the reader in the presentation of the study and explained strategies I used to manage bias.

Definitions of Terms

Cultural competence: "A set of congruent behaviors, attitudes and policies that come together in a system or agency or among professionals that enable effective interactions in a cross-cultural framework" (Cross et al., 1989, p. 13).

Disparity: A difference in health care quality not due to differences in health care needs or preferences of the patient" (Smedley, Stith, & Nelson, 2003).

Evidence-based practices regarding mental health: Practices (a) that are conceptually sound, (b) that are internally consistent, (c) that demonstrate superiority to other practices and include a strong evaluation component, (d) whose results can be replicated, (e) that include a treatment manual, (f) have standardized training protocols,

and (g) have sustained long-term outcomes that can be demonstrated (Lonigan, Elbert, & Johnson, 1998, p. 141).

Multiculturalism: The concept that group differences should be respected and valued (Purdie-Vaughns & Walton, 2011).

Unserved and underserved persons: Those individuals who either have documented low levels of access and use of mental health services, face barriers to participation in the policy making process in public mental health, have low rates of insurance coverage for mental health care, and/or identified as priorities for mental health services (California Department of Health Services, 2016).

Assumptions

I assumed that the clients of study participants are from varying cultures as shown by the agency's location in Los Angeles and the low socioeconomic status of the population served by the agency. To confirm this assumption, I asked study participants to confirm that their clients are from various cultures. I also assumed that because most master's level educational programs teach some form of cultural competence coursework, all study participants were able to respond to questions related to culturally competent care. To confirm this assumption, I asked study participants about their coursework in their master's programs related to cultural competence. Another assumption I made was that study participants would answer openly and honestly. To promote this, I ensured that participants had a thorough understanding of their consent to take part including the

protection of data, confidentiality procedures, and their ability to member check their interview data.

Scope and Delimitations

Delimitations to this study include population of study, location of study, type of social work practiced, and efficacy. The study population that I explored consisted only of the phenomenon from the perspective of associate clinical social workers. The reason for choosing this group was due to the specific focus on cultural competence in the social work profession. I also explored only culturally competent services delivered in community-based settings as opposed to traditional office settings. Another delimitation is that this study specifically explored culturally competent service delivery within the public mental health setting versus privatized mental health centers. Also, although it was the aim of this study to understand how community-based associate social workers are delivering culturally competent services, the results of this study did not reveal efficacy of the practices named.

Limitations

Limitations exist when using qualitative inquiry and they affect the generalizability of research findings (University of Southern California, 2013). For example, qualitative data inquiry relies on skills of the researcher, including the researcher's ability to manage biases which could influence data interpretation (Anderson, 2010). Furthermore, the presence of the researcher during the data collection

process may influence the results of the inquiry (Anderson, 2010). Limitations in this study included measurement tools to gather the data, influence of researcher presence on study participants, and time.

One limitation of the study was measurement. I collected data through the completion of interviews only. This means that data gathering, and analysis relied on only one method of inquiry. If participants are completing a questionnaire, for example, they may have had time to consider their responses differently than they did during the face-to-face interview. To address this concern, participants had time to formulate answers to any questions asked. The consideration of method led to a second limitation of the study, presence of the me, the researcher. The presence of a researcher asking questions has the potential to influence the answers of the participants. To address this concern, I ensured that participants understood the purpose of the research, their ability to withdraw their consent to take part at any time, and the aim of the study. Furthermore, when necessary, I used self-disclosure as a means of addressing the validity of data gathering (Yin, 2011).

Another limitation to this research was time to complete the research adequately. Qualitative inquiry is time consuming (Anderson, 2010). As such, I took measures to ensure that there was no rush to complete the study, or data left incomplete. Measures that I used to address time constraints included ensuring that there was an ample allotment of time for interviews so that participants did not feel rushed by the process and

carving out time on a weekly basis for data analysis so that processes received the time and attention necessary.

Further limitations to the study included population and setting. Because this study only explored the phenomenon of cultural competence for associate clinical social workers, and not psychologists or marriage and family therapists, it is not generalizable to all mental health practitioners. Also, because my focus in this study was on community-based settings, which provide therapists with the opportunity to glean a different clinical picture than in an office setting, it cannot generalize to all mental health settings.

Significance

By conducting research, I found practices that mental health practitioners are currently using about cultural competence that warrant further inquiry and identified barriers to addressing culture in the mental health professional's work with clients. The results of this study contribute to the advancement of best practices in the field of therapy about culture. The increase of quality service delivery to culturally diverse clients could also lead to a larger number of clients having access to needed counseling services (NAMI, 2012).

Summary

More individuals from diverse cultures are seeking mental health treatment and this means that mental health professionals must respond in culturally appropriate ways

to meet their client's needs. Without culturally competent delivery of mental health services, individuals from distinct cultures may not access necessary services, may experience less effective therapy treatment outcomes, or may experience an overall disparity of service delivery throughout the therapeutic process from intake to discharge. Using a qualitative analysis, guided by the theory of multiculturalism, I learned how community-based associate clinical social workers in Los Angeles County are adapting their practices to deliver culturally competent services to diverse clients.

Chapter 2: Literature Review

Introduction

The culturally diverse composition of Los Angeles has and continues to pose challenges to mental health professionals in the city offering mental health services. Examples of challenges to be overcome during delivery of mental health services include language differences, differences in cultural values, cultural variations on views about mental health struggles (Hurley & Gerstein, 2012), and the stigma associated with receiving mental health services (Dadfar & Friedlander, 1982; Heggins & Jackson, 2003; Ibrahim & Ingram, 2007). An increase is occurring in individuals from diverse cultures seeking mental health treatment and this causes mental health professionals be able to respond in culturally appropriate ways to meet their client's needs (The California Endowment, 2013). No clear direction exists on how to deliver culturally competent services, even though a professional mandate has been made to do so (National Association of Social Work Code of Ethics, 2016). In this study, discovered how community-based mental health professionals are delivering culturally competent services to clients in Los Angeles.

The information that follows is an explanation of (a) the current challenges experienced by mental health professionals with regard to delivering culturally competent mental health services to clients, (b) current data that indicates the necessity to adapt mental health services to address the needs of diverse cultural groups, and (c) current

suggested practices attempting to address culture in mental health service delivery. Challenges faced by mental health professionals discussed in this study include an unclear but professional mandate to deliver culturally competent services, a lack of clear definitions on cultural and cultural competency, and a lack of adequate training and education on best practices for culturally competent service delivery by mental health professionals. I used the pertinent literature in this literature review to explore the effects of multiculturalism has on delivery of mental health services. Included in this review is an explanation of current practices in use to address culture about mental health treatment and includes current barriers to their efficacy or tested efficacy.

Literature Search Strategy

The literature that I used in this study came from various Walden library databases, and through keyword searches using Internet Explorer or Google Chrome. Through Walden University, I accessed articles through PsycINFO, SocINDEX, and PsychARTICLES. Some of the search terms that used in these databases, and general search engines, included *cultural competence in mental health*, *cultural competence*, *cultural competence in counseling*, *cultural attunement*, *mental health service delivery to different cultures*, *culture and counseling*, *mental health and the Asian community*, *mental health and the Caucasian community*, *mental health and the Hispanic community*, *mental health and diverse cultural groups*, *multiculturalism,* and *evidence-based practices and culture*. I also searched for the National Association of Social Work Code

of Ethics and American Psychological Association. I chose search terms that paint a picture of the multiculturalism movement in mental health from its start to its current status. Early articles on the effect of culture on the mental health needs of clients led to further search terms such as *evidence-based practices + culture* and *culture + mental health + research*.

The Professional Mandate

A demonstrable need exists for mental health professionals to be able to attend to the unique needs of culturally diverse clients and professionals have a mandate to do so by the National Association of Social Work Code of Ethics (2016). The Social Work Code of Ethics is a set of ethical principles approved by the National Association of Social Work Delegate Assembly in 1996 designed to "to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" (National Association of Social Work, 2016, p. 1).

Within the Social Work Code of Ethics are principles recommending that social workers, a type of mental health professionals, have an ethical responsibility to not only demonstrate competence in all areas of practice, but they must demonstrate cultural competence and attention to issues of social diversity. Specifically, the code explains that social workers:

Should (a) understand culture and its function in human behavior and society,

> recognizing the strengths that exist in all cultures (b) have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups and (c) should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability. (National Association of Social Work, 2016, §1.05)

What is missing, however, from the Social Work Code of Ethics are the service delivery steps social workers should take to develop and show effective therapeutic skills in cultural competence.

Because the Code of Ethics and pertinent supporting literature do not explain the way professionals deliver culturally competent clinical skills, one could surmise that mental health professionals must already know and practice these skills. It is well documented that this is not the case. The development of training programs based on cultural theories (Pope-Davis, Coleman, Lui, & Toporek, 2003; Roysircar, Arredondo, Fuertes, Ponterotto, & Toporek, 2003; Sue et al., 2003) occurs; however, the action steps of culturally competent care have yet to be operationalized and their effectiveness has not yet empirically supported (D'Andrea, 2000; Egede, 2006; Oaks, 2011). Cultural competence training models have acceptance based solely on face validity (Oakes, 2011)

and on intuitive appeal (Worthington, Soth-McNett, & Moreno, 2007). Without empirical support mental health professionals lack specific guidelines on which cultural competence skill demonstrations produce the greatest positive therapeutic outcomes for clients. Furthermore, there is no evidence that those who study and apply culturally competent services are better counselors than those who do not have these skills (Horevitz, Lawson, & Chow, 2013; Kleinman & Benson, 2006; Worthington et al., 2007).

Barriers to Effective Cultural Competency Research

The Surgeon General's Report (2001) found that mental health disparities exist among cultures and despite the time that has passed since, the disparities remain unremedied for several reasons. Complexities on the topic of cultural competence and the variables that influence service delivery appear to make research and progress in this topic area difficult. There is increasing theoretical research that shows the multidimensionality of culturally competent practice including attributes of the mental health professional, attributes of the client, societal influences, and the constructs of the agency providing care (Betancourt, 2006; Cooper, Beach, Johnson, & Inui, 2006; Oaks, 2011). There is still a lack of clarity in the terminology used in the study of culture, and an understanding of how to measure cultural competence (Mollen, Ridley, & Hill, 2003). No one is quite sure what the term culturally competent means or how to deliver culturally competent services (Ahmed, Wilson, Henricksen, & Windwalker-Jones, 2011;

Aisenberg, 2008; Harrison & Turner, 2011; Heppner, Wang, Heppner, & Wang, 2012). There is no outline of skills, knowledge, and practices needed for culturally competent care in any policy documents nor supported by empirical research (Goode, Dunne, & Bronheim, 2006), and therefore it is still an unclear concept (Harrison & Turner, 2011).

The literature uses multiple terms to denote the same concept, which adds to the complexity of understanding what it means to deliver culturally competent care. Terms used interchangeably with cultural competence include "cultural humility, cultural attunement, cultural proficiency, cultural tailoring, cultural awareness, transcultural awareness, multicultural sensitivity, multicultural competence, and cultural interventions" (Horevitz, Lawson, & Chow, 2013, p. 136). Other terms include intercultural sensitivity (Hammer, Bennett, & Wiseman, 2003), cultural intelligence (Earley & Ang, 2003), ethnocultural empathy (Wang et al., 2003), intercultural competence (Lonner & Hayes, 2004), intercultural adjustment (Matsumoto, LeRoux, Bernhard, & Gray, 2004), intercultural proficiency (Clark, Flaherty, Wright, & McMillan, 2009), and cross-national competence (Heppner et al., 2012). There are multiple terms and definitions used to describe the same concept and they continue to evolve (National Center for Cultural Competence, 2004).

According to Harrison and Turner (2011), the concept known as cultural competency, and its predecessor cultural sensitivity, was originally based on work with ethnic minority groups. Since then the concept has evolved to incorporate all groups at

risk of social exclusion including disability, sexuality, and other identity markers (Harrison & Turner, 2011). The concept of cultural competency also now recognizes that cultural identities are not one dimensional (Harrison & Turner, 2011). Given the recognition of culture as being fluid and multidimensional, some counselors believe it is inappropriate to couple the word with the concept of competency (Harrison & Turner, 2011). For this sake of this study, the definition of the term cultural competence will be "to describe a set of congruent behaviors, attitudes and policies that come together in a system or agency or among professionals that enable effective interactions in a cross-cultural framework" (Cross et al., 1989, p. 13).

The Theoretical Basis of Cultural Competence

Although there are no defined skills steps for culturally competent care nor empirical support for efficacy (Oakes, 2011), there are theoretical publications that supply explanations of what clinical behaviors a mental health professional should practice supporting culturally competent care in mental health, and these publications give basic definitions used by researchers in cultural competence. Dunn (2015) explained that culturally competent care entails developing skills for "appreciating, understanding, and interacting with people whose experiences and beliefs can differ from one's own because of diverse factors such as race, ethnicity, socioeconomic status, and disability" (p. 257). The Office of Health and Human Services (2012) used the definition of cultural competency supplied by Cross et al. (1989) and also defined cultural competency as "a

set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables that system, agency, or those professionals to work effectively in cross-cultural situations" (p. 13).

The variety of definitions for cultural competence complicates the application of the concept. For example, Harrison and Turner (2011) reported on a study by Harrison (2009) investigating how practicing mental health professionals defined and understood cultural competence in practice. Questions in the study included "What does the term cultural competence mean to you?" and "Can you give examples in your practice?" Findings showed that study participants viewed culture as being influential in constructing people's identities, forming beliefs of others, and in how people interact socially. The participants recognized the importance of delivering culturally competent care as well as showing awareness of the spirit of the term *cultural competence*, and behaviors that the term signifies. Study participants also recognized that there are ambiguities in the terminology and its meaning. Other participants in the study expressed fear that a focus on culture would perpetuate stereotyping rather than "treating people as individuals" (p. 342). Finally, participants defined cultural competence as respect for differences and the inclusion of marginalized groups or individuals.

Concerning the delivery of culturally competent services, there are also practices known as culturally and linguistically appropriate services (CLAS) defined as those that demonstrate respect and responsiveness to an individual's "current health beliefs and

practices, preferred languages, health literacy levels, and communication needs" (U.S. Department of Health and Human Services Office of Minority Health, 2016, para. 1). CLAS guidelines include addressing communication, language, leadership and workforce barriers that impede access to services for clients and ensuring that continuous improvement strategies are implemented to improve care (Barksdale, Kenyon, Graves, & Jacobs, 2014). These guidelines, although not empirically supported, supply a set of recommended action steps that social workers can take to supply culturally competent clinical services (Diamond, Wilson-Stronks, & Jacobs, 2010).

An exploration of the theoretical concepts that define culturally competent care in social work is not complete without inclusion of the guidelines created by Sue, Arrendondo, and McDavis (1992). The Sue et al. (1992) guidelines served as a foundation for the multiculturalism movement and gave a theoretical framework for many future cultural competence trainings (Arrendondo et al., 1996). Sue (2006) described cultural competence as a multidimensional phenomenon that includes "scientific mindedness, dynamic sizing (sizing to fit the need of the client), and culture-specific skills" (p. 239). Sue's research described culturally competent service delivery as the product of both the mental health professionals' awareness and insight, and the professionals' demonstration of specific skills. Examples of a mental health professionals' awareness, as explained by Sue et al. (1992), include being aware of differing cultures of the client and the professional and respecting those differences, and

showing an awareness of how a professional's own personal background and experiences may influence the therapeutic process. Sue (1992) cited examples of specific skills delivery, which include familiarizing oneself with current research and becoming involved in events with underserved or unserved persons outside of the therapeutic setting. Unfortunately, these are skills not proven empirically.

Despite the professional recognition and support received by the Sue et al. (1992) recommendations about multiculturalism theories, researchers noted that little empirical research evaluated Sue's conceptual model (Chu-Lein, 2012). Sue's contributions to the topic of cultural competence were based on studies that revealed mental health disparities between unserved and underserved persons and other persons (Patterson, 1996). However, Sue's research did not explore the validity of the proposed solutions offered to address the disparities (Patterson, 1996).

Mental health disparity

The lack of empirical support for culturally competent service delivery skills and efficacy has resulted in disparity in mental health service delivery to unserved or underserved persons. Unserved and underserved persons are those individuals who either have documented low levels of access and use of mental health services, face barriers to participation in the policy making process in public mental health, have low rates of insurance coverage for mental health care, and/or identified as priorities for mental health

services (California Department of Health Services, 2016). A disparity is a "difference in health care quality not due to differences in health care needs or preferences of the patient" (Smedley et al., 2003, p. 5). This definition showed that disparities can be rooted in lack of access to quality providers, lack of insurance coverage, or the inability of service providers to supply professional services (McGuire & Miranda, 2008).

Concerns over disparities in mental health care led to an increased emphasis on providing equitable mental health services to all populations in the early 1990s (U.S. Department of Health and Human Services Office of Minority Health, 2001), and this focus is one of the most important trends in mental healthcare over the past few decades (Betancourt, Green, Carrillo, & Park, 2005). A goal of George W. Bush's New Freedom Report on Mental Health, published in 2003, was to "eliminate disparities in mental health service delivery" (p. 5) and yet unserved and underserved populations continue to be less likely to receive mental health care when needed (Browman, 2012). Furthermore, once in treatment unserved and underserved persons are more likely to receive a poorer quality of care (Lakes, Lopez, & Garro, 2006; Snowden, 2012). Despite the movement toward more equal care, African Americans continue to have poorer mental health outcomes (Dobalian and Rivers, 2008; Williams, 2006). Hispanic and African American individuals who develop mental health symptoms tend to have more serious disorders (Breslau, 2006), and a higher number of mental health symptoms (U. S. Department of Health and Human Services, 2001). Mental health disparities continue to exist due to

inequitable distribution of services across populations despite more than ten years of attempts to reduce such disparities (Holden et al., 2014).

When exploring disparity in mental health service delivery, consideration of the factors that influence the data that informs cultural competency research and reporting is important. For example, ethnicity and language can contribute to conservative behavior in reporting mental health symptoms among unserved and underserved individuals (McGuire & Miranda, 2008). A client's culture, race, or ethnicity also affects a client's interview. The affect includes information shared with the mental health professional, what the professional asks of the client, and interpretation of the answers (McGuire & Miranda, 2008). Cultural variations in self-reported questionnaire response styles also pose challenges to researchers about the interpretation of questionnaires (Chu & Sue, 2011). Diversity within subgroups can also affect reporting rates and utilization of services. For example, the heading Asian American consists of Cambodians, Chinese, Japanese, Filipinos, Koreans, Laotians, Asian Indians, and Vietnamese (Chu & Sue, 2011). Of this grouping, there are more than fifty distinct groups and more than thirty languages spoken (Chu & Sue, 2011), and between-group differences are clear in mental health. For example, a study by Kou (1984) revealed that Filipinos have the highest rate of depression among Asian groups in the United States, followed by Koreans (Baello & Mori, 2007). Research also supported that unserved and underserved groups are not homogenous populations, but they are populations that encompass many subcultures and

ethnic identities (Holden et al., 2014). Although there is a great deal of literature supporting that disparities exist in mental health care, no consensus exists on how to measure the disparities accurately (McGuire & Miranda, 2008).

Contributing factors to mental health disparity rates: A client's perspective

Although there is debate regarding exactly how to measure disparity rates for mental health access and use, it remained undisputed that mental health disparities continue to exist between populations (Holden et al., 2014). There are four primary reasons suspected to contribute to this phenomenon as revealed in a meta-analysis by Griner and Smith (2006): "(1) cultural differences between the client and the mental health professional (2) distrust of formal mental health services and providers (3) financial barriers to accessing services and (4) the client's belief system and perceptions of their current symptoms" (pp. 4-5).

Perpetuating the distrust held by potential clients include the lack of resources for clients in their neighborhoods and the lack of mental health professionals who are a cultural match to the client (Roysircar, 2009). Providers are discouraged from delivering services in high-poverty locations due to low rates of insurance reimbursement or the limitations of individuals in these areas to pay for services out of pocket (Guerrero & Kao, 2013). Furthermore, some clients do not have insurance. In Los Angeles County, for example, an estimated 1.4 million adults are uninsured, with the largest percentage at

34% being Latinos (Cousineau, 2009). Limited access to mental health services worsens mental health problems for unserved and underserved persons who reside in these communities and forces these individuals to utilize public hospitals and mental health centers when their mental health needs require assistance (Chow, Jaffee, and Snowden, 2003). This led to an overrepresentation of people with mental illness in high-poverty neighborhoods (Chow et al., 2003). Neighborhood poverty is a compounding factor in understanding disparities in mental health service use for unserved and underserved persons. Poverty rates affect the overall well-being of residents due to high crime rates, substance use, and homeless present in these communities (Guerrero & Kao, 2013).

Asian American. Unavailability of services due to volume and location is only a problem if consumers are seeking services. When examining mental health disparity other causes come into play as well. For example, the Institute for International Education (2011) reported, there are more than 690,000 international students studying in U.S. colleges and universities. Olivas and Li (2006) explained that these international students rarely seek counseling services despite experiencing multiple stressors including "language barriers, difficulty in adjusting to the U.S. educational system, cultural differences, and homesickness" (p. 218). Furthermore, in a study examining usage rates at a university counseling center, Nilsson, Berkel, Flores, and Lucas (2004) found that only 2% of international students sought counseling, and approximately one-third of those consumers did not return to counseling after the intake appointment.

Building on the Nilsson et al. (2004) findings, Akutsu and Chu (2006) stated that the mental health utilization rates of Asian Americans specifically is not much higher when these individuals seek services at ethnic-specific agencies. Asian Americans miss their intake appointments 33% of the time, and 10-22% drop out of treatment after their intake appointment (Akutsu & Chu, 2006). All this trails the Surgeon General's report (2001), which explained that only 17% of Asian American individuals with a psychological problem seek help and less than 6% seek help from a public mental health center. Asian Americans underuse mental health services by either dropping out of service prematurely or seeking services much later into the presentation of their mental health symptoms than their counterparts (Aponte, 1994; Sue, Cheng, Saad, & Chu, 2012). This means that among Asian Americans with a mental health disorder only 28% sought professional mental health services as opposed to 54% of the general population (Wang et al., 2003).

The underutilization of mental health services by Asian Americans has many contributing factors. For example, Asian American individuals conceptualize mental health problems differently than their counterparts from the United States (Lee, Lam, & Ditchman, 2015). The differences in conceptualization can influence how Asian Americans view their mental health symptoms, how and if they seek professional mental health support, and who helps in the decision-making process about whether to seek treatment (Sue & Sue, 2008; Lin & Cheung, 1999). Millville and Constantine (2007)

cited stigma as a deterrent for seeking treatment by Asian Americans. Furthermore, Asian Americans also tend to attribute their mental health symptoms to other factors such as a physical illness (Lee et al., 2015), punishment by ancestors or evil spirits (Wynaden et al., 2005), or an imbalance of the flow of qi (Yeung & Kung, 2004). These assignments of value often lead Asian American individuals to seek help from spiritual healers (Yeung & Kung, 2004) and online supports (Chu, Hsieh, & Tokars, 2011) before professional mental health providers. The assignment of value also leads Asian Americans to seek help from friends and family to help with their symptom reduction and this often results in them waiting too long to engage professional supports (Durvasula & Sue, 1996). When Asian Americans do seek professional support, their symptoms tend to be more severe (Sue & Sue, 2008; Lin & Cheung, 1999). Also, in some Asian American families, seeking outside counseling to address mental health systems is akin to disgracing the family. The expectation is that these individuals resolve their problems using their own resources and willpower (Lee et al., 2015). An added contributing factor is restricted access to services due to language barriers (Unites States Department of Health and Human Services, 2001).

These cultural values may be shifting for the United States born individuals who identify as Asian American. In the National Latino and Asian American Study, Abe-Kim et al. (2007) found:

> The United States born Americans were more likely than first-generation immigrant Asian Americans to use mental health services, and that a third of later generation Asian Americans with diagnosable illnesses sought services at an even higher rate (62%) within the last year. (p. 93)

However, despite this shift Asian Americans are less likely to seek professional mental health support than other racial groups (Abe-Kim et al., 2007).

Asian Americans are not the only underserved or unserved population experiencing mental health disparity. Research suggests that African American individuals are also hesitant to seek professional mental health support for several reasons including poor access to care, stigma, and lack of awareness of mental health issues (Gonzalez & Papadopolous, 2010).

African American. This is a problem as there are 6.8 million African American persons with a diagnosable mental illness (Mental Health America, 2017). Other barriers to seeking formal care for African American persons include financial barriers, poorer quality service delivery (Holden & Xanthos, 2009), and a mistrust of the medical system that stems from well-documented abuse of African Americans in research (U.S. Department of Health and Human Services, 2001). Like the Asian American community, African American individuals often do not pursue formal treatment until their symptoms necessitate formal intervention. When this happens, African Americans tend to seek out

treatment through emergency rooms (Holden et al., 2014). This level of intervention means that African American individuals may not be getting the highest quality care available, especially if the location of the emergency rooms are in poorer neighborhoods (Snowden, Catalano, & Shumway, 2009). The barriers that keep African American individuals from seeking treatment, compounded by the challenges that face all unserved and underserved persons, results in poorer overall mental health outcomes for African Americans (Holden, Bradford, Hall, & Belton, 2013).

American Indian or Alaskan Native. Other individuals experiencing disparity in mental health service delivery are those who identify as American Indian or Alaskan Native. This population has the highest rate of suicide among 15 to 24-year-olds in the United States (Goodkind et al., 2010). Research explained that these individuals are not only dealing with mental health issues but also struggles with substance abuse. For example, a study of 89 American Indian adolescents receiving inpatient residential treatment revealed that 82% of the youth had a diagnosis of both a mental health issue and substance use (Novins & Baron, 2004). One barrier to this group seeking formal mental health treatment is the importance of traditional cultural healing practices to resolve mental health symptoms and promote well-being (Goodkind et al., 2010). Furthermore, a study of American Indian adolescents revealed that stigma and embarrassment were key reasons why the youth did not seek formal support (Freedenthal & Stiffman, 2007).

Hispanic/Latino. Unserved or underserved individuals who identify as Hispanic or Latino are also experiencing disparities in mental health treatment. Hispanics are the largest and fastest-growing minority group in the United States (Garza & Watts, 2010), yet they continue to struggle with access to mental health services. In addition to the general barriers experienced by unserved and underserved individuals, problems with language, lack of awareness about formal mental health services, and limited financial resources are all barriers to these individuals receiving mental health services (Garza & Watts, 2010). Furthermore, Latina women value endurance and overcoming their struggles in silence over *talking therapy* (Cohen, 1980).

Poverty level. It is necessary to include mention of a subset of the Caucasians population, those living in poverty. In this paper I am exploring disparity among various cultural groups that make up Los Angeles County with regard to mental health service utilization. According to Public Policy Institute of California (2016), from 2011 to 2014 Los Angeles County had the highest poverty rate (25.7%) in California. Of the population of Caucasians living in Los Angeles County during this time, 14.1% showed as living in poverty (Public Policy Institute of California, 2016), making them a possibly unserved or underserved population. I was unable to find mental health utilization rates of this population specifically in the published literature. When researchers include Caucasians in mental health service use it is in direct relation to other races and cultures. From this data Caucasians access mental health services at a higher rate than other races and

cultures (Chow et al., 2003; Guerrero & Kao, 2013). What is unclear is the effect of poverty barriers on this group's access to mental health services. Barriers that affect impoverished persons concerning mental health service use include lack of insurance coverage, childcare issues, and lack of transportation to access services (Griner & Smith, 2006; Holden, 2014). One can infer that these barriers to mental health service use affect unserved or underserved Caucasian persons as well.

Contributing Factors to Mental Health Disparity Rates: Professional Challenges

Until now this exploration into mental health disparity investigated barriers to service access for or by consumers. There are other contributing factors to mental health disparity rates that need mediation by the mental health industry. According to Holden and Xanthos (2009), disparity can occur due to lack of cultural competency on the part of the service delivery professional. The solution to this problem is not as simple as teaching cultural competency skills to mental health professionals. The reasons for this are many. The guidelines for culturally competent services are hortatory in nature, with little attention given to how to measure the concept, conceptualize it in terms of skills, implement in daily practice, and formally train (Sue, 2006). Additionally, some educational institutions' counseling programs seem ineffective due to their emphasis on population-specific information consisting of a focus on history and values of differing unserved or underserved groups (Chao et al., 2011).

Despite the attempts of cultural training programs to incorporate the fundamental concepts of cultural competency as outlined by the National Association of Social Work, and mandated by the 2008 Accreditation Standards (Quirk, 2015), most programs do not supply adequate training (Daniel, 2011). One reason for the inadequacy in curriculum development and administration is lack of clarity (Teasley, Archuleta, & Miller, 2014). Accreditation bodies such as the American Psychological Association and the Council on the Accreditation of Counseling and Related Programs lack specificity on course content that teaches cultural competency (Teasley et al., 2014).

Another barrier to students gaining cultural competency skills is the academic curriculum's heavy emphasis on studying the other person (Brown, 2009). Programs that emphasize a mental health professionals' knowing of general information of various other cultures do not emphasize a focus on the counselor learning about self and the role of self in the cultural context of the therapeutic relationship. Warde (2012) states that a student's self-reflection and self-awareness is central to becoming a culturally competent social worker, and he suggests that academic curriculum must include experiential learning activities. Furthermore, Keller (2005) argued that when the focus of training programs is on the other person's culture without self-reflection the result may be endorsement of stereotypes or prejudices about the person who is different (Chao et al., 2011).

Another barrier to the development of social worker cultural competency curriculum is the elusive nature of the concept. Current research suggested that cultural competency is not an attained goal but a continual journey that must occur over time (Saunders, Haskins, & Vasquez, 2015). There are suggestions within the field on how to improve social work curriculum. Parker and Dautoff (2007) suggested that student self-reflection, a tenet of cultural competency, be gained from immersion experiences within other cultures. Teasley et al. (2014) also suggested that cultural competency must receive attention using post-graduate professional development as an ongoing process throughout one's professional career. Evidence suggested that professional counseling programs and mental health agencies are striving to promote cultural competencies among mental health professionals (Hurley & Gerstein, 2013). However, no one model, or curriculum can teach cultural competence due to the complexity of the concept, and the evolution of self and the phenomenon over time (Hurley & Gerstein, 2012).

The mental health professionals' willingness to learn about the topic of culture also affects the professionals' skill development. Some mental health professionals believe they already know what they need to know about the topic of culture, and, therefore, they are not receptive to receiving latest information (Chao et al., 2011). Also, the topic insults some counselors because to address it means that they need it, thus implying that they harbor biases or prejudices that need exploration (Chao et al., 2011). Furthermore, clinicians may not believe that a client's culture is related to the client's

presenting problem and therefore the clinician may not use a cultural lens to address the problem (Sehgal et al., 2011). Due to the unwillingness or inability of some counselors to learn about culture on counseling, disparities will continue to exist.

Mental Health Disparities: The Outcome

One outcome of mental health disparity rates is the client's chosen lack of use of formal mental health supports. Because of the current system, some clients may either choose not to seek counseling or not to continue with their current counselor because of the counselor's lack of cultural competence (NAMI, 2012). For example, a study by Chow et al. (2003) revealed that Asian clients have fewer contacts with social services and are less likely to have received treatment for mental health symptoms. Furthermore, a study by the Surgeon General's Office (2001) revealed that only 17% of Asian Americans experiencing psychological difficulties pursued therapeutic treatment (Wang & Kim, 2010). The Chow et al. (2003) study also revealed that some groups, specifically African Americans, are at a higher risk for referral to formal mental health supports involuntarily by law enforcement officials rather than seeking it independently. The explanation for the lack of service acquisition by Asian Americans is the inability of the clients to match ethnically and linguistically with a provider (Wang & Kim, 2010).

Another outcome of inadequate client service delivery on culture is a misdiagnosis of client symptomology (National Alliance of Mental Illness, 2007). A

demonstration of this can occurs within the Latino community. Some symptoms are culturally patterned behaviors but are in fact misdiagnosed mental illness resulting in clients not receiving proper treatment (Office of the Surgeon General, 2011).

Cultural differences between the client and mental health professional may also affect the counseling process, specifically hindering the shared-decision making process (Lee et al., 2015). If impairment of the decision-making process within treatment occurs, impairment of communication may follow resulting in client termination of services prematurely (Lee et al., 2015). In the Asian American community, for example, communication styles are implicit when confronting a serious matter and rely on silent communication (Lee et al., 2015). The professional must attune to the client's non-verbal cues or risk missing important diagnostic information important to the case. This also suggests that should the professional not attend to the body language or silent communication the professional may misunderstand the client's family dynamics or the client's agreement to the treatment planning (Lee et al., 2015).

Another outcome of mental health disparity is premature termination of services. According to A Supplement to Mental Health: A Report of The Surgeon General (2001), premature termination has been particularly problematic for unserved and underserved individuals who did seek treatment. Contributing factors include lack of insurance coverage, a belief system that attributes mental health problems to a religious problem, and a lack of culturally responsive and compatible providers (Chow et al., 2003).

Regarding culturally compatible providers, a study by Atkinson and Lowe (1995) found compelling evidence that when other conditions are equal, unserved, and underserved persons prefer an ethnically similar counselor. A follow-up study by Cabral and Smith (2011) confirmed the Atkinson and Lowe findings. Cabral and Smith's meta-analysis (2011) revealed that clients showed a strong preference for a counselor that matched their race and ethnicity. The results confirmed a preference for matching within unserved and underserved communities more than within White-European communities (Lee et al., 2015). The lack of diversity among counselors is a contributing factor to mental health disparities for underserved or unserved persons (Chapa & Acosta, 2010). A new precedence began to appear. Between 1999 and 2006, counselors from varying ethnic and cultural groups increased from 17.6% to 21.4% in psychiatry, from 8.2% to 12.9% in social work, and from 6.6% to 7.8% in psychology (Goebert, 2014).

Evidence-Based Practices: A Failed Attempt at a Solution

In psychotherapy practice, there is a convergence of two concepts: multiculturalism and evidence-based practice (Morales & Norcross, 2010). Multiculturalism is the concept that group differences need respect and valued (Purdie-Vaughns & Walton, 2011). The theory of multiculturalism focuses on cultural groups as the basis for the formation of a person's identity (Kymlicka, 1999; Verkuyten & Martinovic, 2006). Multiculturalism also recognizes that cultural groups can consist of a multitude of categories including age, socioeconomic status, race, ethnicity, religion,

sexual orientation, geography, and physical or psychological ability (Purdie-Vaughns & Walton, 2011). Evidence-based practices for mental health are defined as:

> Those practices (1) which are conceptually sound (2) that are internally consistent (3) that demonstrate superiority to other practices and include a strong evaluation component (4) whose results can be replicated (5) that include a treatment manual (6) have standardized training protocols and (7) have sustained long-term outcomes that can be demonstrated. (Lonigan, Elbert, & Johnson, 1998, p. 141)

In the field of mental health, there are multiple evidence-based practices believed effective in working with diverse populations to reduce disparity, but these views are controversial. A meta-analysis on evidence-based practices by Miranda et al. (2005), revealed that evidence-based practices are effective treatment protocols for unserved or underserved persons. The research also showed that evidence-based care practices for depression showed improved outcomes for African American and Latino individuals equal or better than the outcomes for Caucasian individuals (Miranda et al., 2005). Interpretation of these findings can mean that evidence-based practices can be universally applied with the same efficacy.

The Miranda et al. (2005) research is not without criticism, however. Some researchers argue that the body of literature supporting the universal efficacy of evidence-based practices is small and focuses only on the areas of depression and anxiety

(Aisenberg, 2008; Bernal, 2006). Aisenberg (2008) explained that a closer look at the research reveals a limitation. Current evidence-based practices highlight scientific outcomes over epistemologies (Aisenberg, 2008). The argument that without incorporating indigenous ways of healing, evidence-based practices may have legitimized efficacy treatments for unserved or underserved persons (Tanenbuam, 2005). Morales and Norcross (2010) also noted that all evidence-based practices research was in English during the development stage, and there were no translations to into other languages. The argument that merely adapting the current evidence-based practices to "fit culture" is also inadequate as those adaptations lack scientific rigor (Aisenberg, 2008).

There is a lack of investigation for the appropriateness of evidence-based practices for people from varying cultures (Aisenberg, 2008). Researchers noted that current evidence-based practice research often does not include samples of unserved or underserved persons in its development or research thus silencing its cultural relevance (Goebert, 2014; Morales & Norcross, 2010). Furthermore, when cultural adaptations to evidence-based practices are suggested they often perpetuate the dominant culture's views on what constitutes cultural norms for groups (Aisenberg, 2008).

To address the controversy over whether evidence-based practices are effective with unserved and underserved persons, the American Psychological Association (APA) published an addition to the previously cited definition of evidence-based practice, thus changing the criteria. By the intentional expansion of the definition, APA included a

client's culture as part of the development process (Morales & Norcross, 2010). The new definition, as published by the APA Task Force on Evidence-Based Practices (2006) reads, "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). This definition calls for a shift from evidence-based practice to practice-based evidence (Goodkind et al., 2010).

Implications for future research

The lack of existence of an empirically-based, culturally competent mental health service-delivery plan that includes actions steps has been proven. The lack of a service-delivery plan is a problem as culturally competent service delivery is a professional mandate. The lack of a delivery plan is also a problem as the unclear guidance on how to administer culturally competent services to clients creates continued disparities with regard to mental health service use across cultures in Los Angeles County.

Although research around cultural competence is inadequate, current research does show what types of service adaptations need further research for efficacy moving forward. Waitzkin et al. (2010) suggested that the mental health profession employ community health workers, or *cultural brokers*, to address gaps in service delivery between the client and the professional (Dunn, 2015). Researchers have also called for increased research on the efficacy of culturally adapted practices on diverse clients concerning the reduction of symptoms (Worthington, Soth-McNett, & Moreno, 2007). Hook, Davis, Owen, Everett, and Shawn (2013) also suggested that cultural humility

should be tested as a factor affecting culturally competent service delivery. Hook et al., (2013) conducted preliminary research on this topic and revealed that clients consider cultural humility to be a key factor in the client-professional relationship when evaluating a professional's culturally competent service delivery. They suggest that mental health professionals and clients should partner to determine which aspects of the client's cultural background can be negatively or positively affecting the presenting problem or the therapeutic relationship (Hook et al., 2013).

Chu and Sue (2011) offer another suggestion for future research around cultural competence concerning Asian clients specifically. They suggested teaming of a paraprofessional with a mental health worker in all cases. The paraprofessional's role would be that of "culturally-sensitive" support (Chu & Sue, 2011). They base their suggestion on earlier research by Yeung et al. (2010) which showed a seven-fold increase in treatment engagement rates among the Chinese community with paraprofessional supports in place.

Another suggestion for improving culturally competent service delivery is a movement toward integrated healthcare. Integrated healthcare is a service delivery method by which people can receive both physical and mental health support, and in which their practitioners could collaborate (USDHHS, 2012). This type of service delivery introduces mental health services to clients from varying cultures who would otherwise only seek medical treatment for their problems (USDHHS, 2012). This type of

care is also a way for medical providers to find mental health problems with clients and make direct referrals to mental health professionals as a result (USDHHS, 2012). This type of service intervention is new, and currently there is a lack of existing research on the effectiveness of this type of service delivery (Bao et al., 2011).

Further research on this topic should include the societal context in which culturally competent service delivery is occurring. Flaskerud (2007) argued that cultural competence service delivery cannot reduce mental health disparities until a change occurs in the social contexts in which they exist. This includes barriers such as unequal distributions of wealth, lack of resources and social influence, educational barriers, and discrimination (Flaskerud, 2007).

Other culturally competent practice suggestions that call for further study include Culturally Sensitive Theory (CST), Cultural Accommodation Model, and Multicultural Relationship Model, Cognitive Match Model, Racism Acknowledgement Model, Acculturation Model, and the Spirituality Model (Roysircar, 2009). CST Theory addresses the within and between-group differences within cultural groups that would show the need for several types of interventions (Roysircar, 2009). The Cultural Accommodation Model sees clients as belonging to three groups. They are members of humanity, of the cultural group to which they identify, and an individual (Leong & Lee, 2006). The Multicultural Relationship Model requires that mental health professionals challenge themselves to be successful in five areas: “communication, relationship

building, dialectic reasoning, observation of a client's culture, and model management through self-reflexivity" (Roysircar, 2009, p. 71).

The Cognitive Match model promotes an understanding by the therapist of the client's worldview and how it affects symptomology (Roysircar, 2009). The Racism Acknowledgement Model is based on the work of Fuertes, Meulle, Chauhan, Walker, and Ladany, 2002). In this model, the mental health professional addresses oppression and racial identity development, even if the client does not bring it up, to strengthen the relationship (Roysircar, 2009). In the Acculturation Model, the professional makes it a goal to learn the client's level of acculturation as a means of helping with the current problem (Atkinson, Thompson, & Grant, 1993). Finally, the Spirituality Model acknowledges the ways in which a client's spirituality affects a person's psychology (Roysircar, 2009).

Summary

Mental health professionals are ethically mandated to supply culturally competent services to clients. To date, research and documentation illustrates that they do not receive the formal training to do so. There is still no universal definition of the term culturally competent nor any empirically-based explanation of what it means to deliver culturally competent services to clients. There is a strong theoretical base for the concept of cultural competence, but it is imperative that research continue to determine which skill delivery steps, based on theory, yield positive outcomes. Further research is also

called for to learn how counselors are currently adapting their practices to deliver culturally competent care. This qualitative study revealed how community-based social workers in Los Angeles County are adapting their mental health practices to address the ethical mandate of supplying culturally competent care to clients.

Chapter 3: Research Method

Introduction

My purpose in this qualitative study was to understand the ways in which community-based associate clinical social workers are delivering culturally competent counseling services to their clients during the engagement phase of treatment. In this chapter, I explain the method of this study in detail. Topics covered here include the rationale for the study, the purpose of the research and research questions, sampling information, and analysis. I also outline ethical considerations of this study.

Research Design and Rationale

The research question that framed this study is:

RQ1: How are associate clinical social workers who provide in-home mental health services in Los Angeles County delivering culturally competent services to their clients?

For the study, I pursued a qualitative method of inquiry and a descriptive case study design. The choice to use a case study design was based on a few factors. First, I chose a case study design to understand the phenomenon of culturally competent services within the context of in-home mental health service delivery in Los Angeles (Baxter & Jack, 2008). Using a case study is necessary when the researcher is looking to understand the how of a phenomenon (Baxter & Jack, 2008). For this study, the use of a case study research design was appropriate to understand *how* mental health professionals apply the

concept of cultural competency to their work. This study should add to the body of research and contribute to a shared meaning of the concept of cultural competence as it relates to counseling. I chose to use a descriptive case study for this research because it allowed me to describe how associate social workers are attending to culture while supplying mental health care to clients within the context of Los Angeles homes specifically (Yin, 2003).

Other research designs, such as phenomenology or narrative inquiry could also have supplied information about the concept of cultural competency. I ruled out narrative inquiry as a design method for this study due to the limited number of study participants and the determination that the results would not be as rich about the specific data this study wanted to investigate. Phenomenology was inappropriate as a design method due to the volume of information that is currently known about the topic of cultural competence from a theoretical perspective. Case study was the best paradigm to look at the *how* of a phenomenon.

The theoretical basis for this study was multiculturalism. Multiculturalism refers to the way in which people use context, rooted in culture, to interpret their reality, and as such counseling treatment must also address the cultural origin of people's reported treatment issues (Comas-Diaz, 2012). Multicultural theory as it relates to counseling also suggests tailoring treatment interventions to meet the needs of the individual while drawing upon the person's strengths (Hays, 2009).

Using multiculturalism as a lens for this study, I ensured that the study design and delivery was in a culturally competent fashion for the participants (Arriaza, Nedjat-Haiem, Lee, & Martin, 2015). This meant the assurance that while conducting the interviews I used the most comfortable language for each participant even if this meant I needed to get the help of a translator. Fortunately, all the participants were comfortable conducting the interviews in English. It also meant that I needed to be humble and ask questions about cultural terms with which I was unfamiliar, rather than making assumptions of the term's meaning. Furthermore, it meant that I needed to consider that some participants may have an initial distrust of me and the study due to my cultural and racial identity, and I needed to have awareness that this could affect the participant's responses.

Multiculturalism also served as a lens for data analysis. This meant that at times I used member checking to ensure that I understood a concept or term. It also meant that due to my racial identity as Caucasian and my cultural background as European, I enlisted the help of a peer reviewer who identifies as being from another racial and cultural group to review the interview questions and study results for validity.

Role of the Researcher

I conducted the interviews for this study and recruited the sample from a mental health agency in Los Angeles County that employs community-based associate clinical social workers practicing in-home therapy. I was formerly a corporate trainer for the

parent agency and I did not have relationships with research participants at other company locations outside of the corporate office. All chosen participants I interviewed were from agency sites with which I did not have a working or personal relationship. As I was conducting the interviews there was potential for bias in the study. In qualitative studies the researcher must make interpretations and assessments of the data (Carcary, 2009). To address potential bias, I conducted systematic interviews, engaged in critical reviews of the data, and produced convincing arguments to support the research findings (Mason, 2002).

Methodology

My study included interviews with eight participants of varying age, culture, and race. The participants consisted of license-waivered therapists trained in social work who practice in-home care in Los Angeles County. License waived therapists hold a master's degree in social work and for this study I used the term *associate clinical social worker* when referring to them (Board of Behavioral Sciences, 2012). This variation is useful as the goal was to show themes of behavior across these variations, because they relate to a therapist's culturally based therapy delivery behaviors. This decision was based on Yin's (2011) suggestion that if a researcher is looking for variation among study participants using a larger sample size may be necessary. After eight interviews the data were not revealing new information so saturation was reached.

I used a typical purposive case sampling structure for this inquiry (Tongco, 2007). The use of this strategy allowed for the collection of a diverse sample of therapists who practice in-home therapy with minority clients, and who are of varying ages, degrees, races, and cultures thus enriching the data. To address issues such as sampling bias and sample distortion, I requested participation from people unknown to me, who self-referred to participate, and who are all employed by various agency sites during the morning, afternoon, and evening shifts.

Recruitment

I sent an email to the director of the participating mental health agency with the recruitment flyer attached, asking her to distribute the flyer to associate clinical social workers on the agency teams. The flyer had both my phone number and email and asked interested parties to contact me directly. I received emails and/or phone calls from interested parties and contacted possible participants either by phone or email, whichever they preferred, to briefly review the study and set up a research interview. I then asked participants to name a public location to meet that is quiet and comfortable for them. I was prepared to offer a space, but all participants were able to suggest a space. Finally, I sent individual confirmation emails to research participants to confirm interviews.

Instrumentation

I generated the instrumentation for this inquiry and it consisted of questions that addressed both demographical information as well as the research question of this study.

See appendix A for a copy of the interview tool. I chose to generate a research tool as current tools are quantitative in nature and did not allow for the gathering of qualitative data to address this study's research question. To address content validity of the tool I ensured that the tool aligned with the theoretical framework (Leung, 2015).

The interview tool consisted of three demographic questions and one interview question designed to understand how community-based associate social workers deliver culturally competent mental health services. The first question was followed by four exploratory questions in case the research question was not thoroughly addressed by the respondent's answer to the initial question. I collected the research data personally and limited the interviews to 60 minutes or less. No interview surpassed the sixty-minute mark although I allotted time to schedule a second interview if necessary. Interview responses were audio tape recorded for transcription to ensure against losing valuable information during the interview process.

After the study, I debriefed the participants using a debriefing tool that reminded the participants of the purpose of the study, issues of confidentiality, and provided them with resources should they want more information on the topic. The tool also included information for the participants to obtain support should they find themselves emotionally triggered by any questions in the study. Within a week of the interview I provided the participants with a copy of the transcription of their interview to complete member checking. Completion of this step ensured trustworthiness of the data and

allowed interviewees a chance to add anything they believe they missed during the original interview (Nelson, Onwuegbuzie, Wines, & Frels, 2013), or that I missed during the transcription process.

Analysis

I conducted the in-depth interviews with the goal of understanding the delivery of culturally competent services (DiCicco-Bloom and Crabtree, 2006). Using an interview tool allowed me to ask follow-up questions as they organically arose from the interview data. I used a coding system to uncover themes from the gathered data. Codes are the labels assigned to address the descriptive or inferred meaning of the data (Miles, Huberman, & Saldana, 2014). I used short phrases or key words used directly by the interview participants (Thomas, 2006). I then interpreted the codes for meaning and generated preliminary findings written in a descriptive manner, which should allow readers to draw similar conclusions to mine when reviewing the data. I checked for validity prior to dissemination of the findings. The primary type of validity considered for this inquiry was face validity. Face validity shows that readers who read the study will draw similar conclusions to mine based on the data (Shenton, 2004).

In addition to the validity strategy discussed above, I also attended to other validity strategies in the research process. These strategies included attending to credibility, authenticity, criticality, and integrity. For credibility, I used member checking to ensure that the interpretation of the data was correct (Yin, 2011). For authenticity, I

ensured that the interviews were varied among people from varying ages, educational institutions, races, and nationalities. When addressing criticality, I described the themes revealed in detail, rather than trying to find data that supported previously published data or hypotheses (Patton, 2002). About integrity, I ensured that I showed the reader all biases in the presentation of the study and that strategies were used throughout the study process to manage bias.

Finally, about data analysis was the matter of record retention and storage. I moved all data from this study to a flash drive and removed them from my computer after analysis. I locked this data and all other data, such as audio recordings and field notes, related to this study in a file cabinet where they will stay for five years and destroyed at the end of five years.

Issues of Trustworthiness

This section will discuss the various forms of trustworthiness any research study must show for the sake of credibility.

Dependability

In a 2001 study by Patton (as cited by Golafshani, 2003), reliability, or dependability, is said to be a factor that needs consideration throughout the research process. To address dependability, I implemented two strategies. First, in the publication of the research I used thick descriptions of the research process so that future researchers

can replicate the study. Second, I made all research information available for an inquiry audit as appropriate.

Limitations

There are limitations which exist when using qualitative inquiry and they affect the generalizability of research findings (USC, 2013). For example, qualitative data inquiry relies on skills of the researcher, including the researcher's ability to manage biases which could influence data interpretation (Anderson, 2010). Furthermore, the presence of the researcher during the data collection process may influence the results of the inquiry (Anderson, 2010). As limitations always exist in research, it is helpful for the researcher to acknowledge them (Anderson, 2010). About this study, limitations included the measurement tool to gather the data, influence of my presence on study participant, and time.

One limitation of the study proposed here was measurement. Data collection occurred through the completion of interviews only. This meant that data gathering, and analysis relied on only one method of inquiry. If participants were completing a questionnaire, for example, they may have time to consider their responses differently than they did during the face-to-face interview. The consideration of method leads to a second limitation of the study, my presence. The presence of a researcher asking questions always has the potential to influence the answers of the participants. To address this concern, each participant understood the purpose of the research, their ability to

withdraw their consent to take part at any time, and my aim of this study. Furthermore, when necessary, I used self-disclosure as a means of addressing the validity of data gathering (Yin, 2011).

Another limitation to this research was time to complete the research. Qualitative inquiry is time consuming (Anderson, 2010). As such, I needed to take measures to ensure that I did not rush the study, or left data incomplete. Measures I took to address time constraints were to ensure that I allotted ample time for interviews so that participants did not feel rushed by the process and carving out time on a weekly basis for data analysis so that processes could receive the time and attention necessary. I also obtained consent from participants to follow up with them later if further clarification of their study participation was necessary.

Ethics

Ethics speak to a researcher's ability to protect research subjects from harm, and they are imperative to any research study (Orb, Eisenhauer, & Wynaden, 2000). Ethical issues that received attention in this study included informed consent, confidentiality, and referrals for care. I provided all participants with informed consent including providing them with a written statement of the study's goals and their rights as research participants, as well as a formal explanation of both. This explanation also included informing participants of their right to withdraw from the study at any time (Richards & Schwartz, 2002). Furthermore, I also obtained signed consents to tape record the sessions,

which included thorough explanations of tape storage and usage, as well as what will happen with the data following the completion of the study. About confidentiality, I explained how confidentiality pertains to the participants and how I would take measures to keep participant information confidential. Measures to protect participant information include coding the data without using information that could identify the participant by an outside party and ensuring the safe-keeping of data where only I can access it for a period of seven years after the completion of the study. Finally, should any participant have experienced psychological discomfort because of participation in the study, I was prepared to offer them referrals for supportive services. But all offers of referrals for aftercare were not necessary.

Summary

This study aimed to understand the ways in which community-based associate clinical social workers are delivering culturally competent services to clients during the engagement phase of treatment. This study used a qualitative research tradition, a case study design, and included in-person interviews with eight research participants. Following data collection, I coded and analyzed data to reveal themes about service adaptations by the research participants regarding culturally competent service delivery.

Chapter 4: Results and Findings

Purpose of the Study

My purpose in this qualitative, descriptive case study was to understand the ways in which community-based associate clinical social workers deliver culturally competent mental health services to clients in the engagement phase of client treatment. Of interest were the practices social workers used that they found were particularly effective, and barriers to addressing culture in their work with clients. In addition, I explored how the introduction of evidence-based practices has affected social worker's attention to culture during the mental health treatment of clients. I coded responses to a semistructured interview tool to understand how associate clinical social workers show cultural competence based on the following questions:

1. Describe how you do your job of providing mental health services in a way that attends to a client's culture.

a. What are your thoughts about the need to attend to a client's culture during treatment and can you speak a little to how you have come to this belief system?
b. Please describe any specific training you have had that helps you with attending to a client's culture during service delivery?
c. Please describe any challenges to attending to a client's culture during service delivery?
d. How has the shift towards the use of evidence-based practices altered attention to culture during service delivery?

Review of Data Collection Process

Collection of the data for this qualitative study were using in-person interviews. The researcher collected all data between July 19, 2018, and August 3, 2018.

Interviews. I conducted eight individual interviews using a semistructured interview tool found in Appendix A. I gave the interviewees the opportunity to choose a place to meet for the interview. Seven of the eight participants chose to meet at their places of employment, noting that each could arrange a private conference room, which they did. One of the eight participants requested to meet at her home, where she was able to arrange for the interview to be private. I audio recorded the interviews and the only people present in the room were the researcher and the participant. I created field notes during and after the interviews to summarize participant responses, show emerging themes, and record my observations. Each participant's audio recording received a

number for privacy and anonymity. All numbered audio tapes went via the internet to a transcription service, GoTranscript. When I received the transcripts, I emailed them individual to each participant for preliminary member checking. Each participant received only their transcript and asked to read their transcript and add or change any data that they believed was incorrect or incomplete. I included written instructions to please not research anything and add it to the data. Each participant returned their transcript within 1 week. Only Participant 2 (P2) added to the data, which he said was for clarification purposes. I then compared the returned data with my field notes to determine themes of the research and to begin the analysis process.

Respondent Demographics

Six identified as female and two identified as male. One participant reported identifying as African American, two participants reported identifying as Caucasian, two participants reported identifying as Hispanic, two reported identifying as Latino, and one reported identifying as Mexican. The years of practice experience in the field ranged between 2 and 18 years. Refer to Table 1 for demographic information.

Table 1

Demographics

Respondent	Gender	Years in practice	Culture
R1	Female	2	Hispanic
R2	Male	10	Latino
R3	Female	3.75	Caucasian
R4	Female	5	Latino
R5	Male	18	African American
R6	Female	3	Mexican
R7	Female	6	Caucasian
R8	Female	5	Hispanic

Data Collection

After receiving Institutional Review Board approval for the study on June 27, 2018, I emailed a recruitment flyer to a community-based Los Angeles mental health agency director. The director then distributed the flyer in person to her agency teams at the next agency manager's meeting. The director asked agency managers who supervise community mental health workers to share the flyer with associate clinical social workers on their teams who might qualify for the study. The flyer listed the topic of the study, inclusion criteria, location, time commitment and it clearly stated that everyone's participation was in no way related to their job at that agency. The flyer explained that participation was voluntary, and that participants' personal contributions would not be

shared with their employer. Within two weeks of the agency distribution of the flyer I received phone calls or text messages from eight associate social workers willing to take part in the research. I spoke with each volunteer by phone to ensure they met the study criteria, and when they did, I scheduled an in-person interview with each.

I often had to wait for the participants when I arrived at their agencies for the interviews. While in the lobby I noted that the clientele of the agencies was often diverse, and in one case I noted that the clients waiting in the lobby did not speak English. I also saw that the staff behind the reception desk were bilingual in all three offices I visited and the literature around the offices were in both English and Spanish. I also saw that the agency staff entering and exiting the lobby appeared diverse and I did see them to be bilingual in many cases.

At the start of each in-person interview I provided each participant with a consent form that clearly explained the study and I verbally reviewed the study with each participant as well. In addition, I reminded each participant that they could withdraw from the study at any time and I asked each participant if they had any questions prior to obtaining their written consent. I also offered each participant a copy of their signed informed consent. All eight participants appeared comfortable with signing the consent and few participants asked questions. Questions included my motivation for running the study, my doctoral process in general, and whether they could have a copy of the study

results. I answered all questions, ensuring that participants knew they could review the study results if desired. This all occurred prior to the signing of the consent.

The primary data collection instrument for this study was a semi-structured, interview tool I created. The time and location for the interviews was set by the participants and the locations proved to be private and uninterrupted. All but one interview occurred at each interviewee's workplace per their preference. One interview occurred at an interviewees home, per her request. The duration for the interviews was a predetermined 60-minutes, however the longest interview was only 49 minutes in length. The average length was 25 minutes. The structure of the interviews allowed for each participant to speak about each topic as extensively as they chose. In addition, I asked follow-up exploratory, open-ended questions related to the participant's responses for the purpose of clarity and depth. Only one of the participants displayed outward signs of stress because of taking part in the interview. I gave her the choice to end the interview. She chose to take a brief break and return to the interview. She reported that her discomfort was for personal reasons and not related to the study itself.

Following completion of the interviews each participant was offered the option of receiving a counseling referral if necessary. All participants declined the referral. Following completion of the interviews I also made $20 donations to charities of the participant's choice if they asked that I do so. The donations were incentives for

participation. Seven of the eight participants asked for a donation to their charity of their choice.

Data Analysis

Initial Findings and Observations

The topic of cultural competence was met with comfortability as evidenced by the pace of the interviews, the response time of willing participants to partake in the study and the ease with which the interviewees spoke about the topic. Only one participant displayed visible discomfort during the interview and needed to take a brief break before voluntarily choosing to return to the interview. When she returned to the study, she stated that her visible upset was due to countertransference that emerged when discussing a family and was not induced by the study topic itself. The ease of participation contrasts with previously published research that claims that no one understands the term culturally competent nor do they understand the concept of culturally competent services (Ahmed et al., 2011; Aisenberg, 2008; Harrison & Turner, 2011; Heppner et al., 2012).

Only one participant (P5) addressed the term *cultural competence* before answering the research questions. P5 opened the interview, once hearing the topic, by supplying definitions of the diverse types of cultures and clarifying that he does not believe the phenomenon of cultural competency exists, but that he believes one should work toward cultural attunement. This is in line with previously published research acknowledging the complexity of the terms culture and competence (Harrison & Turner,

2011). P5 defined cultural attunement, different than cultural competency as “trying to work with the family’s current views and being respectful of where they may be coming from while not trying to influence them with your own pre-conceived ideas of how they should behave or act”.

Since P5 was the only participant to address the term culture specifically as a topic of discussion. I was concerned that the other participants did not know the definition of the term culture. This led me to have concern about their ability to address the study’s questions. However, their interview responses showed that all participants have a thorough understanding of various categories of culture. Their responses also showed that they address culture regularly but do so more from an organic perspective than a formal or instructional one. A discussion will follow in the themes section of this study.

Five clear themes appeared from the data: (a) attending to culture builds therapeutic relationships; (b) culture is not influencing treatment planning; (c) cultural knowledge is learned in several ways; (d) discrimination can be present in the therapeutic relationship; (e) and evidence-based practices are not addressing culture. Furthermore, subthemes appeared about culture’s role in building relationships. Sub-themes present include that cultural inquiry to build rapport occurs in various ways, therapists attend to culture because they realize it make their job easier in addition to benefiting the client,

and some therapists believe they have immediate rapport due to commonalities that exist between them and the client with regard to culture.

Theme 1: Attention to culture builds relationships

The most notable theme revealed by my research is that clinicians believe it is important to attend to culture when providing mental health services as doing so sets up rapport with the client and builds a deeper therapeutic relationship. From the beginning of the interviews, 100% of the participants spoke about how attending to culture "ensures that a connection is being made" (P7). When speaking of attending to culture to build the relationship, responses from participants included, "I attend to culture to make sure I am respectful", "if they think I understand them or I get where they are coming from they are more willing to participate in therapy", and "I just don't want to offend someone". One participant also noted that "culture informs how I work with the parent regarding explaining their child's diagnosis". She further explained that she was fearful that without attention to culture she could damage the working relationship with the parents.

Three of the eight participants also explained that they are willing to use their own cultural similarities with the client to their advantage for the purpose of deepening the therapeutic relationship. Participant responses included:

> P1: On the assessment paperwork I look for things we have in common. Then I'll relate with them about that. If they are religious, for example. 'Oh yes, when I got baptized, there was something…'. I build rapport with that.

P2: My parents are immigrants. I was born here but my grandparents were immigrants. Being able to relate to them from that perspective. Knowing some of the challenges my parents faced when they came to this country. Also, as far as racism, having witnessed racism on first-hand experience.

P8: I find myself to relate to some of the population I work with because I myself grew up in the area and I grew up very underprivileged, so I find some-- I always have ways to connect with them. Some of them went to the middle school I went to. Others went to the same high school I went to and then others, we share cultural background whether that's language or experiences, our upbringing. Sometimes when you are in session, they disclose a lot of information. I try not to disclose my own, but sometimes for the sake of building rapport, I do some light self-disclosure and I feel like that happens more often than not. It happens to strengthen their relationship, the therapeutic relationship between the client and the therapist.

Sub-theme 1: Cultural inquiry occurs in various ways. As revealed above, some families speak openly about culture due to cultural similarities between the clinician and the client or family. When cultural similarities are not obviously present, clinicians in this study reported that they often ask clients or their families for

information about their culture directly as opposed to making assumptions or avoiding the topic of culture. Reasons for this vary and include:

"To learn about this individual client's culture and the culture of this home" (P5).

"To know the rules. Also, so they can teach me how to fit in with their family for the hour I am there each week" (P3).

"To build a stronger bond" (P5).

"To avoid confusion. I have had instances where I just try to avoid questions like that and they feel more offended because I didn't ask" (P6).

An alternate strategy to asking questions and relying on similarities is to take part in traditions and rituals with a client system. Two participants spoke about attending to culture by taking part in traditions or rituals with their clients.

> P3: A lot of Latino families, if they offer you a water bottle, I'm going to take a water bottle, even though I have my own because I don't want them to feel offended that I am not accepting their water bottle.

> P4: Food with Latino families. Definitely, food was one of the big one where they would always offer you something. There were times when I sit down and eat a lunch, or a dinner and it would turn into a family session.

As the responses above reveal, clinicians appear to be asking questions about their client's culture for the purpose of building the relationship with the client. During the

first exploration of culture none reported exploring the topic of culture for its influence on mental health treatment goals or interventions. Only when I specifically asked if culture plays a role in the design of the goals did the correlation seem to come into awareness for participants. Further discussed later in this study.

Sub-theme 2: It makes the job easier. Of the study participants, all reported that attention to culture was important to building the therapeutic relationship. As such, participants noted that attending to culture makes their job easier. Responses included, "if a client feels respected they are more willing to participate in therapy", "if I grew up in a similar way to the client the client thinks I get them and they are more willing to participate", and from a parent, "I'm glad my daughter worked with you. I feel like she identifies with you so much and saw you as a role model".

Two participants reported that they will often use self-disclosure to help clients feel comfortable to move their therapeutic work forward. Their intention was not to manipulate the relationship but to deepen the connection so that therapy could occur. P4, for example, stated, "My stepdad is black so I tell my black clients that, so they might think I understand where they are coming from". P6 explained that she often self-discloses with a client's parents to try to bridge gaps. She stated:

> Some parents aren't ready to hear 'things are different now' when we first meet. I don't want to have that conflict right away. I try to get their information, where they came from, how they grew up, all that stuff so that when I speak with the

> client, it's like 'Okay, my dad or mom is this way because these are the experiences they grew up with, but now we're in the United States. We're in a different state or whatever the case may be'. Then I try to explain to the parent, 'You know what, I get it. My parents come from the same location' or 'I grew up during that time and I know where you are coming from, but we have got to take into consideration what is going on now.'

Regarding these two participants the self-disclosure was deliberate, however other participants self-disclose also. They just appear to do so in a more organic way, so they do not see it as being done for the purpose of making their job easier.

Sub-theme 3: Commonalities bridge the gap

Many participants in this study acknowledged having similarities to the clients whom they serve. As such, clinicians will sometimes vocalize their commonalities while other times the commonalities are clear. The latter shown by qualifiers such as skin color or language spoken. At the agency where I conducted this research there are many monolingual Spanish speaking clients. As a result, the participants in this study who identified as Hispanic/Mexican/Latino and are bilingual reported often being *matched* with clients, or parents, who speak only Spanish. They reported feeling an immediate connection to the families due to the language spoken and relayed that the families reported the same to them. P1 reported:

> As a little girl I had to translate for my parents and help them do a lot of things. These kids are doing this for their parents too. I know what it's like when you feel like someone is looking down on your parents. It's hurtful and you automatically get defensive. I want to be sure my families don't feel like that so they will be more vulnerable.

P2 also spoke about how he can relate to his clients in many ways. P2 stated:

> Having experienced racism on a first-hand experience, both as a Latino, Spanish speaking Latino, and being told I can't speak Spanish in the military or I would be punished for it.

P2 was able to generalize his experience of discrimination to others and believes it makes him a better clinician. He assumes that if he knows the feeling of discrimination, especially for being a *light skinned Latino* then he can put himself in the shoes of a Black man facing discrimination. He does not presume that feeling or experience is the same but believes he can relate, and the relate-ability can deepen the therapeutic relationship. P2 spoke at length of many possible relatable experiences between he and his clients including verbal and physical abuse, witnessing community violence, having a father incarcerated, and growing up in the same locations as the clients served. P2 reported seldom using self-disclosure with clients but uses his experiences to inform how he approaches his cases, including the patience or attention to certain issues that he brings to his work.

Theme 2: Culture and treatment planning

Given that all the participants think attending to culture is important, one might assume that culture influences the participant's conceptualization of a client's case and the case treatment planning. What this research revealed is that only two clinicians were considering culture when developing treatment goals or a client's diagnosis. P2 and P8 were the only participants in the study to address culture on diagnosis. P2 stated that he sees the value in acknowledging that some mental health presentations, such as seeing ghosts, may be culturally based. However, his supervisors do not allow him to address this consideration of causality of symptom presentation in his clinical work, so he does not report on it. P8 stated, "culture is important in creating treatment and also that we can better write something (goals) that's going to benefit their overall treatment and their progress". One participant did acknowledge that culture should be a lens through which the presenting problem is viewed so that "you can know what is a problem and what is part of their culture". Conversely, another participant stated, "I don't know if culture plays a significant role in clinical treatment". One participant reported that she considers culture in treatment planning only insomuch as it informs to whom she will link the client for support services. For example, if a client's family is religious, she will link the client to church activities if possible and proper. Three participants reported that they focus their goals more on the presenting problem or specifically on the theoretical lens informing treatment. One participant, for example, stated that she writes the client goals

specifically to issues such as anger or depression and does not take culture into consideration. Furthermore, one participant said she intentionally leaves out culture when she writes a goal if she believes the client's family cannot handle seeing the goal with a cultural consideration, such as in the case of a client who identifies as gay.

Theme 3: How does one learn about culture?

In this study I asked participants to describe any training they had that has prepared them to address culture in their work with clients. The responses to this question varied greatly and few participants had similar answers. P1, P2, P3, and P5 all spoke about learning "a little" about culture in their educational settings. P2, who just completed a doctoral dissertation on culture, cited the Sue and Sue book as being something his University introduced him to. He also reported that he had both cultural courses at school and that the topic of culture was covered in other classes at his school. P1 and P3 were clear that they never had specific classes on culture but that the topic of culture was "mixed into other classes". P4 stated that she has no memory of culture ever being addressed in her college classes.

Several participants also spoke about gaining knowledge about cultural and mental health treatment through formal work trainings. P3 stated that there are "mandatory annual trainings on culture" at her agency and trainings she needed to complete as a new hire. P2 and P4 also mentioned the mandatory trainings but could not describe what they learned in these trainings. P4 stated, "I wish I could remember more

from the LGBTQ training". P4 also reported that she "thinks there is a cultural attunement training series at her place of employment, but she is not sure". As the former Corporate Training Manager for this company and author of several of the training modules I can attest that there is a cultural training series, both in person and online.

Other participants spoke to getting knowledge about the topic of culture and mental health treatment more organically. P6 explained that as a child she used to have to "translate for her parents" so she learned about cultural discrimination and hardships by having lived them. P3 explained that her mother was a social worker and exposed her to the topic of culture and working with diverse types of individuals at an early age. P4 stated that she watches documentaries to learn more about diverse cultures. P4 also explained that she has learned from being "thrown into different situations and having to figure out how to make them work". She says having a diverse clientele has provided her with a "cultural education". P5 says he learns about culture through conversations with coworkers and through case discussions at treatment team meetings. P8 says,

> I would be lying if I would have told you that it's because of my experience with working with different populations. I think it's mostly because of my own experiences. Growing up, I did feel more influenced by people who 'understood me', who got where I was coming from. They didn't necessarily have to be Hispanic. They didn't have to be female. They just had to understand where I was coming from. My counselor from high school was the person who made the

> biggest impact on me. She happened to be white. She happened to be a bisexual female, but she was understanding of my needs and my emotional state and she cured everything she had towards that. She didn't focus on other aspects of them, so she was like, 'What, do you need from me? And I'm going to help you'. I saw the way she did it. The fact that race nor sexuality had any role in it. It's just her listening and understanding and just taking in it as it was and not trying to like, Oh I don't really know it, can't really understand you because I didn't experience the same thing you did. No, but you learn from my experience.

In addition, P1 says that when necessary she will complete independent research on a cultural topic if it will help in her work.

Theme 4: Discrimination can exist in the therapeutic relationship

While discussing challenges that therapists face when addressing culture, I became aware of two things. First, that the therapists interviewed for this study did not report running into many challenges in addressing culture, and that the therapists see challenges both as theirs and as those experienced by the clients. About the latter, therapists acknowledged that their race, age, and gender can be barriers to treatment at times. P2 reported that sometimes female clients will not feel comfortable working with him because he is male. P3 reported that "some people are afraid of white people" so they do not want to work with her. P5 reported that some clients do not want to work with him because he is black, and P2 says he has experienced this as well for being Latino. P1, P3,

and P6 all reported that clients have refused to work with them due to their age, and specifically P6 said a barrier for a client system was that she “has no kids”.

Challenges faced by therapists about culture and mental health treatment include not understanding a culture, discriminating against a person’s culture, inter-generational gaps, and language. Regarding the lack of understanding, P1 spoke about now knowing about some cultures, such as Jehovah’s Witnesses, and having a client system that is not willing to discuss it with the therapist. P4 shared a story also of how a lack of knowledge was a challenge, but hers related to not knowing how to help. In this culturally-bound story, P4 explained that a grandmother was raising her grandchildren and was experiencing extreme poverty and health concerns. Grandmother is monolingual Spanish speaking also. About this story, there were several cultural considerations at play and the therapist felt overwhelmed by need of this family system.

Discrimination as cited by P2 specifically related to working with the LGBTQ community. He described that he grew up Catholic and he did not understand nor support homosexuality. This was a barrier to his working with some clients. However, this participant reported that he has a cousin who is a social worker and has recently come out as a lesbian. As such, he is reassessing his view on this topic.

Therapists in this study also noted that inter-generational gaps are a challenge to their work with clients. Stories they shared included age differences, such as in cases where grandparents are raising their grandchildren, and differences between the culture of

the family and American culture. The latter included stories of cultures accepting corporal punishment versus the United States which does not.

Another challenge noted by therapists included addressing culture in client treatment is language. The study participants reported that due to their geographic location they get many referrals in which the family does not speak English, or where English is the second language. P6 spoke extensively about this. Fortunately for P6, she speaks Spanish, so she can navigate this challenge well. Other participants spoke of having to work with translators to develop relationships with the client's parents, which they feel can hinder the therapist-client relationship.

Theme 5: Evidence-based practices are not the solution to culturally attuned mental health treatment

Of the eight participants interviewed, few practiced the same evidence-based practice. Evidence-based practices represented in this study included Managing and Adapting Practices (MAP), Alternative for Families Cognitive Behavioral Therapy (AFCBT), Trauma Focused Cognitive Behavioral Therapy (TFCBT) and Incredible Years IY). Of the eight participants, none of them spoke of their experience with evidence-based practices improving their attention to culture. However, several participants did note that the evidence-based practices they have used do address culture. One participant spoke of her understanding of MAP. In this practice she explained that client data is put into a "dashboard" and recommended interventions are generated

because of the data inputted. She revealed that often if cultural specifiers are a part of the client descriptors then the choice of interventions is limited. As such, she often excluded culture as a client descriptor when using the dashboard. One participant spoke of his experience with TFCBT. He believes TFCBT decreases attention to culture and focuses instead on "time", defined by how quickly one can complete the model. He explained, "some cultures take 4 to 5 sessions to build rapport, whereas with this model you only have so much time to be finished so this is not an option". He also spoke of his awareness that TFCBT does not "respect Catholic Latino immigrant's beliefs in apparitions".

Another participant also addressed the role of TFCBT on culture and mental health treatment. She explained that the design of TFCBT is more for "office-based work" and that she thinks the model does not take into consideration the community setting in which they have to work. She acknowledged that she will do her best to adapt the practice to address culture whenever possible but that there are logistic concerns that often get most of her attention.

Another participant also spoke of her experience with MAP. She explained that the dashboards will lay out treatment for the therapist but she "is going to do what she thinks is in the client's best interest" and then she will find a way to write it into a note that passes the evidence-based practice criteria. She further explained that if the client "needs to be at a different place than the session of that practice dictates I am going to be where the client needs".

One participant spoke of his experience with IY. He explained that IY is manualized treatment for clients and families. He believes that IY often does not respect the cultures with whom they work. He suggested that this has to do with where this model was created (Seattle), the creation setting (classrooms), and the creator (a Caucasian individual). He did acknowledge that the agency staff where he works do adapt the model to better address the cultural needs of their clients.

One participant spoke of her experience with AFCBT and IY. She expressed satisfaction with the AFCBT model's design in that it gives the therapist a structured way to discuss the family history. She believes this gives her a chance to address culture through a structured interview. She expressed thinking that this piece is missing in IY. This participant further explained that she finds IY "idealistic" in that this is how life "should be" but that it is seldom like that, so she and her co-workers adapt the model to better fit the needs of the clients.

One participant did not appear to have experience with evidence-based practices personally but did have knowledge of them through her position at the agency. She believes that evidence-based practices are "hard to do with families because they are so broad, and families need specific treatment". An example of this, she explained, would be a client may not need to walk through a treatment module in its order but may need to focus on communication skills or assertiveness.

The results of this inquiry show that evidence-based practices have not answered the question of how to address culture when supplying mental health treatment. As revealed, some evidence-based practices do have a cultural influence, but none was reported rooted in a cultural foundation by the participants. Furthermore, most participants reported having to adapt whichever model they were delivering to address culture more effectively. In some cases, the therapists even removed cultural considerations to use their evidence-based practice, such as in the case of MAP.

Outliers

The was some data revealed in this study that is notable although did not prove to be a theme. P2 raised the question of what clients should expect from therapists about culturally attuned care. In other words, he reported that clients do not understand the concept of culturally competency and therefore they do not expect it about their care nor know how to rate it if asked about whether they are receiving it. He suggested some form of education to clients about when they should expect regarding culturally attuned care.

P4 raised a concern on how to balance learning with productivity. At this agency, the employees have a productivity quota to meet. Although this participant would like to attend more trainings to increase her cultural competency, she reports that she "does not have time to go" and the company does not flex productivity to accommodate training.

P6 also expressed a desire to attend more trainings, and experiencing a time constraint, however her motivation was specific. P6 reported being aware that sometimes

she experiences biases with her clients and she believes more education would assist her with addressing this and improving her overall care to clients.

Summary

The purpose of this qualitative, descriptive case study was to understand the ways in which community-based associate clinical social workers deliver culturally competent mental health services to clients in the engagement phase of client treatment. The eight participants of this study proved to be ethnically diverse as well as diverse in training and length of time in practice. Despite their differences, themes appeared about their attention to culture when they work with clients. The prevalent themes of this study are that (a) attending to culture builds therapeutic relationships (b) culture is not influencing treatment planning (c) cultural knowledge is learned in several ways (d) discrimination can be present in the therapeutic relationship (e) and evidence-based practices are not addressing culture. In Chapter 5 I will interpret these findings as well as address their implications for future research.

Chapter 5: Conclusions and Recommendations

Overview of Findings

My purpose in this qualitative, descriptive case study was to understand the ways in which community-based associate clinical social workers deliver culturally competent mental health services to clients in the engagement phase of client treatment. I looked to learn the practices that social workers use and find to be particularly effective as well as barriers to addressing culture in their work with clients. In this chapter I include a discussion of the major findings of this study as related to previously published literature of culturally competent mental health service delivery. In this chapter I also include a review of the limitations of the study and areas for future research.

To better understand how community-based mental health professionals deliver culturally competent services to clients during the engagement phase of treatment, the following research question framed the research:

> RQ1: How do associate clinical social workers who provide in-home mental health services in Los Angeles deliver culturally competent services to their clients?

In this study, I used a qualitative research tradition and a descriptive case study design, and I included in-person interviews with eight research participants. The theory that guided the research and research interpretation was multiculturalism. The prevalent themes revealed from this study are that (a) attending to culture builds therapeutic

relationships, (b) culture is not influencing treatment planning, (c) learning cultural knowledge occurs in many ways, (d) discrimination can be present in the therapeutic relationship, and (e) evidence-based practices are not addressing culture.

Interpretation of the Findings

My motivation to conduct this research stemmed from more than 20 years of practice in the social work arena in Los Angeles, where the pressure to deliver culturally competent mental health services has continued to grow. However, unlike with other practice mandates such as evidence-based practices that have clear cut practice steps or models of delivery when releasing them, the construct of cultural competency and its execution remain nebulous. I initially thought I must lack knowledge of the subject, so I dove into the subject matter to find the answers I needed to understand the concept of cultural competency and meet the needs of clients. Admittedly, I was surprised to find a gap in literature on this subject. Social workers have a mandate to deliver culturally competent care (NASW Code of Ethics, 2016), yet literature revealed that no one really knows how to do so (Ahmed et al., 2011; Aisenberg, 2008). This revelation begs the questions then of whether social workers are meeting their mandate and, if so, how they are doing it.

The results of this study revealed that there is no one practice being used by the study participants as the gold standard of culturally competent care. The study participants did not even list some best practices about cultural competence. The

participants' responses to the question of how they do their job in a way that attend to culture elicited varied responses. Some participants rely on their therapeutic training to guide their clinical work and build rapport with clients without attention to culture, whereas others are attending to culture for relational reasons rather than clinical ones. The primary theme of this study revealed that attending to culture builds therapeutic relationships. Other participants implement a wait and see mentality. In other words, they read the situation and respond accordingly. Some use commonality between them and the client to bridge the cultural gaps, whereas others ask questions about culture. It appears that despite the continued attention to the topic of cultural competence, social workers are still unsure of what it means to deliver culturally competent services. What is clear is that they know it is important to address culture and they try in many ways to give some attention to culture in their clinical work with clients.

One of the historical reported barriers to social workers addressing culture with clients is the lack of a clear definition of the term. The definition of *culture* used in this study comes from Merriam et al.'s (2007) definition of *culture* as "the shared behavior and symbolic meaning systems of a group of people" (p. 223). In 2011, the term *cultural*, and thus *cultural competence*, expanded to include all groups at risk for exclusion (Harrison and Turner, 2011). A positive outcome of the study presented here is that participants reported an understanding that culture includes more than place of origin. In several instances the study participants referenced other cultural groups such as religious

groups, racial groups, groups of a certain socioeconomic status, and those who identified as gay, lesbian, bisexual, transgender, and questioning. Social workers appear to have a solid understanding of the definition of culture, yet they do not seem to know how to best address culture in their work with clients in a way that will generate positive outcomes. Participants spoke confidently, in most cases, of adapting their practices organically to address culture and learning from their experiences on what worked or did not.

Study participants spoke comfortably about the topic of culture but only one addressed the wording of *culture competence* specifically. Participant 5 explained that he does not believe that cultural competence is a phenomenon. He explained that he sees the process of gaining cultural awareness as an ongoing one throughout one's professional career. This is in alignment with earlier research that explained cultural competence as a continual journey as opposed to a destination (Saunders et al., 2015). Furthermore, current research has shifted the term yet again and the latest incantation is cultural humility. Cultural humility focuses on a respectful relationship between the provider and the client, and on the need for the provider to practice reflection and behavioral adjustment when needed (Danso, 2016; Kools, Chimwaza, & Macha, 2015).

Only one study participant mentioned the term *cultural competence*. Does this mean the others do not consider the topic at all? All study respondents reported that it is important to address culture in work with clients, but very few spoke of gaining cultural knowledge or skills as a personal goal or necessity to becoming better clinicians. No

participants spoke of wanting to master a certain level of skill about cultural competence. I wonder if this is because they do not understand what a threshold of success would be in this area. Other participants spoke of recognizing that they would like to better their skills around cultural competence but when dealing with competing work priorities they often allow cultural trainings to fall to the bottom of their task list, or to fall off of the list altogether.

Earlier literature also reported that some clinicians do not want to learn about culture (Chao et al., 2011) or do not think it is important to a client's presenting problem (Sehgal et al., 2011). Half of the participants in this study spoke as if they know learning about culture is important but they do not think it is imperative. No one shut down the idea of attending cultural trainings, however most participants preferred to use their clinical skills to assess client (cultural) interactions and adapt their work with attention to people skills rather than textbook knowledge about other persons of a particular culture. This became clear when one participant stated that she does not read anything about a client prior to meeting them despite being given demographic and historical information about them ahead of time. She explained that she does this because she wants to form her own impressions of them and read the situation without preconceived judgements. In another example, when speaking about evidence-based practices one participant said she specifically removes cultural qualifiers when trying to determine interventions for clients as she prefers to find the therapeutic *best fit* in her clinical impression rather than what

has been prescribed based on culture. Furthermore, several participants reported that although they know they did attend cultural trainings at their workplaces they do not remember what they learned. This shows they did not think it was important enough to internalize the information and use it in their work.

With the professional mandate for social workers to deliver culturally competent care it seems helpful to have support from the social worker's agency to do so, such as when study respondents spoke of receiving the help of translators if they do not speak the language of the parents of their clients. This is one place where the agency that allowed recruitment for this study seemed to support its staff. In 2012 the Office of Health and Human Services released guidelines for culturally and linguistically proper services (CLAS). CLAS are those practices that demonstrate respect and responsiveness to an individual's "current health beliefs and practices, preferred languages, health literacy levels, and communication needs" (USHHS Office of Minority Health, 2016, para. 1). Per my observations, and study participants reports, the agency where the respondents work have front office administrative staff who are bilingual and multiracial, has literature for clients in multiple languages, and offers mental health services in multiple languages. Furthermore, per participants' reports, this agency has an extensive training program offered to their staff on culture and the coursework is both online and in person. Unfortunately, the participants of this study reported that finding time to attend trainings is a challenge due to work productivity requirements, so they often do not attend the

trainings available to them unless mandated to do so. In addition, as has been previously reported, two participants reported not remembering what they learned at the trainings, and one said she "wished she remembered more."

Another significant finding of this study that is in alignment with earlier research and clearly warrants further exploration is whether there is merit to cultural matching in mental health work, and if so, whether this variable creates more significant outcomes in mental health treatment than other variables such as training or years in practice. Per reports of the study participants, the participants serve a large monolingual Spanish speaking population and culturally matching the clients with Spanish speaking clinicians who identify as being of Hispanic/Latino/Mexican descent. Per the participant's reports, the cultural matching provides instant rapport in most cases and often results in the families reporting feeling more comfortable with the services they were receiving. In this study another revelation was that some families did not want to work with a certain social worker because of the social worker's race or culture due to distrust of that culture. Earlier literature has showed that one contributor to mental health disparities is lack of cultural matching (Roysircar, 2009) and my findings appear to be saying that clients find comfort with being culturally matched.

Implications

Despite the years of attention to the concept of cultural competence in the social work profession, social workers are clearly still struggling with what the term means. My

study revealed that without direction practitioners are trying various methods to address culture with clients such as using self-disclosure, asking questions, and taking part in rituals with clients to gain cultural knowledge and align with the client. The effectiveness of these practices is still unclear, but culture is receiving attention in mental health work with clients. According to earlier research, a lack of attention to culture leads to disparity in mental health services between the mainstream community and unserved or underserved persons. At least some attention to culture is occurring, but currently the effects of this attention are unknown. This shows an area of future exploration. It is important to learn if clients perceive the attention to culture they are receiving by their social workers as helpful, and if so, in what ways. Furthermore, research is necessary to learn how specific cultural interventions, such as cultural matching or cultural conversations, affect treatment outcomes.

Another area for future research relates to cultural matching. Racial and cultural tensions in Los Angeles are critically high due to the political climate. If certain racial and cultural groups were historically hesitant to work with social workers from other cultures due to historical wounds, the challenge may be even greater now for social workers to help client systems from diverse cultures to feel comfortable to receive mental health services from them. Many of the study participants reported that their clients' families appreciating being culturally matched. The effect on mental health disparity rates need measuring when using cultural matching techniques. Mental health professionals

need to learn in what ways cultural matching affects disparities rates in mental health service delivery and use. Furthermore, do families feel that cultural matching is more important than skill level or relational skills when it comes to receiving mental health services? What variables create better service outcomes? Studies in this area are also necessary.

Limitations

The limitations for this study included the data collection tool, the presence of the researcher, and time. I recognize that I used only one tool to gather research data. This meant that the data were not as rich as if I had gathered interview data and surveys from clients, for example. However, the interview questions were deliberately broad, and this allowed the participants to respond as they deemed appropriate without any direction from me. The broadness of the questions also kept the interviews open and helped manage bias as there was no steering from me toward any preconceived ideas of what the data should reveal.

Qualitative research also has the limitation of time. Time could have been a challenge both in terms of conducting interviews and analyzing the data. To address the time constraints about the interviews I scheduled each first interview to be 60 minutes and then additional time was set aside for follow up interviews if needed. No participant needed an added interview meeting. About data analysis, I scheduled time each week to

work with the data and set realistic goals for myself so that I did not overlook any important themes or rush analysis.

My presence in the interviews is also a limitation. My presence could have intimidated interviewees. To offset this potential barrier, I thoroughly explained that I have no affiliation with their employer, the parameters of confidentiality for their participation, and that any and all data they shared with me would be valuable. Prior to beginning the questions, I explained that an answer of "I don't know" would even be valuable data so to please be honest as it was all important to the study. When I attended the interviews, I tried to appear warm and approachable to create a welcoming environment and I dressed casually.

Conclusion

Social workers have the mandate to supply mental health services to clients in a way that attends to culture yet have no clear direction of what that means. There are practices suggested that are theoretical in nature and have face validity such as Sue and Sue's (2008) multicultural practice guidelines, but there is no clear picture of how to deliver culturally competent services. As such, social workers are continuing to use their intuition married with trial and error and educational knowledge to try to meet the mandate. What is clearly necessary is an industry standard definition, at a national level, of the concept of cultural competency recognized across the profession. If such a definition existed and was recognized profession-wide, then it could serve as the frame of

reference by which practice professional skill level could be assessed. This definition could also be the benchmark by which practice protocols, such as evidence-based practices, could measure about cultural standards. This would address the barrier that study participants spoke of when they reported that most evidence-based practices either do not address culture or do not do so effectively.

Therapists clearly recognize the importance of the topic of culture when working with clients, as this study revealed addressing culture is with all study participants whether through client-therapist commonalities or intentional cultural exploration and deliberate design. Furthermore, earlier research highlights that the mental health industry recognizes that when culture goes unaddressed in mental health treatment then disparities in mental health use and service delivery exist for unserved and underserved populations. If social workers want to reduce disparities for unserved and underserved populations how would they do so? Participants in the study described trying various tactics to address culture and then adjusting their attempts according to the responses they believe they receive from the clients. Although I commend their efforts, I would suggest that a more directed model would be more effective. Further research needs to determine which cultural interventions generate the greatest treatment outcomes. This research would need to be rigorous and extensive as there are multiple variables to consider including practitioner's length of time in practice, practitioner's skill level, client diagnosis and addressing treatment issues to name a few. When certifying evidence-based practices as

such they come with a set of interventions that repeated over time and have proven positive treatment outcomes for clients. This should be the same standard for any culturally competent programming. For example, the design of a study could be to determine if cultural matching generates greater treatment outcomes than treatment protocol for referral issue. In other words, would cultural matching create greater treatment outcomes for a client than a client not culturally matched to the therapist but receives an evidence-based intervention designed to treat grief and his referral problem is death of a spouse?

Not only do the types of cultural interventions call for exploration but the degree does as well. For example, there could be the revelation that cultural matching is helpful but not imperative. Or, that cultural matching is vital to better treatment outcomes for clients. How important the cultural factors and interventions are, such as practicing humility and asking questions, is vital information to the therapeutic process also.

The data revealed in this study aligns with previously published research and clearly shows the next step. Social workers understand that cultural is important to the mental health treatment process. The participants in this study stated that they address culture for the purpose of rapport building and sustaining the therapeutic relationship. Study participants also understand the ways in which not addressing culture can be a barrier to the treatment process. This is also in alignment with previously published research, which states that there is a disparity of mental health service utilization rates

among unserved and underserved persons and the mainstream population. Furthermore, historical research and this study both revealed that practitioners are trying various techniques to address culture because they do not know which techniques generate the best treatment outcomes. Therefore, it is vital to establish a nationally recognized definition of culturally competent care as the industry standard. This definition would serve as the gauge by which mental health professionals could measure their service delivery, practice protocols such as evidence-based practices could measure their attention to culture, and clients could measure their receipt of culturally competent mental health service delivery.

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Appendix A: Interview Tool

Name: _____

Interview Question:

Describe how you do your job of providing mental health services in a way that attends to a client's culture.

a. What are your thoughts about the need to attend to a client's culture during treatment and can you speak a little to how you have come to this belief system?

b. Please describe any specific training you have had that helps you with attending to a client's culture during service delivery?

c. Please describe any challenges to attending to a client's culture during service delivery?

d. How has the shift towards the use of evidence-based practices altered attention to culture during service delivery?

For how many years have you been working in the field of mental health?

_____

How do you identify with regard to ethnicity? _____

How do you identify with regard to gender? _____

Appendix B: Informed Consent

CONSENT FORM

You are invited to take part in a research study about culturally competent mental health service delivery. The researcher is inviting associate clinical social workers who deliver mental health services to their clients in the client's home, or in the community, in the city of Los Angeles to participate in the study. Participation in this research is no way affiliated with your employment at Star View Community Services. Participation is completely voluntary. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Christine Cearfoss, who is a doctoral student at Walden University.

Background Information:
The purpose of this study is to understand how associate clinical social workers who provide in home mental health services in Los Angeles deliver culturally competent services to their clients.

Procedures:
If you agree to be in this study, you will be asked to:

- Meet with Christine Cearfoss at a location of your choosing, or if you prefer, at a private and convenient location arranged by Christine, for a 60 minute interview.
- Allow Christine to audio record the interview for transcription of the audio following the meeting. The transcription will be shared with you at a later date.
- Schedule a follow-up meeting at your convenience if you feel that you have not adequately expressed everything that you would like to say about the topic in the original 60 minute interview.
- Read a transcript of the interview, that will be provided to you via email, to ensure that you are represented as you desire to be represented. Reading the transcript should take no more than 30 minutes.
- After reading the transcript you will be asked to add to it if you feel anything was missed. Please do not consult with outside sources in doing so.
- Read, correct or add to the transcript if necessary and return the transcript to the researcher via email within one week.

Here are some sample questions:

- Describe how you do your job in a way that attends to a client's culture.
- Desccribe challenges around delivering culturally competent services?
- How do evidence-based practices play a role in the delivery of culturally competent services?

Voluntary Nature of the Study:
This study is voluntary. You are free to accept or turn down the invitation. No one at Star View Community Services will treat you differently if you decide not to be in the study. If you decide to be in the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:
Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as becoming upset or stressed discussing the topic of cultural competency or barriers to mental health service delivery. Being in this study would not pose risk to your safety or wellbeing.

Your participation in this study can benefit clients receiving mental health services via a community mental health service delivery model. Specifically, your contribution will help to identify where current gaps exist in training and service delivery regarding cultural competence, while it can also help to identify best practices with regard to culturally competent mental health service delivery. Research has shown that when there is attention to cultural competency in the delivery of mental health services then more clients engage in mental health care, stay longer in treatment, and demonstrate greater positive mental health gains.

Payment:
For your participation in this study, a donation of $20 will be made in your name, or anonymously if preferred, to a social cause of your choosing.

Privacy:
Reports coming out of this study will not share the identities of individual participants. Details that might identify participants, such as the location of the study, also will not be shared. The researcher will not use your personal information for any purpose outside of this research project. Data will be kept secure by (1) each participant will be assigned a number and his/her responses will be attached to their assigned number, not their name (2) the key for the number/name assignment will be kept separate from all other research data and will be password protected (3) all research data will be kept on a password protected computer. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via phone at 562-276-8573 or email at Christine.cearfoss@waldenu.edu. If you want to talk privately about your rights as a participant, you can call the Research Participant Advocate at my university at 612-312-1210. Walden University's approval number for this study is **06-27-18-0294117** and it expires on **June 26th, 2019.**

The researcher will give you a copy of this form to keep.

Obtaining Your Consent

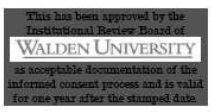
If you feel you understand the study well enough to make a decision about it, please indicate your consent by signing below.

Printed Name of Participant _____

Signature of Participant _____

Date of Signature _____

Signature of Researcher _____



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