

California State University, San Bernardino

**CSUSB ScholarWorks**

---

Theses Digitization Project

John M. Pfau Library

---

2002

## Project design of the multicultural education and training structured interview for cultural formulation

Dione Nicole Johnson

Follow this and additional works at: <https://scholarworks.lib.csusb.edu/etd-project>



Part of the [Multicultural Psychology Commons](#)

---

### Recommended Citation

Johnson, Dione Nicole, "Project design of the multicultural education and training structured interview for cultural formulation" (2002). *Theses Digitization Project*. 2117.

<https://scholarworks.lib.csusb.edu/etd-project/2117>

This Project is brought to you for free and open access by the John M. Pfau Library at CSUSB ScholarWorks. It has been accepted for inclusion in Theses Digitization Project by an authorized administrator of CSUSB ScholarWorks. For more information, please contact [scholarworks@csusb.edu](mailto:scholarworks@csusb.edu).

PROJECT DESIGN OF THE MULTICULTURAL EDUCATION AND  
TRAINING STRUCTURED INTERVIEW FOR CULTURAL  
FORMULATIONS

---

A Project  
Presented to the  
Faculty of  
California State University,  
San Bernardino

---

In Partial Fulfillment  
of the Requirements for the Degree  
Master of Science  
in  
Psychology:  
Clinical/Counseling Psychology

---

by  
Dione Nicole Johnson

June 2002

PROJECT DESIGN OF THE MULTICULTURAL EDUCATION AND  
TRAINING STRUCTURED INTERVIEW FOR CULTURAL  
FORMULATIONS

---


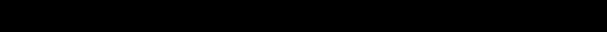
A Project  
Presented to the  
Faculty of  
California State University,  
San Bernardino

---

by  
Dione Nicole Johnson  
June 2002

Approved by:

  
  
David Chavez, Chair, Psychology

  
  
Robbin Huff-Musgrove

  
  
Jean Peacock

06/05/02  
Date

## ABSTRACT

The purpose of this project is to outline a validation study demonstrating the utility of the Multicultural Education and Training Structured Interview For Cultural Formulations (METSICF). This tool is multidimensional. Primarily, it is designed to assist staff in assessing cultural factors that might impact symptom manifestation. Interviewing clinicians should develop an illustrative cultural formulation using an in-patient forensic population from the following racial groups: African American, Latino, Asian American, and Caucasian. A representative number of clinicians from identical racial groups across the disciplines of psychiatry, psychology, and social work will administer the structured interview and use the elicited information to write a culturally-sensitive treatment summary report. Expert judges will rate both the items in the structured interview and summary reports, creating rating criteria to establish content validity.

An analysis of summary reports will compare the number of culturally sensitive statements by level of interview, structured and unstructured. Ethnic matching between the clinician and patient in the structured and unstructured interview groups serves as the controls for the effects of ethnicity on the elicited number of reported statements. Clinicians will complete the

California Brief Multicultural Competence Scale (CBMCS) because it is expected that their degree of cultural competence will influence the quality of cultural formulations.

Descriptive statistics and a two-way ANOVA will be used in the future to summarize the data and test construct validity, respectively. Experts in the field of cross-cultural psychology will evaluate the interview tool to establish content validity. Implications for the structured interview to facilitate a more culturally sensitive treatment plan are explored.

## ACKNOWLEDGEMENTS

I would like to thank the members of my project committee: Dr. Robbin Huff-Musgrove, Dr. David Chavez, and Dr. Jean Peacock. Thank you Robbin for all of your patience and dedication. Words cannot begin to express how thankful I am to you for all of the kindness and support that you have given me since my move to California.

Many thanks to Dr. David Chavez and Dr. Jean Peacock. David, much appreciation for providing opportunities for expression and growth without judgment. Dr. Peacock, I am truly appreciative of your time and input.

## DEDICATION

To my family - our accomplishment

## TABLE OF CONTENTS

ABSTRACT .....	iii
ACKNOWLEDGEMENTS .....	v
CHAPTER ONE: THE IMPETUS FOR DEVELOPING A STRUCTURED INTERVIEW	
Statement of the Problem .....	1
Scope and Significance .....	2
Definitions .....	4
Limitations of the Project .....	5
CHAPTER TWO: LITERATURE REVIEW	
Introduction .....	7
History and Sociology .....	10
Spirituality .....	15
Psychological Practices .....	26
Cultural Competence .....	31
New Direction in the Diagnostic And Statistical Manual .....	37
Multicultural Education and Training Structured Interview For Cultural Formulations .....	40
Initial Hypotheses .....	44
CHAPTER THREE: PROPOSED METHODOLOGY	
Introduction .....	47
Instrumentation .....	47
Procedures .....	51
Data Analyses .....	56
Secondary Hypotheses .....	56



#### CHAPTER FOUR: ANTICIPATED RESULTS

Introduction .....	58
Expected Findings .....	58

#### CHAPTER FIVE: DISCUSSION

Summary .....	61
Conclusions .....	63
Recommendations .....	63

APPENDIX A: CALIFORNIA BRIEF MULTICULTURAL COMPETENCE SCALE .....	65
APPENDIX B: MULTICULTURAL EDUCATION AND TRAINING STRUCTURED INTERVIEW FOR CULTURAL FORMULATIONS .....	69
APPENDIX C: CULTURAL FORMULATION REPORT TEMPLATE .....	77
APPENDIX D: MULTICULTURAL EDUCATION AND TRAINING CULTURAL FORMULATION SCORING SHEET .....	79
APPENDIX E: CLINICIAN INFORMATION AND BACKGROUND FORM .....	82
APPENDIX F: MULTICULTURAL EDUCATION AND TRAINING STRUCTURED INTERVIEW FOR CULTURAL FORMULATIONS: EXPERT RATER FORM .....	84
APPENDIX G : MARLOWE-CROWNE SOCIAL DESIRABILITY SCALE .....	92
APPENDIX H: CALIFORNIA RESEARCH PARTICIPANT'S BILL OF RIGHTS .....	95
APPENDIX I: PATIENT INFORMED CONSENT .....	97
APPENDIX J: CLINICIAN RECRUITMENT SCRIPT .....	101
APPENDIX K: CLINICIAN RECRUITMENT LETTER .....	103
APPENDIX L: PATIENT RECRUITMENT SCRIPT .....	105
APPENDIX M: CLINICIAN INFORMED CONSENT .....	107

APPENDIX N:	MANUAL FOR THE ADMINISTRATION OF THE MULTICULTURAL EDUCATION AND TRAINING STRUCTURED INTERVIEW FOR CULTURAL FORMULATIONS .....	111
REFERENCES	.....	117

CHAPTER ONE

THE IMPETUS FOR DEVELOPING A  
STRUCTURED INTERVIEW

Statement of the Problem

The number of individuals, particularly ethnic minorities, whose behaviors and symptoms are misdiagnosed or overpathologized by mental health professionals, is disturbing. In particular, individuals whose cultural values and beliefs clash with those of their primary clinician may often times be misconstrued. For example, such errors are seen in the number of African Americans who present with depressive symptomatology that are misdiagnosed with schizophrenia (Russell, Fujino, Sue, Cheung, & Snowden, 1996). Good and Good (1986) also report that as many as 75% of Latino clients may be overpathologized and misdiagnosed.

One explanation for misinterpretation of behavior that is outside of the dominant culture's standards for behavior is what Good and Good (1986) termed the "category fallacy." A category fallacy is at work when categories developed for one cultural group are imposed onto other cultural groups without establishing the necessary applicability to generalize. Such assessments and diagnoses that were not based on varying group mores and standards can lead to greater diagnostic error.

In an attempt to understand divergent hypotheses when viewing behavior, one needs to understand the way in which experiences are filtered through cultural perspectives. Some have suggested that culture is defined as certain meanings and behavioral norms that are learned and passed on within the main social group (Lu, Lim, & Mezzich, 1999). Cultural norms shape the perception of behaviors and symptoms as pathological or normative; indeed, the behaviors of individuals who are not part of a dominant culture may be more often perceived as pathological (Lu et al., 1999).

#### Scope and Significance

The purpose of this project is to outline a validation effort of a structured interview designed to examine the influence of cultural and spiritual factors to psychopathology. Some of the most important aspects of culture include religious and spiritual dimensions which are extremely influential in shaping beliefs, values, behavior and illness patterns (Browning, Gobe, & Evison, 1990). Culturally- predetermined factors such as beliefs and illness patterns are illustrated in the literature to be predictive of patterns of distress, perceived causes, and preferences for help seeking and treatment (Weiss, 1997). Cultural beliefs and practices affect varying aspects of treatment. For example, assessment and diagnosis, illness and help seeking behavior, and patient and practitioner

expectations, are influenced by cultural perceptions of psychopathology. The necessity of a framework from which to better guide clinical work will lead to an increased understanding of patients' unique and often idiosyncratic ideas and experiences of illness (Weiss, 1997).

The suggested validation of the tool would occur via analyses of cultural summary reports. These reports would include culturally sensitive information to be used in forming an integrated treatment plan for patients. The participants in the proposed study will come from the following four ethnic groups: African Americans, Latinos, Asian Americans, and Caucasians. With the ever-increasing ethnic and spiritual diversity of the twenty-first century, there is a need, now more than ever, for mental health professionals to enter treatment to incorporate the possible influences of culture.

New treatment plans should incorporate more culturally relevant information elicited from patients during the structured interview. The implications of such research appear to be promising as the first psychometric instrument designed to assess the cultural and spiritual formulation of judicially committed forensic inpatients. Additionally, the tool will better assist treatment staff in identifying cultural factors that are relevant for assessment, treatment planning, and service delivery. Moreover, if successful, the

project will provide an evidence-based approach to cultural assessment, diagnosis, and treatment planning.

### Definitions

Within the field of cross-cultural and ethnic minority psychology, there is a need to clearly identify and define constructs that will be examined. Constructs such as culture, race, sensitivity, and identification can often lend themselves to varying results in research depending on how investigators operationalize the effects of such terms on variables (Parham & Helms, 1981). This study will borrow from Lu, Lim, and Mezzich (1999) to define culture, which includes meanings and behavioral norms that are initially learned then passed on within the main social group.

A common definition of ethnicity refers to a social group of people within a cultural and social system that are united on the basis of commonalties, such as religion, language, ancestry, and phenotypic traits. The project will rely on this definition of ethnicity to justify the use of ethnic matching as an independent variable in the tool validation and inform expected results. Cultural competence is defined as attitudinal and skill-based, in that one is culturally aware of self and others in light of necessary skills to successfully interact with others from diverse cultural backgrounds (Hogan-Garcia, 1999).

Spirituality will include the referencing of certain beliefs and behaviors about a Higher Power. Beliefs and behaviors can be evidenced in a group or corporate manner, such as religious ceremonies or activities, or in an individual manner through meditation or prayer. Religion is usually defined by participation in social institutions that reflects one's views on divine and sacred ideals and practices (Miller & Thorsen, 1999).

#### Limitations of the Project

The major limitation of this project is that this is not the validation study of the METSICF. Due to reasons beyond control, the validation of the tool was not able to occur at this time. However, once implemented, the validation study of the tool will be in the beginning stages of establishing psychometric properties. The primary goal of this paper lies within outlining a validation effort of the Multicultural Education & Training Structured Interview For Cultural Formulation (METSICF). Therefore, establishing validity of the instrument is paramount. Also, as this research is a seminal piece to many forthcoming efforts, establishing reliability of the tool, via test-retest methods will occur at a later time.

This project introduces a study that is quantitative in design. The outlined validation study does not attempt to explain or clarify the possible emergence of themes that may

be present in both within- and between-group interview transcripts. Once the validation study occurs, future thematic content analysis of the interview transcripts and cultural formulations may reveal significant ethnic and racial differences in information reported, which may lead to increased item sensitivity and additional refinement.

Although an in-patient population is employed to collect data, future validation should occur with an outpatient sample. The applicability of such data to an outpatient sample will provide additional support for the inclusion of the structured interview into the standard assessment battery of clinicians. Future research should also focus on treatment outcome. More specifically, the effectiveness of the structured interview will correlate with more sensitive diagnoses and treatment plans, the amelioration of symptoms, and decreased length of hospital stay.



## CHAPTER TWO

### LITERATURE REVIEW

#### Introduction

A growing diverse ethnic and racial population in the United States suggests that the subsequent mental health needs of such groups will be just as varied. In the United States Surgeon General's report, *Mental Health: Culture, Race, and Ethnicity - A Supplement to Mental Health: A Report of the Surgeon General (2001)*, the recognition of disparate access to and quality of mental health care to racial and ethnic minorities is highlighted. The mention of existing inequalities serves as an impetus to set in motion changes in current government and community standards, policies, procedures, and practices aimed at the elimination of inconsistencies in mental health services for some of the nation's most under-served and under-represented populations.

A crucial step in eradicating disparities begins with the acknowledgement of the profound impact of culture in influencing and shaping attitudes toward mental illness, explanations of the illness, and the resulting help-seeking behavior. Even before the inception of a therapeutic

relationship, potential clinician and patient dyads are embedded within a cultural milieu with each inevitably bringing into the dyad cultural predilections of themselves and the other. For many minority clients, therapists are viewed as individuals whose purpose is not to help. Rather, such clients see therapists as perpetrators of cultural oppression (Sue, 1981) that label individuals without the recognition of societal influences on symptom development, manifestation, and expression (Szasz, 1974).

Central to the counseling profession is a set of cultural values and norms used to judge clients (Katz, 1985) that fails to appropriately assesses the behavior of many minorities. Criterion values and norms, drawing heavily from Eurocentric models and standards of behavior, stifles the profession's ability to be effective cross-culturally (Ivey, 1980). As a result, the traditional counseling theories - psychodynamic, existential-humanistic, and behavioristic - have been criticized (Katz, 1985). An emphasis on childhood experiences, developing self-concept or behavior modification fails to adequately avail treatment to addressing environmental factors such as racism or sexism (Katz, 1985).

Effective treatment of a racially and ethnically varied population calls for clinicians to demonstrate the ability to practice within and provide services that reflect a culturally competent level of care. Culturally competent care is defined as the "ability to provide services that are perceived as legitimate for problems experienced by culturally diverse persons" (Dana, Behn, & Gonwa, 1992). Such services use acceptable styles of service delivery to impart assessments and interventions.

An integral component to cultural competence at the treatment level includes considering the influence of race and ethnicity on clinical presentations and the possible impact of racially- and ethnically- biased stereotypes on the conclusions made by mental health providers. Some (Neighbors, Jackson, Campbell, & Williams, 1989; Adebimpe, 1981) have suggested that the development of a structured interview may hold constant the effect of race on clinical impressions and eliminate racial differences in diagnosis. A study conducted by Simon, Fleiss, Garlans, et al. (1973) compared the diagnoses of patients interviewed by research psychiatrists and hospital clinicians. Research psychiatrists utilized structured mental status interviews to diagnose. Results illustrated a differential

relationship between race and diagnosis in the assigned diagnoses of research psychiatrists and hospital clinicians. Race and diagnosis were strongly associated for the hospital clinicians as their diagnoses varied more across racial and ethnic groups and were similar to other studies in the assignment of disorders to certain racial and ethnic groups (Adebimpe, 1981). The diagnoses of the research psychiatrists showed no relationship between race and diagnosis as the use of a structured interview appeared to control for the influence of race in diagnosing.

## History and Sociology

### Anthropological Framework

The writings of Szasz (1974) highlight the necessity of understanding rules that influence classification and the purpose of outlined criteria. The field of anthropology informs the process of psychiatric diagnosis by accounting for cultural relativism. Cultural relativism points to the variability in diagnostic criteria and questions the applicability of such standards across cultures (Good and Good, 1986). The concept of cultural relativism is operationalized through "interpretive anthropology." "Interpretive" anthropology examines the societal and

culture-bound construction of illness (Kleinman, 1980). Standard procedures for diagnosing, which entail either characterizing individuals or groups according to a set of beliefs, or hypothesizing about a distinct personality type are tabled. Rather, clinicians and researchers rely on meaning systems, idioms of distress, and modes of expression that are culturally determined. In this manner, "interpretive" anthropology is primarily concerned with the shaping of belief systems and personality types of groups by such meanings (Good and Good, 1986).

Verbal and nonverbal communication of some ethnic minority groups illustrates interpretive differences on clinical presentations. The language of African-Americans and Hispanics, both rich with cultural connotations, meanings, and expressions, can often lead to confusion and misinterpretation in diagnosis. Often viewed as indirect and ambiguous, such communication has a protective function in conveying unorthodox and socially deviant beliefs and feelings (Szasz, 1974). Such meanings exert influence on "the experience, the expression, the character, and the projected course of distress" (Mezzich, Kleinman, Fabrega, & Parron, 1996).

With white behavior as the standard, the behavior of African-Americans, and many other ethnic minority groups, is frequently labeled pathological (Mezzich et al., 1996). For example, blacks often communicate their feelings by using vocabulary that denotes feelings of despair, frustration, and violence. The incorporation of such parlanes into speech may be an artifact of the frequent witnessing of violence in the black community. This language may be conducive to survival in certain subcultures in the black community.

Diagnosis. Patients who hold cultural values and beliefs that are in conflict with the treating clinician may be subjected to overpathologizing bias and misdiagnosis. Adebimpe (1981) and Neighbors et.al (1989) found such bias in the assessment of African American clients. African Americans with depressive symptoms tended to be misdiagnosed with schizophrenia. Good and Good (1986) also report that as many as 75% of Latino clients may be overpathologized and misdiagnosed. In an analysis by Mukherjee et al., (1983) the records of 76 bipolar patients revealed that more than two thirds of the clients had been previously diagnosed with schizophrenia. The earlier diagnosis of schizophrenia was considered

inaccurate because of the following: 1) the patients were in remission without residual signs of schizophrenia, 2) the patients were maintained with lithium for three years, and 3) none of the patients' diagnosis was revised to schizophrenia. A regression analysis revealed that Latinos and African Americans were previously mis-diagnosed with schizophrenia significantly more often than were Whites (Russell, Fujino, Cheung, & Snowden, 1996).

Similar discrepancies in clinical impressions were found in a study assessing the influence of culture on the diagnostic approaches of therapists with Chinese Americans. In a study conducted by Li-Repac (1980) five Chinese American and White American male therapists rated the functioning of Chinese and White male clients during a videotaped interview. This study found that the ethnicity of both clients and the therapists affected therapists' clinical judgements. White therapists rated Chinese American clients anxious, awkward, confused, and nervous. While Chinese therapists perceived the same clients as alert, ambitious, adaptable, honest and friendly. White therapists rated White American clients as affectionate, adventurous, sincere, and easy-going. Yet, Chinese therapists judged the same clients to be active,

aggressive, rebellious, and outspoken. In addition, White therapists rated Chinese clients as more depressed, more inhibited, less socially poised, and having a lower capacity for interpersonal relationships than did Chinese therapists. Chinese therapists rated the White clients as more severely disturbed than did White therapists (Russell et al., 1996).

Assessment. As illustrated, culture and ethnicity are key components to consider when relying on an interpretive framework to dictate clinical research and practice. In order to understand the divergent views of behavior, one needs to understand the way in which experiences are filtered through cultural perspectives. Some have suggested that culture is defined as certain meanings and behavioral norms that are learned and passed on within the main social group (Lu, Lim, & Mezzich, 1999). A culture's norms would influence the perception of behaviors and symptoms as pathological or normative; indeed, the behaviors of individuals who are not part of a dominant culture may be perceived more often as pathological (Lu et al., 1999).



## Spirituality

### Religion versus Spirituality

Religion and spirituality are not synonymous or interchangeable. Religion speaks to organized acts by particular sects that espouse to certain beliefs, rituals and practices (Miller & Thorseen, 1999). However, spirituality allows for frequent intrapersonal and subjective experiences that sometimes flow out of religion. Spirituality often adds meaning as the focus is on intangible elements outside of the boundaries embedded within attitudes and behaviors often set forth by organized religion. Part of the "new age spirituality" movement stems from organized religion, allowing persons to define and conceptualize those experiences that provide direction and purpose.

More often than not, the development and growth of spirituality is sabotaged by religion and religiosity (Miller & Thorseen, 1999). Where some teach that spiritual enhancement may be motivated by social and pious agendas of religious practice (Miller & Thorseen, 1999), others (Glock and Stark, 1965) view spirituality within religion according to the following four domains: the experiential, the ritualistic, the intellectual, and the consequential. Yet,

some categorize spiritual components within religion according to the mythological, ritual, experiential, dispositional, social, and directional (Capps, Rambo, & Ransohoff, 1976). Yet, a position of spirituality that lends itself more fully to qualitative and quantitative assessment methods conceptualizes spirituality within a psychosocial perspective embodying cultural, ethnic, socioeconomic, and religious differences (Miller & Thorseen, 1999). This view outlines spirituality in terms of spiritual practices, beliefs, and experiences.

Spiritual practices in terms of overt behavior are observed in some religious activities such as worship, singing, public prayer, or in fasting, meditation, and contemplation (Miller & Thorsen, 1999). Often set forth by culture, spiritual beliefs influence ideas about transcendence, deity, and dimensions extending beyond sensory and intellectual knowledge. Concepts of God, self-image, and personal morality and values are also encapsulated within spiritual beliefs. Integral to empirically understanding spirituality is spiritual experience. However, a consistent lack of clarity as to what embodies a spiritual experience persists. In addition to identifying the meaning and nature of such events, a

description of the experiences in nature and topography leads to inquiries attempting to measure such phenomenon empirically.

#### Race and Ethnic Influences on Symptom Etiology and Expression

One reason for diagnostic inaccuracy and error relates to the influence of race on diagnosis (Neighbors et al., 1989). Many of the nosological schemas used to classify psychiatric and psychological illnesses are based on European and North American characteristics (Fabrega, 1988). Such schemas represent the Western belief in the demarcation of the mind and body, or the separation between the psychological and physiological processes (Mezzich et al., 1996). However, many ethnic minorities conceptualize psychopathology in terms of a mind, body, and spirit connection with a pervasive and underlying religious and spiritual explanation.

Some scholars (Neighbors, 1990; Vega & Murphy, 1990) suggest that the lack of help-seeking behavior in some minorities stems from a poor fit between commonly held beliefs about mental illness in their community and the disease model which structures the treatment that mental health-care practitioners provide. For example,

attribution of mental illness by African-Americans and Latinos to character flaws, lack of willpower and moderation (Alvidrez, 1999; Schnittker, Freese, & Powell, 2000) gainsays the disease-oriented perspective that typically dominates treatment. Whites are more likely to attribute psychopathology to biological causes (Milstein, Guarnaccia, & Midlarsky, 1995) as compared to ethnic minorities endorsing spiritual, supernatural, or environmental causes to mental illness (Alvidrez, 1999; Castro, Furth, & Karlow, 1984; Landrine & Klonoff, 1994). Not only do people of color tend to view supernatural causes as more important in explaining illness. In addition, Landrine and Klonoff (1992) state that the primacy of such beliefs could account for ethnic differences in health-related behavior.

For example, in a sample of low income African American, Latino, and European American women, Alvidrez (1999) examined ethnic variations in mental health attitudes and utilization of services. Causal explanations for illness varied with ethnicity. Latinas were less likely to endorse medical causes, African American adhered to a more supernatural and religious causes for mental illness, and European Americans attributed more value to balance factors

(e.g., lack of rest, diet, and lack of harmony with nature or with other people). The results also found that Latinas and African American women were least likely to make a mental health visit.

Cross-cultural similarities also demonstrate the influence of religious beliefs on mental health and help-seeking behavior in Asians (Shams & Jackson, 1993) and Orthodox Jews (Greenberg & Witzum, 1991). Lowenthal and Cinnirella (1999) provide an in-depth examination on the impact of cultural-religious group membership and beliefs about the efficacy of psychotherapeutic interventions for depression and schizophrenia. Fifty-nine British women from black Christian white Christian, Hindu, Jewish, and Muslim faith participated. Interviewers were matched from the same ethnic/cultural/religious background conducted the interviews. Results implicate prayer as the most valued intervention for Christians and Muslims. These participants perceived praying to God as the most effective way to treat their illness. Yet, the results illustrate racial and ethnic group membership between perceptions of prayer and help-seeking behaviors. For example, Black Christian and Muslim women sought more privacy with prayer compared to the White participants valuing open disclosure of their

difficulties and elicited prayers from others. Muslim women expressed negative feeling toward seeking outside religious assistance. Similarly, black Christians were pessimistic about seeking professional help. Possible explanations for the resulting differences could be due to the lack of Black and Muslim mental health professionals, possibly increasing the expectancy to feel misunderstood and encounter racism (Lowenthal & Cinnirella, 1999). Or, perhaps religion may exert a greater influence on identity and social support (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000).

#### Clinical Research and Practice Regarding Spirituality

The breadth of spirituality and its place in a person's life extends to beyond physiological and psychological health. Individuals see their identity as multi-faceted, with a spiritual component helping to solidify an integrated identity, viewing spirituality as one dimension of health. This perspective leads to the incorporation of examining the impact of spiritual factors on changes in spiritual behaviors, beliefs, and experiences to promote health and reduce pathology (Thoresen, 1998). As clients want to be treated as a whole person, practitioners should be aware of their spirituality in developing

comprehensive and competent treatment plans (Miller & Thoresen, 1999).

A few studies implicate the positive impact of including spiritual components into scientifically based treatment approaches without diminishing the efficacy of treatment approaches (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992). Such data support the importance of delineating between the religious values of the client and those of the therapeutic milieu in increased understanding of clients for whom spirituality is a central aspect in their lives (Worthington, 1988). Indeed, a clinician's view of spiritual experiences can drastically alter assessment, diagnosis, and treatment (Turner, Lukoff, Barnhouse, & Lu, 1995).

Multiaxial diagnoses, with particular attention paid to the psychosocial and environmental contributors to pathology on axis IV, might better identify overlap between pathology and religious/spiritual identification. More specifically, literature points to common overlaps existing between mental disorders and religious or spiritual problems found in manic psychosis and obsessive compulsive disorders (Turner et al, 1995; Goodwin & Jamison, 1990). Some mental health care providers have identified and

implemented assessment methods to differentiate between religious and spiritual problems from psychopathology (Lovinger, 1984; Pruyser, 1984; Spitzer, Gibbon, Skodol, Williams, & Hyoler, 1980). For example, the Chaplain-Program at St. Elizabeth's Hospital in Washington, D.C. conducts a "spiritual needs assessment" on each inpatient. The assessment concludes with a treatment plan that has identified religious and spiritual needs and recommends subsequent activities to alleviate symptoms (Turner, et.al., 1995).

Others (Bradford, 1995) note the therapeutic value in addressing an individual's religious and spiritual connotation. Sixty percent of APA-member psychologists report that their clients express experiences using religious references and that one in six of their patients presented with issues involving religion or spirituality (Shafranske & Maloney, 1990). Seventy-two percent of psychologists in Lannert (1991) indicate their addressing religious or spiritual issues in treatment; in addition, 29% of psychologists, psychiatrists, social workers, and marriage and family therapists agreed that religious issues are important to consider in treatment (Bergin & Jensen, 1990).



Barnhouse (1986) suggests that the assessment of spirituality should be part of the assessment process due to the difficulty in differentiating religious references that are indicative of pathology between those that are not. However, research has demonstrated that many mental health professionals are less religiously oriented than much of the general public (Gallup, 1985). Such a phenomenon, which Bergin (1991) calls a professional "religiosity gap," appears to inform a clinician's approach to religious and spiritual issues in treatment.

Historically, the investigation between psychotherapy and spirituality exists as a discussion of the relationship between science and religion (Kurtz, 1999). Currently, psychotherapy and spirituality appear to complement each other in definition and goal. Both aim to lessen mental and emotional distress (Kurtz, 1999). Psychotherapy aims to achieve this goal via an analysis of and a working through of past and present stressors and the impact on interpersonal relationships. On the other hand, spirituality focuses on the core spiritual issues as they are embedded within theological work. Therefore, psychotherapy as a method and spirituality as an attitude

(Kurtz, 1999) both strive for increased psychological and emotional congruity.

Theoretical perspectives and goals that shape therapeutic interventions such as cognitive behavioral or rational-emotive and pastoral or counseling with a Judeo-Christian perspective appear to closely resemble each other. For example, spirituality seeks to monitor and adjust harmful ways of thinking, and consequently, maladaptive ways of negotiating one's environment. What rational- emotive therapists call irrational beliefs, cognitive-behaviorists rest on cognitive distortions. Fourth century religious recluse Evagrius Ponticus writes that man's difficulties stem from bad thinking that causes him to operate from a false place of fear and unreality (Kurtz, 1999). Thus, the secular and the non-secular counselor seek to alter harmful patterns of thinking via divergent orientations (Kurtz, 1999).

Traditionally, clinical literature exhibits a tendency to minimize the incidence and significance of spiritual experiences or ignore studies that indicate the positive impact of spirituality and religion on mental health (Lukoff, Lu, & Turner, 1995). According to Greyson and Harris (1987), the clinician's interpretation of spiritual

and religious problems can dictate the inclusion or exclusion of such variables on treatment. However, a lack of training in the assessment and treatment of religious and spiritual issues can potentially influence clinical interpretations. Such impressions can determine whether or not these experiences are integrated into treatment plans as unique dimensions of the patient's identity, indicative of pathology, or ignored.

Neeleman and Persaud (1995) describe the demarcation between religion, psychiatry and psychology as two-fold. First, as psychiatry tends to offer more biological and psychological explanations for mental illness, religious explanations are seen as less central. Some therapists may view a discussion of religion as limiting and fruitless, viewing science as the only perspective from which to address mental health issues (Stander, Peirce, MacKinnon, & Helmeke, 1994). But, religious beliefs and practices have been found to hold a central place in the lives of those that they treat, especially psychiatrically hospitalized patients (Kroll & Sheehan, 1989). For example, assistance has been provided to mental health workers in the form of a training program to better understand the psycho-spiritual development of their patients (Gopaul-McNicol, 1997).

Existing research and clinical practice does not provide an in-depth examination of understanding the influence of spirituality in the lives of the mentally ill (Turner et.al., 1995; Lukoff, Lu, & Turner, 1992). For example, a review of four psychiatric journals during a 5-year period found that only 2.5% (59 out of 2,348) of the articles included religious variables. When these variables were studied, they were viewed in a more negative manner.

Added to this phenomenon is the lack of journal literature examining how cultural and spiritual beliefs of ethnic minorities differ from dominant culture (Sue, 1999; Graham, 1992). A three year review of empirical, theoretical, and treatment-oriented psychology journals shows that only 1.3% of published articles focus on U.S. minority groups (Iwamsa & Smith, 1996).

## Psychological Practices

### Professional Underpinnings

Some argue that traditional counseling programs perpetuate the training of therapists who practice within an encapsulated framework (Pederson, 1988). Such practice contributes to the failure of therapists to recognize and

differentiate their values and belief systems from those of their clients. Without this awareness, practitioners will not recognize alternate cultural beliefs as equally credible and valid (Wrenn, 1985) and impose their value system onto culturally different clients (Ponterotto & Casas, 1991).

The imposition of White mainstream and majority values also informs the scientific method, which presents to be a challenge in effectively examining multicultural and ethnic specific issues empirically. Sue (1999) suggests that the emphasis on establishing internal validity over external validity in studies whose primary group of interest is ethnic minorities explain why minority research is difficult and meager. The standard quantitative manner relied upon does not easily avail itself to the investigation of complex constructs such as culture and ethnicity (Pederson, 1988). As knowledge and information has historically been communicated orally in many ethnic minority communities (Ponterotto & Casas, 1991), the emphasis on written history and research in White American culture inevitably biases the field against qualitative methods which may better address multicultural issues.

Related to this dilemma is a balance in accommodating constructs to White middle-class culture to emphasize the scientific method through dualistic thinking, cause effect relationships, and quantitative methods (Katz, 1985) while employing creative methodologies to examine the underlying psychological, developmental and social determinants of psychopathology and resulting behaviors.

### Theoretical Basis

Thomas and Sillen (1972) introduced the theory of "scientific racism" to explain the difficulty in examining race and ethnicity with current practices of psychological research. "Scientific racism" is the bias and prejudice against ethnic minority groups that continues to be perpetuated by theories and empirical research (Thomas & Sillen, 1972). Specific aspects of "scientific racism," or at least scientific bias, are enumerated is some of the theories now used to explain, or at least, frame the behavior of non-mainstream and racial and ethnic minority populations. Of the theories, the pathological model has historically suggested that Blacks and other minorities were less psychologically oriented due to their "primitive psychological organization" (Thomas & Sillen, 1972). This model can be evidenced in the way in which past research

has assessed pathology in minorities. Previous research has utilized psychological assessments normed on White middle class culture (Ponterotto and Casas, 1991), with results inappropriately categorizing and pathologizing Blacks as more anxious and paranoid (Sue, 1981).

Closely tied to the pathological view, is the genetically-deficient model holding that minorities are biologically inferior to Whites resulting in less intellectual advances and achievement. Biological deficits were based on differences such as speed of nerve conduction, smaller brains, and a more primal, lower, and more "childlike" stage according to Darwin's biological evolution (Thomas & Sillen, 1972). Thus, many of the early efforts in intelligence testing of minority individuals were again developed and standardized to assess fluidity with White middle-class beliefs and values with findings biased toward non-White groups.

Most recently, the culturally-deprived model has received much attention in the social sciences and on subsequent challenges to existing research and clinical diagnosis, assessment procedures, and treatment. Highlighting more environmental and social conditions such as poorer social conditions and less cognitive stimulation

(Ponterotto & Casas, 1991) to explain why racial and ethnic minorities succeed or fare less than their White counterparts, many attempt to identify weaknesses and deficits with remediation as the goal (Ponterotto & Casas, 1991; Sue, 1981). Again, dominant White middle-class values drive such efforts in the following ways. First, the individualistic, autonomous, and utilitarian core beliefs inherent in White culture minimize a culture's historical and political interactions with the dominant White culture and subsequent psychological and social conditions. To assert the term "deprived" continues to reinforce many of the deviant and negative perspectives (Whaley, 1998) through which non-majority individuals are viewed. On the contrary, everyone inherits a culture and has been molded by a cultural background (Sue, 1981). Conceptualizing minorities from a "deprived" perspective supports the view that deviations away from White values and beliefs are pathological (Thomas & Sillan, 1972) and stands in need of correction.

#### Professional Dilemma

To feign "color blindness" (Thomas & Sillan, 1972) and accept the idea of universality in theories and concepts (Sue, 1981) is a major professional and ethical impasse not



just for racial and ethnic minorities clients and clinicians; indeed, the burden also impacts Whites. To justify truly deviant behavior and pathology primarily as manifestations of social conditions acts as a disservice to the client and profession. However, to pretend socio-cultural parameters do not impact certain aspects of pathology and psychological dysfunction is equally harmful (Thomas & Sillen, 1972). Culturally- sensitive therapists facilitate treatment that involves an ever present balance in considering universal norms (etic) and specific group norms (emic) (Dragnus, 1981). The clinician then differentiates between normal and pathological behavior, forms impressions of behavior etiology, and incorporates necessary interventions (Lopez, Grover, Holland, Johnson, Kain, Kanel, Melins, & Rhyne, 1989).

### Cultural Competence

#### Professional Responsibility

Many clearly articulate that care, policies, and procedures informed by just knowledge and awareness of culture do not ensure ethically responsive treatment (Mock, 1999; Sue, 1998; Sue and Zane, 1987). The inability to provide culturally specific and appropriate forms of

treatment exacerbates problems in service delivery (Sue and Zane, 1987). Knowledge must transform into skill (Sue and Zane, 1987). As clinicians typically identify with a particular theoretical orientation and provide care from this perspective, cultural competence serves as a precedent by which all encounters and practices are evaluated. Cultural competence is multidimensional, exerting influence at the micro- and macroscopic levels. Cultural awareness and understanding exists intra- and interpersonally for the practitioner and collectively in any given organizational and administrative infrastructure (Hogan-Garcia, 1999).

As the field of psychology will move beyond publishing articles that advocate for greater diversity of services (Iijima Hall, 1997), the profession will engage in the assessment of macroscopic policies and practices to ensure cultural sensitivity. This will include examining how the field has or has not addressed power dynamics and differences and the subsequent influence on the provision of care to mental health care consumers (Mock, 1999). Culturally-competent mental health will rely on historical experiences of prejudice, discrimination, racism and other culture-specific beliefs about health or illness, culturally unique symptoms and interventions with each

cultural group to inform treatment (Dana, Behn, & Gonwa, 1992).

Organization and agency policies will be impacted in many ways. Professionals engage in self-assessment of personnel (Dana, Behn, & Gonwa, 1992; Dana & Matheson, 1992; Lu, Lim, and Mezzich (1999); Gurung & Mehta, 2001). For example, Dana et al (1992) have developed a checklist to agencies to evaluate the cultural competence of personnel. Items that speak to the flexibility of employees to use culturally appropriate assessments, interventions, and services are listed in the following five clusters: 1) culturally competent attitudes evidenced in staff selection and agency policy, 2) available services, 3) relationship to the ethnic community, 4) training, and 5) evaluation (Dana et al., 1992).

Psychology programs and departments will recruit minority staff and faculty (Iijima Hall, 1997; Kagehiro, Mejia, & Garcia, 1985). Researchers and administrators will actively rally for the implementation and requirement of more culturally responsive and academic and research courses at the undergraduate and graduate levels (Iijima Hall, 1997; Sue, 1981). Finally, programs, organizations and agencies will require culturally-relevant in-service

training and contracted services (Dana et al., 1992) and adapt assessment tools and methodology (Dana, 1996).

### Clinical Obligations

Cultural competence at the consumer level affords clients the ability to dialogue about one's own culture and advocate for necessary services or changes. Assessments will include an evaluation of the patient's cultural orientation that clarifies the degree patient acculturation, or commitment to and investment in his or her native racial and ethnic group (Dana, 1996). The understanding of the consumer's "cultural self" informs the selection of assessment tools and applicability of service styles (Dana, 1996) to best accommodate and meet etic (culture general) or emic (culture specific) clinical needs.

Emic approaches make room for the in-depth assessment of and inquiry to the cultural community for the description of illnesses, behavior and attitudes leading to the appropriation of more ethnic specific interventions and methodology (Dana, 1996). In order to better facilitate emic assessments and interventions, the clinical repertoire should include a sufficient awareness and understanding of culture and it's impact on psychopathology, assessment and

intervention (Lopez et al., 1989). Clinicians must be culturally competent. Indeed, Sue (1998) posits that an important detriment to therapy is not the demographic difference of race or ethnicity between the clinician and client.

However, differences in cultural attitudes and beliefs and the clinician's adaptation to such dissimilarities are what interfere with the therapeutic process and outcome (Sue, 1998; Sue & Zane, 1987). The constructivist realm, in which reality is based on individual thought and experience, challenges mental health professionals to extract from and expound upon the clinical utility of subjective experiences (Howard, 1991). A collaborative process between the assessor and consumer informs therapy as the clinician is able to enter into the consumer's worldview and help construct meaning to and the purpose of class, ethnicity, culture, and race (Sue, 1998; Howard, 1991).

Culture influences the meaning and significance of symptoms and guides the diagnostic value of such symptoms (Corin, 1996). Cross-cultural variations in rates of a disorder can influence choices for diagnostic criteria (Kleinman, 1988). For example, delusions that are common in

schizophrenia and vary according to their content may reflect cultural themes. More importantly, implications for misdiagnosis increase as individuals vary in their clinical presentation of symptoms. Corin (1996) has called for the creation of a diagnostic manual mentioning the kinds of symptoms that are more likely to be misdiagnosed in certain ethnic groups.

Misdiagnosis of presented clinical symptoms also stems from the differential attributing of normative behavior as determined by culture. Behaviors considered normal can have pathological significance when viewed from the context of a groups norms and values (Egellan, Hostetter, & Eshleman, 1983). Idioms of distress, an anthropological concept, has been developed in an attempt to account for cultural underpinnings in the variation of clinical presentations (Corin, 1996). The term helps to illustrate an individual's tendency to use culturally relevant descriptors to express their distress, emphasize symptoms that possess a cultural value or de-emphasize others that are either culturally non-significant or stigmatized (Corin, 1996).

## New Direction in the Diagnostic and Statistical Manual

The tendency to continue to ignore the interaction between the individual, the environment, and resulting lifestyle and treat each distinctively hinders the conceptualization of the importance culture in shaping the expression of behavior. In search of a more informed manner to consider and account for varying symptoms and manifestations evidenced in patients and resulting interactions with clinicians, examination of attitudes, beliefs, and behaviors specific to cultural milieu are integral to diagnosis and treatment.

A central goal of therapy aims to facilitate intentionality, as the client is able to fluidly generate verbal and nonverbal sentences for communicating with self and others in a culture (Ivey & Simek-Downing, 1980). The utility of words and modes of expressions take on significance in that the language of the client often conveys less superficial and more germane perceptual meanings, experiences, and thoughts such as distortions and generalizations (Ivey & Simek-Downing, 1980). Flexible term-based and language-based communication in client

responses becomes a central goal for the intentional therapist (Ivey & Simek-Downing, 1980).

The reverse is true in the role of the clinician. Intentionality does not simply need to be an external goal from which professionals gauge client development and growth. Meeting standard of care requires professionals to "speak the language that their clients feel most comfortable using" (Padilla, 1981). Culturally pluralistic therapy recognizes the ways in which a client's beliefs, values, and behaviors are influenced by his culture (Padilla, 1981). The pluralist clinician is aware of the subsequent impact of majority and minority cultural standards and the nexus of the two on the intra- and inter-personal issues.

Such therapy does not seek conformity in that individuals are not expected to fit into or adopt the expected preferences, expectations, and treatment biases of the therapist (Goldstein, 1981). On the contrary, therapy is adapted to recognize client specificity. The presenting characteristics, preferences, and expectancies of the client determine the proceeded course of treatment (Goldstein, 1981). For example, the ability of many individuals to successfully negotiate their way in dominant



White culture via full assimilation or move between mainstream society and their own subgroup vis-à-vis biculturalism, has been a necessary survival skill and also a source of internal stress and conflict. Culturally pluralistic therapy seems to achieve this mean. Clinical work is evidenced by a fluidity and clinical acumen that frames the client's attitudes and feelings, areas of stress, and maladjustment within the client's cultural conceptualizations (Torrey, 1972).

A working knowledge of culture-bound expressions can allow clinicians to better evaluate co-morbidity between culture-bound symptoms and psychiatric disorders (Guarnaccia & Rogler, 1999). In an effort to elucidate the importance of culture and its impact on diagnostic accuracy the National Institute for Mental Health (NIMH) sponsored a Group on Culture, Diagnosis, and Care to enhance the cultural validity of the Diagnostic and Statistical Manual-IV (DSM-IV) (American Psychiatric Association, 1994). The workgroup worked collaboratively with the DSM-IV Task Force and workgroups. This effort resulted in significant innovations in the DSM-IV. They are as follows: the inclusion of an introductory cultural statement, explicit cultural considerations for the use of diagnostic

categories and criteria, a glossary of culture bound syndromes and idioms of distress, and an outline for cultural formulations (Mezzich, Kirmayer, Kleinman, Fabrega, Parron, Good, Lin, & Manson, 1999).

### Multicultural Education and Training Structured Interview For Cultural Formulations

#### Interview Development

Weitzel, Morgan, Guyden, et al (1973) comment on the potential of a structured interview to provide a more complete and accurate clinical presentation and an increase in diagnostic accuracy. Concerted efforts by scholars, clinicians, and researchers in the fields of cross-cultural psychology, anthropology and ethnic minority research have led to the development of the Multicultural Education and Training Structured Interview For Cultural Formulations (METSICF) created by the Director of the Multicultural Education and Training Program at Patton State Hospital. The development of the tool stemmed from a need identified by the Clinical Quality Improvement Committee at Patton State Hospital. The tool serves to improve the quality of services delivered to ethnic minority patients hospitalized at Patton. The METSICF was designed to assess for

culturally relevant variables that impact the diagnosis and treatment of the culturally diverse patient population hospitalized at Patton State Hospital.

Interview construction was based upon the DSM-IV Outline for Cultural Formulation and Glossary of Culture Bound Syndromes. Item development was based upon the five subsections and descriptions contained within the outline. They are as follows: 1) Cultural identity of the individual, 2) Cultural explanation of the individual's illness, 3) Cultural factors related to psychosocial environment and levels of functioning, 4) Cultural elements of the relationship between the individual and the clinician, and 5) Overall cultural assessment for diagnosis and care.

The outline for cultural formulation was a significant innovation. The following is a list of the five broad dimensions relevant to a cultural formulation resulting from a review of the literature: 1) the cultural identity of the patient, including reference group (s), language, spiritual/religious affiliations, and multicultural identity; 2) cultural explanation of the illness (e.g., idioms of distress, explanatory models, and popular and professional sources of care); 3) cultural factors related

to the psychosocial environment and functioning (e.g., the meaning of social support and stigma); 4) cultural aspects of the relationship between patient and clinician (e.g., attitudes toward authority, dependency, and relevance to transference and countertransference; and, 5) overall formulation, synthesizing elements critical to diagnosis and care (Mezzich et al., 1999).

The proposed outline embodies the goal of qualitative research, which is primarily meant to be descriptive (Ponterotto & Casas, 1991). Field tests were conducted on the outline with African Americans, American Indians, Asian Americans, and Latinos. The results were positive and demonstrated the utility of the outline and resulted in illustrative case formulations. The NIMH Group on Culture, Diagnosis, and Care has recommended the development of educational aids to facilitate the appropriate use of the Outline for Cultural Formulation (Mezzich et. a., 1999).

In keeping with the recommendations given by the NIMH Group on Culture, Diagnosis and Care in the article entitled: The Place of Culture in DSM-IV (Mezzich et al., 1999), the Multicultural Education and Training Program at Patton State Hospital, under the direction of the Clinical Quality Improvement Committee, has created such a

tool, the Multicultural Education and Training Structured Interview For Cultural Formulations (METSICF). Upon consultation with members of the NIMH Group on Culture, Diagnosis, and Care, the principal investigator of the tool was encouraged to pursue this avenue of development and research given that no such tool exists.

#### Project Expectations

Thus far, this project has served to provide a theoretical basis explaining and justifying the need for a clinical interview to provide more culturally-sensitive assessments and treatment. The purpose of this project will be to outline and clarify the methodology and recommendations for implementing a validation study of the METSICF at Patton State Hospital. Given the diversity of the patient population of the hospital, and the fact that clinicians use the DSM-IV-TR (the subsequent version) to diagnose the patient population, it behooves the field of psychology to fully apply the methods of application stipulated in the DSM-IV-TR. This project will also propose how such research will increase efforts to gain maximum diagnostic accuracy, which will directly impact treatment efficacy. Thus, the use and proper application

of the Outline For Cultural Formulations is clinically and ethically warranted.

### Initial Hypotheses

The project will discuss a proposed validation effort examining the utility of the METSICF in developing illustrative cultural formulations. The information obtained during the interview should assist staff in assessing cultural factors that impact the manifestation of symptom presentation as well as the delivery of treatment services. The construction of the METSICF was based upon the DSM-IV Outline for Cultural Formulations. Item development was based upon the following five domains: 1) Cultural identity of the individual, 2) Cultural explanation of the individual's illness, 3) Cultural factors related to psychosocial environment and levels of functioning, 4) Cultural elements of the relationship between the individual and the clinician, and 5) Overall cultural assessment for diagnosis and care.

In a future design, fifty-two culturally diverse clinicians (Psychiatrists, Psychologists, and Social Workers) will conduct interviews on 200 culturally diverse, judicially committed inpatients. Proposed research will

examine the relationship between the quality of cultural formulations developed by clinicians using the structured interview (i.e. METSICF) versus those who use an unstructured format in conjunction with their level of cultural competence. An experimental between subjects randomized block design will be implemented to establish construct validity through the investigation of causal relationships between the two independent variables: Type of interview (i.e. structured versus unstructured), and Level of Cultural Competence (i.e. High versus Low) in relation to the dependent variable, quality of cultural formulation. In the future, the hypothesized relationships will be as follows:

- 1) Clinicians using the structured interview (METSICF) will produce better cultural formulations than those using an unstructured interview approach.
- 2) Clinicians who possess a high level of cultural competence will produce better cultural formulations than those who are low in cultural competence.
- 3) Clinicians using the structured (METSICF) interview who possess a high level of cultural competence will produce a cultural formulation that is comparable in quality to those clinicians who are using the

structured interview and are low in cultural competence.

- 4) Clinicians using an unstructured interview who possess a high level of cultural competence will produce a better cultural formulation than those clinicians that use an unstructured interview approach and are low in cultural competence.



## CHAPTER THREE

### PROPOSED METHODOLOGY

#### Introduction

The participants in the study will consist of two groups: Patients and Clinicians. The following is a description of 200 male and female culturally diverse (i.e. African American, Hispanic, Asian, Pacific Islander, and European American) judicially committed inpatients at Patton State Hospital. They will have a hospital stay of 30 days or greater and a Global Assessment Functioning (GAF) score of 50 or greater. The clinicians will consist of 52 male and female participants from the disciplines of psychiatry, psychology, and social work. The following racial groups will be recruited: African American, Hispanic, Asian, Pacific Islander, and European American.

#### Instrumentation

The following instruments will be used in the proposed study: The California Brief Multicultural Competency Scale (CBMCS), Multicultural Education and Training Structured Interview For Cultural Formulations (METSICF), The Marlow-Crown Form C (Reynolds, 1982), Cultural Formulation Template, Identification/ Background Questionnaire,

Multicultural Education and Training Structured Interview:  
Expert Rater Form, and the Cultural Formulation Scoring  
Sheet.

#### Clinician Cultural Competency

The CBMCS will be used with the clinicians to measure their degree of cultural competence across four domains: knowledge, racial identity, skills, and awareness (Appendix A). Subjects will receive scores in each domain as well as a total score. The CBMCS is a new tool developed by the Tri-City Mental Health Center, Multicultural Research Committee in Pomona, California (Unpublished Manuscript). The instrument is a compilation of the best items selected through a factor analytic approach (based upon 1,000 clinicians) from five of the leading cultural competency instruments. The instruments are The Cross-Cultural Counseling Inventory-Revised by LaFromboise, Coleman, and Hernandez (1991), the Multicultural Awareness/Knowledge/Skills Survey by D'Andrea, Daniels, and Heck (1991), The Multicultural Counseling Awareness Scale by Ponterotto, Rieger, Barrett, Harris, Sparks, Sanchez, & Madigs (1993), The Multicultural Counseling (Sodowsky, Taffe, Gutkin, and Wise, 1994), and The Multicultural

Counseling Competence and Training Survey by Holcomb-McCoy and Myers (1999).

### Cultural Formulation

Clinicians will administer the METSICF to patients in an effort to obtain information to write an illustrative cultural formulation. This tool is designed to assist staff in assessing cultural factors that may impact the manifestation of symptom presentation, and the delivery of treatment services (Appendix B). The construction of METSICF was based upon the DSM-IV Outline for Cultural Formulations. Item development was based upon five domains: Cultural identity of the individual, Cultural explanation of the individual's illness, Cultural factors related to psychosocial environment and levels of functioning, Cultural elements of the relationship between the individual and the clinician, and Overall cultural assessment for diagnosis and care. Upon completion of the interview clinicians will write up their findings using a Cultural Formulation Report Template (Appendix C) based upon the five dimensions of the DSM-IV Outline for Cultural Formulations.

### Cultural Formulation Scoring Sheet

Raters will use The Cultural Formulation Scoring Sheet to rate the quality of the cultural formulations. The construction of the scoring sheet was based upon the five domains in the DSM-IV Outline for Cultural Formulations and the qualitative description in each domain (Appendix D). Each domain contains a topical list of areas that should be included in each section. The scoring sheet will yield a score based upon the presence of culturally illustrative statements contained within the cultural formulation.

### Supplementary Questions

Identifying data will be collected on both clinicians and patients through the use of an Information and Background Questionnaire (Appendix E). The information collected will serve as locator information to make interview assignments, in addition to providing additional descriptive information about our clinician and patient sample.

### Expert Ratings

Experts in the field of cross cultural psychology and psychiatry will be solicited to rate the METSICF for item usefulness. They will use the Multicultural Education and Training Structured Interview For Cultural Formulations:

Expert Rater Form developed by the Multicultural Education and Training Program at Patton State Hospital (Appendix F). Items are rated not useful, somewhat useful, useful, and very useful. The ratings range from 1 to 4. Mean ratings will be generated and used to eliminate items that are not useful.

### Social Desirability

Response bias is a potential artifact when using self-report measures such as the California Brief Multicultural Competency Survey. Because of this inherent risk, it is advisable to measure this variable and take its effects into consideration in interpreting findings. The Marlow-Crown Form C (Reynolds, 1982) consists of 13 items (Appendix G) that will be used as a measure of social desirability. For the purposes of analysis a sum MC score will be computed.

## Procedures

### Preliminary Evaluation

In an effort to improve the validity of the METSICF five cross cultural mental health experts, four of whom are original members of the NIMH Group on Culture, Diagnosis, and Care, will be asked to rate the usefulness of the

items. They will receive a copy of the METSICF: Expert Rater Form (Appendix H) and rate each item for its usefulness for inclusion in a structured interview designed to develop a cultural formulation. Means will be calculated across five raters on each item. Item means below 2 will be eliminated from the structured interview. The ratings provided by the expert evaluators will also be used to establish content validity.

#### Recruitment

Approximately 1,200 patients hospitalized at Patton State Hospital will be stratified across four racial groups (African American, Hispanic, Asian, Pacific Islander, and European American). Those having a Global Assessment of Functioning (GAF) score of less than fifty, hospitalized less than thirty days, and are currently participating in a research project at Patton State Hospital will be eliminated. Of those patients remaining, two hundred racially stratified patients will be randomly selected. Fifty will come from each of the four racial and ethnic groups. These patients will be seen individually and receive a recruitment presentation (Appendix L) along with the Research Participants Bill of Rights (Appendix H). At

that time they will be asked to give their written consent (Appendix I).

Fifty-two clinical staff (i.e. Psychiatrist, Psychiatrists, and Social Workers) at Patton State Hospital will be recruited to participate in the study. They will be recruited during discipline meetings where they will receive a group presentation (Appendix J). Letters of solicitation will also be sent out (Appendix K). They will receive the Research Participants Bill of Rights, the clinician consent form and be asked to provide their written consent (Appendix M).

#### Interview Assignments and Administration

Clinicians will be given the Information and Background Questionnaire, the Marlow-Crown Form C social desirability scale, and the CBMCS to determine their level of cultural competency. Clinicians will be blocked on their level of cultural competency (High or Low) and then randomly assigned to administer one of the two treatment conditions: the METSICF or an unstructured interview. Prior to the interview all clinicians will be given written instructions on how to conduct the interview along with the cultural formulation report template. The clinicians will

conduct between three and four individual interviews. The tool will take approximately one hour to administer and between two to three hours to write the cultural formulation report.

Patients who have been blocked on race will be randomly assigned to one of four treatment conditions: 1) Unstructured interview with a clinician who rates high on cultural competency, 2) Structured interview with a clinician who rates high on cultural competence, 3) interview with a clinician who rates low on cultural competency, or 4) Unstructured interview with a clinician who rates low on cultural competence. The interview will take approximately one hour.

#### Structured Interview Training

All clinician volunteers will receive group training on administration procedures for the METSICF. They will receive the manual for administration (Appendix N) and be instructed to ask a member of the treatment team to assist them in addressing those sections of the interview that require treatment team input.

#### Cultural Formulation Scoring

Two raters will be recruited from either the clinical staff or from local graduate programs. Hospital



recruitment will occur within the disciplines of Psychiatry, Psychology, and Social Work. Outside of the hospital, recruitment from the schools of Psychiatry, Clinical Psychology, and Clinical Social Work for external raters will be compensated monetarily. Internal raters will receive commensurate time away from their normal duties while working on the project. Both raters will be trained in the use of the Cultural Formulation Scoring Sheet and how to determine the presence of culturally illustrative statements related to the five domains of the outline for cultural formulations. Each rater will score two hundred reports in an effort to ensure inter-rater agreement. Raters will compare ratings on each interview and develop decision rules with assistance from the principle and co-investigators to ensure one hundred percent agreement.

#### Impact of Social Desirability

Pearson correlations will be computed to test the association between the Marlow-Crown scale of social desirability and the California Brief Multicultural Competency Survey to measure the degree to which response biases may distort the responses on the CBMCS. If there are significant findings this will be taken into consideration

when interpreting counterintuitive findings as they relate to level of cultural competence and type of interview.

### Data Analysis

Descriptive statistics will be generated to summarize the data. Content validity should be established through the application of a two-way Analysis of Variance (ANOVA). A two-way ANOVA will be performed to test the relationship between the two independent variables: Type of interview (METSICF versus Unstructured Interview) and Level of Cultural Competence (High versus Low) relative to the dependent variable Cultural Formulation (illustrative quality).

### Secondary Hypotheses

The following hypotheses will be tested: Clinicians who use the structured interview (METSICF) will produce better cultural formulations than those using an unstructured interview approach:

- 5) Clinicians who possess a high level of cultural competence will produce better cultural formulations than those who are low in cultural competence.
- 6) Clinicians using the structured (METSICF)

interview who possess a high level of cultural competence will produce a cultural formulation that is comparable in quality to those clinicians who are using the structured interview and are low in cultural competence.

- 7) Clinicians using an unstructured interview and possess a high level of cultural competence will produce a better cultural formulation than those who use an unstructured interview approach and are low in cultural competence.

## CHAPTER FOUR

### ANTICIPATED RESULTS

#### Introduction

The project presented hypotheses to be tested in future research. Therefore, the preliminary results to be presented are tentative. This section will present what will be expected from the hypotheses including identifying the expected and emerging relationships between variables. This section will also present the expected significance of such findings and the expected meaning will be for such significance.

#### Expected Findings

Of the clinicians that will participate in the study, those using the structured interview (METSICF) should produce better cultural formulations than clinicians that use an unstructured interview approach. The cultural formulations of clinicians using an unstructured interview approach will not incorporate as much culturally-specific information (e.g., cultural explanations of mental illness, cultural and psychosocial stressors, etc.). Those participants who possess a higher level of cultural competence will be better able to facilitate the discussion

of culturally-specific information to be incorporated in cultural formulations. These clinicians should possess an increased awareness to more culturally-specific modes of communication and expression coupled with the ability to adapt the assessment process to a patient's culturally-specific needs.

As the literature suggests, clinicians that are more culturally competent will be better able to facilitate more emic (culture-specific) approaches. Therefore, it will be expected that clinicians that use an unstructured interview approach and who are high in cultural competence will produce better cultural formulations than clinicians low in cultural competence and who use an unstructured interview approach. However, it is expected that the use of a structured interview will control for varying levels of clinician cultural competence on the quality of cultural formulations. Regardless of level of cultural competence, the information elicited by using the structured interview should result in comparable cultural formulations for clinicians both high and low in cultural competence. Even if a clinician is low in cultural competence, using the structured interview should provide enough of a framework to enable clinicians to elicit from the patient culturally-

specific information that will inform the assessment process.

## CHAPTER FIVE

### DISCUSSION

#### Summary

The significance and implication of a validation study of the METSICF are two fold: significance to research, and significance to clinicians. Many research efforts have been put forth to address cultural and spiritual issues in diagnosis and treatment. However, there are no established instruments that are incorporated into treatment that simultaneously examine the impact of these variables on symptom expression, diagnosis and treatment. The implementation of the present project will bring to fruition a measure that is based on the newest addition to the DSM-IV Appendix I, The Glossary of Culture Bound Syndromes.

Interviewing clinicians will develop summary reports, which should highlight cultural and spiritual variables reported by patients during interviews. In particular, clinicians who will use the structured interview will better qualifying cultural and spiritual variables during the assessment process, which will be quantified in summary reports. Therefore, construct validity of the structured

interview in the initial goal. Secondly, this project outlines the ability of the tool to elicit more culturally specific statements in summary reports, thereby creating content validity.

The use of such an interview tool in diagnosis and assessment will assist in more differential diagnoses. Clinicians will be able to implement more accurate treatment plans, which will more accurately differentiate cultural and spiritual expressions from pathology, and better assist in the presence of such themes in symptom expression. Approximating a clinician's level of cultural competence helps the clinician self-monitor and gauge his or her ability to be empathetic toward and tolerant of cultural, spiritual, and worldview differences. More specifically, how well the clinician accommodates such differences in the therapeutic milieu will lead to better skilled clinicians, more flexible approaches to treatment and interventions, and increased understanding to promote stronger therapeutic alliances and better treatment outcome.



## Conclusions

The present project continues to expand upon empirical and clinical measures aimed at providing culturally-competent systems of care. The structured interview seeks to capture many diverse facets and components of an individual's identity, while simultaneously informing symptom expression, assessment and treatment. The importance of spirituality to the experience of psychopathology and resulting behaviors serves to qualify the content of delusions, hallucinations, and other indicators of illness.

The ability of service providers, researchers, and many others that impact the delivery of services to meet the growing ethnic, spiritual, and language diversity needs of society is crucial. Knowledge of and familiarity with differing explanatory models of illness serve to facilitate client specificity in theoretical models and interventions, both culminating in the creation of cultural formulations.

## Recommendations

The project presents a proposed initial step in validating the METSICF. Therefore, validation of the tool is the first step in this research. Additional studies will

test for reliability of the tool. Once more psychometric information is gathered on the tool, it would be beneficial to look at the tool in differentiating between more stereotypical diagnoses, and treatment outcomes. More specifically, clinical interventions should be more specific and inclusive to the presence of cultural nuances. has the ability to profoundly impact community mental health and its various components of care.

The continued examination of ethnic and race matching between clinicians and clients in research points to necessary interactions. Although many studies illustrate the positive impact of matching on the therapeutic process, Gurung & Mehta (2001) caution against viewing matching as the panacea for all therapeutic biases. The supposition that surface similarities such as skin color or ethnic group membership in the therapy dyad fails to consider the therapist's degree of ethnic identification. In some instances, matching will hinder the relationship if the therapist has unresolved issues toward his or her identity (Gurung & Methat, 2001). Therefore, the structured interview will be an excellent first step in extrapolating the positive interactions to mismatched dyads in helping to increase more positive treatment outcome (Sue, 1998).

APPENDIX A  
CALIFORNIA BRIEF MULTICULTURAL  
COMPETENCE SCALE

# CALIFORNIA BRIEF MULTICULTURAL

## COMPETENCE SCALE

Below is a list of statements dealing with multicultural issues within a mental health context. Please indicate the degree to which you agree with each statement by circling the appropriate number.

**(1) Strongly Disagree   (2) Disagree   (3) Agree   (4) Strongly Agree**

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Agree</b>	<b>Strongly Agree</b>
1. I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.	1	2	3	4
2. I am aware of how my own values might affect my client.	1	2	3	4
3. I have an excellent ability to assess, accurately, the mental health needs of persons with handicaps.	1	2	3	4
4. I am aware of institutional barriers that affect the client.	1	2	3	4
5. I have an excellent ability to assess, accurately, the mental health needs of gay women.	1	2	3	4
6. I have an excellent ability to assess, accurately, the health needs of older adults.	1	2	3	4
7. I have an excellent ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons from different cultural, racial, and/or ethnic backgrounds.	1	2	3	4
8. I am aware that counselors frequently impose their own cultural values upon minority clients.	1	2	3	4
9. My communication skills are	1	2	3	4

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Agree</b>	<b>Strongly Agree</b>
appropriate for my clients.				
10. I am aware that being born a White person carries with it certain advantages.	1	2	3	4
11. I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes.	1	2	3	4
12. I have an excellent ability to critique multicultural research.	1	2	3	4
13. I have an excellent ability to assess, accurately, the mental health needs of men.	1	2	3	4
14. I am aware of institutional barriers that may inhibit minorities from using mental health services.	1	2	3	4
15. I can discuss, within a group, the differences among ethnic groups (e.g. low socioeconomic status (SES) Puerto Rican client vs. high SES Puerto Rican client).	1	2	3	4
16. I can identify my reactions that are based on stereotypical beliefs about different ethnic groups.	1	2	3	4
17. I can discuss research regarding mental health issues and culturally different populations.	1	2	3	4
18. I have an excellent ability to assess, accurately, the mental health needs of gay men.	1	2	3	4
19. I am knowledgeable of acculturation models for various ethnic minority groups.	1	2	3	4
20. I have an excellent ability to assess,	1	2	3	4

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Agree</b>	<b>Strongly Agree</b>
accurately, the mental health needs of women.				
21. I have the ability to assess, accurately, the mental health needs of persons who come from very poor socio- economic backgrounds.	1	2	3	4

APPENDIX B

MULTICULTURAL EDUCATION AND TRAINING STRUCTURED

INTERVIEW FOR CULTURAL FORMULATIONS

MULTICULTURAL EDUCATION AND TRAINING STRUCTURED  
INTERVIEW FOR CULTURAL FORMULATIONS

A. Cultural Identity

1. **What ethnic/racial group do you identify with? (circle one and specify subgroup membership or nationality)**

- a. Black or African-American (specify) \_\_\_\_\_
- b. Hispanic or Latino (specify) \_\_\_\_\_  
(e.g. Mexican, Cuban, Puerto Rican or other Spanish culture or origin, regardless of race etc.)
- c. Asian or Pacific Islander (specify) \_\_\_\_\_
- d. Native-American or Alaska Native (e.g. Eskimo, Aleut specify) \_\_\_\_\_
- e. White (specify) \_\_\_\_\_
- f. Other (specify) \_\_\_\_\_

2. **What spiritual or religious group do you identify with?**

- a Protestant:
  - 1) Baptist
  - 2) Methodist
  - 3) Episcopalian
  - 4) Presbyterian
  - 5) Lutheran
  - 6) Pentecostal
  - 7) Evangelical
  - 8) Other: \_\_\_\_\_
- b Catholic
- c Jewish:
  - 1) Orthodox
  - 2) Conservative
  - 3) Reformed
- d Muslim:
  - 1) Orthodox: (Sunni, Shiite)
  - 2) Nation of Islam
  - 3) Other \_\_\_\_\_
- e Other: \_\_\_\_\_  
List other religions

3. **Place of Birth**

- a. Where were you born/reared? \_\_\_\_\_
  - 1) If the patient is not from this country how did he/she come to this country? (Circle one)
    - (i) immigrant
    - (ii) Refugee
    - (iii) Other \_\_\_\_\_  
(specify)
- b. What year did the patient come to the U.S. \_\_\_\_\_

4. **Language Capacity**

- a. What is your native language? \_\_\_\_\_  
(What is the first language you learned to speak?)
- b. What language would you prefer services be provided to you? \_\_\_\_\_
- c. Based upon the patient's response to (a.) and the interviewers observations of the patient's expressive (oral and written) and receptive (oral and written) language, does language pose a barrier to treatment? (circle one)



1	2	3	4	5
None	Mild	Moderate	Significant	Extreme

- d. Do you speak more than one language or dialect? Y/N  
(Including non-standard English dialects e.g. Black, English, urban or rural geographical dialects that may impact communication)

1) If yes, please specify which languages or dialects \_\_\_\_\_

**5. Acculturation/Family Organization and Relational Roles**

- a. Is your traditional cultural heritage (e.g. ethnic, racial religious) important to you?

1	2	3	4	5
Not	Slightly	Somewhat	Important	Very

- b. What is your (ethnic, racial and/or religious) cultural heritage? \_\_\_\_\_  
(Specify)

- c. What religion was practiced while you were growing up? \_\_\_\_\_

- d. Do you observe cultural customs and celebrations unique to your traditional ethnic, racial and/or religious heritage? Y/N

1) If yes, what are they? \_\_\_\_\_

- e. If American culture important to you?

1	2	3	4	5
Not	Slightly	Somewhat	Important	Very

- f. When you were growing up were your neighbors and friends the same ethnicity, race/or religion as you?

1	2	3	4	5
Not	Slightly	Somewhat	Mostly	All the same

1) If they were not the same what was their ethnicity, race and/or religion?  
\_\_\_\_\_

- g. Since you were an adult have your close personal friends been the same ethnicity, race and/or religion as you?

1	2	3	4	5
Not	Slightly	Somewhat	Mostly	All the same

1) If they were not the same what was their ethnicity, race and/or religion?  
\_\_\_\_\_

- h. Do you have a close relationship with your immediate family (e.g. parents, siblings, wife, children)?

1	2	3	4	5
Not	Slightly	Somewhat	Close	All the same

- i. Is it important to you to know your extended family (e.g. aunts, uncles, cousins and grandparents) and to have a close relationship with them?

1	2	3	4	5
Not	Slightly	Somewhat	Important	Very

- j. While growing up in your family who made the major decisions?  
\_\_\_\_\_

k. What responsibilities did you have in your family as a child?

---

**6. Current Religious Beliefs and Practices**

a. To what degree do you practice any particular religion now?

1                      2                      3                      4                      5  
Never      Seldom      Periodically      Often      Daily

1) If you are practicing a religion, what do you practice? \_\_\_\_\_

2) If you are not practicing any religion are you interested in exploring your spirituality of religion?

1                      2                      3                      4                      5  
No      Slightly      Somewhat      Interested      Very Interested

b. Is your spirituality or religion important to you?

1                      2                      3                      4                      5  
No      Slightly      Somewhat      Important      Very

c. Are there traditional religious and/or cultural clothing, dietary, or other items/customs you would like to be permitted to utilize of practice as a part of your cultural or religious expression? Y/N

1) If so, what would they be? \_\_\_\_\_

d. How does your religion or spirituality influence your life's purpose?

e. What effect has the absence of presence of your spirituality or religion played in where you find yourself today (e.g. incarceration, hospitalization)?

f. How do you see your religion or spirituality effecting your recovery and discharge from the hospital?

**1) Treatment Team Considerations Related to the Patients Culture and Spirituality**

(i) Is the patients reported spiritual/religious experiences consistent with the normative practices within his/her culture or professed religion? Y/N

(ii) If not consistent, how do they deviate? \_\_\_\_\_

(iii) Is there consistency between the patients stated importance of his/her religion/spirituality, and the degree to which his/her religious, cultural traditions and beliefs are actually followed?

1                      2                      3                      4                      5  
None      Slight      Somewhat      Consistent      Very Consistent

(iv) What is the quality of the patient's religiousness/spirituality? (Circle one or more that apply)

a) It is open to consider and appreciation of viewpoints other than one's own.

b) It is closed and depreciating toward viewpoints other than one's own.

- c) Religion is used to obtain supported benefits  
(e.g, social recognition prosperity, freedom from fear, healing etc)  
Religion is practiced as meaningful in and of itself in  
prayer, worship, ministry to others

**7. Gender Identity and Sexual Orientation**

- a. How do you Identify in terms of your gender?  
1) Male  
2) Female  
3) Other (specify) \_\_\_\_\_
- b. What is your sexual orientation? (Please ask if they would feel comfortable enough to share their sexual orientation)  
1) Heterosexual  
2) Homosexual  
3) Bisexual
- c. Does your sexual orientation or sexual behavior conflict with your traditional cultural, ethnic, and/or spiritual identity? Y/N
- d. How have the above gender and sexual issues affected your life?  
\_\_\_\_\_

**B. Cultural Expressions and Explanations of Mental Illness**

**1. Idioms of Distress**

- a. In your own words how would you describe your symptoms or conditions?  
\_\_\_\_\_
- b. Are there any cultural or spiritual/religious terms you use to describe your condition?  
\_\_\_\_\_
- c. Are these kind of symptoms common in your family or within your cultural or religious group?  
\_\_\_\_\_

**2. Cultural Explanations of Mental Illness**

- a. How do you or your family explain the symptoms you are experiencing?  
\_\_\_\_\_
- b. How do others from your cultural and or religious/spiritual background explain the symptoms you are experiencing?  
\_\_\_\_\_
- c. What treatment have you tried in the past either professionally, culturally (folk remedies), or spiritually/religiously to eliminate these symptoms?  
\_\_\_\_\_

**C. Culturally Related Psychosocial Environmental Stressors and Supports  
(Please note culturally relevant interpretations of stressors)**

**1. Cultural and Psychosocial Stressors**

- a. What kind of difficulties have you had with your primary sources of support (e.g. family separations, disruptions, abuse, etc. See DSM-IV description)?  
\_\_\_\_\_
- b. What kind of difficulties have you had related to your social environment (e.g. no social support, difficulty with acculturation, discrimination, etc. See DSM-IV description)?  
\_\_\_\_\_
- c. What kind of educational problems have you had, if any (e.g. illiteracy, academic problems inadequate school environment etc. See DSM-IV description)?  
\_\_\_\_\_
- d. What kind of occupational problems have you had, if any (e.g. unemployment, difficult work conditions, discord with boss or co-workers etc. See DSM-IV description)?  
\_\_\_\_\_
- e. What kind of housing problems have you had if any (e.g. homelessness, inadequate housing, unsafe neighborhood, etc. See DSM-IV description)?  
\_\_\_\_\_
- f. What kind of economic problems have you had (e.g. extreme poverty, inadequate finances, insufficient welfare support)?  
\_\_\_\_\_
- g. What kind of problems have you had gaining access to health or mental health care services (e.g. inadequate services, no transportation to health care facility, inadequate health insurance)?  
\_\_\_\_\_
- h. What kind of problems have you had with the legal system (e.g. arrest, incarceration, victim of crime etc.)?  
\_\_\_\_\_

**2. Culturally Related Supports**

- a. I have family support (e.g. family visits, phone calls, letters, financial, emotionally)?  
1                  2                  3                  4                  5  
No                  Seldom                  Sometimes                  Often                  Very Often
- b. I have supportive friends from my cultural and religious community (e.g. visits, letter, phone calls)?  
1                  2                  3                  4                  5  
No                  Seldom                  Sometimes                  Often                  Very Often
- c. I have contact with people from my religious community (e.g. visits, letter, phone calls)?

**D. Cultural Elements of the Relationship Between the Patient and Treatment Providers**

**1. Cultural and Spiritual Factors Impacting the Patient and Provider Relationship**

- a. I feel I can trust my treatment team or individuals on the team even if they are ethnically, racially, culturally or religiously different from me.

1	2	3	4	5
No	Seldom	Sometimes	Often	Very Often

- b. I feel that the treatment team or individuals on the team may be biased towards me because of my ethnicity, race, social class or religious beliefs .

1	2	3	4	5
No	Seldom	Sometimes	Often	Very Often

- c. I feel that the treatment team or individuals on the team may misunderstand me or my behavior because I am ethnically, racially, culturally, linguistically, or religiously different from them.

1	2	3	4	5
No	Seldom	Sometimes	Often	Very Often

**2. Culturally Relevant Factors Pertaining to the Treatment Team That Can Impact the Provider Relationship TO BE ANSWERED BY TREATMENT TEAM**

- a. What are the differences between the patient's culture and the organizational culture that the treatment team represents?

Please check all the following areas where differences exist

- 1) Ethnicity/Race
- 2) Culture
- 3) Social Class
- 4) Preferred language
- 5) Religion/Spirituality

**E. Implications for Different Diagnosis and Treatment Planning  
TO BE ANSWERED BY TREATMENT TEAM**

**1. Are the Assessment Tools and Methods That are Being Utilized to Treat this Patient Culturally Sensitive and Appropriate for the Patient?**

- a. Given the limitations of assessment tools and methods what steps have been taken to acquire more culturally appropriate measures sensitive to the needs of the patient?

---

- b. Have you made adjustments in your interpretations of the findings and noted this in the appropriate documents (e.g. court reports, integrated treatment plans and psychological assessments, etc.)?

---

- c. What are the possible diagnostic biases and rule outs that exist for the ethnic, racial, religious, cultural group this patient represents?

---

*(For example: African-American tend to be overly diagnosed as paranoid schizophrenics; Hispanics tend to present with somatic complaints versus complaints versus common symptom manifestations indicative of more severe mood or psychotic disorders)*

- d. Has the patient's language fluency affected his/her ability to communicate effectively during the assessment processes?

---

- e. What are the cultural barriers and supports that may impact the diagnostic and treatment process?

---

- f. What kind of consultations would be appropriate to consider to assist in the assessment diagnostic, and treatment planning process (e.g. cultural, linguistic, religious/spiritual)?
- 

2. **Ethnopsychopharmacological Considerations**

- a. Are there any possible ethnopsychopharmacological considerations as it relates to varying metabolism rates by ethnicity and race for this patient (e.g. some African-Americans tend to be slow metabolizers and can suffer significant adverse side effects when administered standard doses of certain psychotropic medications)?
- 

**SUMMARY OF PERTINENT  
ETHNIC/CULTURAL, SPIRITUAL/RELIGIOUS FINDINGS  
IMPACTING DIFFERENTIAL DIAGNOSIS, AND TREATMENT PLANNING**

Please note the salient findings in the **NEW INTEGRATED TREATMENT PLAN** in the following sections: **Integration of Assessments and or Patient strengths** and on the newly proposed **Cultural and Spiritual Assessment Summary Report Form (pending approval from the Medical Records Committee)** to be filed in the Assessment Section of the Chart

APPENDIX C

CULTURAL FORMULATION REPORT TEMPLATE

## CULTURAL FORMULATION REPORT TEMPLATE

- I. Clinical History**
- II. Cultural Formulation**
  - A. Cultural Identity**
  - B. Cultural Explanation of the Illness**
  - C. Cultural Factors Related to Psychosocial Environment and Levels of Functioning**
  - D. Cultural Elements of the Clinician-Patient Relationship**
  - E. Overall Cultural Assessment**



APPENDIX D

MULTICULTURAL EDUCATION AND TRAINING

CULTURAL FORMULATION SCORING SHEET

MULTICULTURAL EDUCATION AND TRAINING  
CULTURAL FORMULATION SCORING SHEET

**INSTRUCTIONS:** As you read each formulation, please note whether the following issues are addressed in the formulation. If a statement or a series of statements are present, place a check mark next to the item descriptor. If no statements are present, please leave it blank.

**I. CLINICAL HISTORY**

1. Patient Identification \_\_\_\_\_
2. History of present illness \_\_\_\_\_
3. Psychiatric history and previous treatment \_\_\_\_\_
4. Social and developmental history \_\_\_\_\_
5. Family history \_\_\_\_\_
6. Course and outcome \_\_\_\_\_
7. Diagnostic formulation \_\_\_\_\_

**II. CULTURAL FORMULATION**

**A. CULTURAL IDENTITY**

1. Cultural reference group(s) \_\_\_\_\_
2. Language \_\_\_\_\_
3. Cultural factors in development \_\_\_\_\_
4. Involvement with culture of origin \_\_\_\_\_
5. Involvement with host culture \_\_\_\_\_

**B. CULTURAL EXPLANATION OF THE ILLNESS**

1. Predominant idioms of distress and local illness categories \_\_\_\_\_
2. Meaning and severity of symptoms  
In relation to cultural norms \_\_\_\_\_
3. Perceived causes and explanatory models \_\_\_\_\_
4. Help-seeking experiences and plans \_\_\_\_\_

**C. CULTURAL FACTORS RELATED TO PSYCHOSOCIAL  
ENVIRONMENT AND LEVELS OF FUNCTIONING**

1. Social stressors \_\_\_\_\_
2. Social supports \_\_\_\_\_
3. Levels of functioning and disability \_\_\_\_\_

**D. CULTURAL ELEMENTS OF THE CLINICIAN-PATIENT  
RELATIONSHIP**

1. An indication of difference between the clinician and the patient's culture or social status when it exists. \_\_\_\_\_
2. Acknowledgement of any barriers that these differences may cause (e.g. language, communication) in eliciting symptoms or understanding their cultural significance. \_\_\_\_\_
3. Acknowledgement of relational differences due to culture in establishing rapport with the patient \_\_\_\_\_

## **E. OVERALL CULTURAL ASSESSMENT**

1. A discussion of how cultural considerations  
(Where there is evidence) specifically influence  
Comprehensive care in the following areas:     <sup>a</sup>  
diagnosis, and treatment planning. \_\_\_\_\_

**Total Score:** \_\_\_\_\_

APPENDIX E

CLINICIAN INFORMATION AND BACKGROUND FORM

CLINICIAN INFORMATION AND BACKGROUND FORM

Name: \_\_\_\_\_ Program: \_\_\_\_\_ Unit: \_\_\_\_\_

PSH Phone #: \_\_\_\_\_ FAX: \_\_\_\_\_ Email: \_\_\_\_\_  
(optional)

Discipline: \_\_\_\_\_ Licensure Status: \_\_\_\_\_

Gender: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_

APPENDIX F

MULTICULTURAL EDUCATION AND TRAINING STRUCTURED

INTERVIEW FOR CULTURAL FORMULATIONS:

EXPERT RATER FORM

MULTICULTURAL EDUCATION AND TRAINING STRUCTURED  
INTERVIEW FOR CULTURAL FORMULATIONS:  
EXPERT RATER FORM

How useful are these items in the development of a cultural formulation?

Use the numbers below to indicate the usefulness of each statement.

(1) Not useful (2) Somewhat useful (3) Useful (4) Very useful

1. What ethnic/racial group do.....1 2 3 4  
you identify with?
2. What spiritual or religious.....1 2 3 4
3. What language would you.....1 2 3 4  
prefer services to be provided  
to you?
4. Based upon the patient's.....1 2 3 4  
response to the above and the  
interviewer's observations of  
the patient's expressive (oral  
and written) and receptive  
(oral and written) language, does  
language pose a barrier to  
treatment?
5. Do you speak more than one.....1 2 3 4  
language or dialect?
6. Is your traditional cultural.....1 2 3 4  
heritage (e.g., ethnic, racial,  
religious) important to you?
7. What is your (ethnic, racial,.....1 2 3 4  
and/or religious) cultural  
heritage?
8. What religion was practiced.....1 2 3 4  
while you were growing up?
9. Do you observe cultural.....1 2 3 4  
customs and celebrations  
unique to your traditional, ethnic, racial, and/or religious heritage?

(1) Not useful (2) Somewhat useful (3) Useful (4) Very useful

10. Is American culture.....1 2 3 4  
important to you?
11. When you were growing up.....1 2 3 4  
were your neighbors and  
friends the same ethnicity,  
race/or religion as you?
12. Since you were an adult have.....1 2 3 4  
your close personal friends  
been the same ethnicity, race  
and/or religion as you?
13. Do you have a close relation-.....1 2 3 4  
ship with your immediate  
family (e.g., parents, siblings,  
wife, children)?
14. Is it important to you to know.....1 2 3 4  
your extended family (e.g.,  
aunts, uncles, cousins, and  
grandparents) and to have a  
close relationship with them?
15. While growing up in your.....1 2 3 4  
family who made the major  
decisions?
16. What responsibilities did you.....1 2 3 4  
have in your family as a child?
17. To what degree do you practice.....1 2 3 4  
any particular religion now?
18. If you are practicing a religion,.....1 2 3 4  
what do you practice?
19. If you are not practicing any.....1 2 3 4  
religion are you interested in  
exploring your spirituality or  
religion?
20. Is your spirituality or religion.....1 2 3 4  
important to you?



(1) Not useful (2) Somewhat useful (3) Useful (4) Very useful

21. Are there traditional religious.....1 2 3 4  
and/or cultural clothing, dietary,  
or other items/customs you  
would like to be permitted to  
utilize or practice as part of your  
cultural or religious expression?
22. How does your religion or.....1 2 3 4  
spirituality influence your life's  
purpose?
23. What effect has the absence or.....1 2 3 4  
presence of your spirituality or  
religion played in where you find  
yourself today (e.g., incarceration,  
hospitalization)?
24. How do you see you religion or.....1 2 3 4  
spirituality effecting your  
recovery and discharge from the  
hospital?
25. Is the patient's reported spiritual/.....1 2 3 4  
religious experiences consistent  
with the normative practices  
within his/her culture or professed  
religion?
26. Is there consistency between the.....1 2 3 4  
patient's stated importance of his/  
her religion/spirituality, and the  
degree to which his/her religious,  
cultural traditions and beliefs are  
actually followed?
27. What is the quality of the.....1 2 3 4  
patient's religiousness/  
spirituality?
28. How do you identify in terms.....1 2 3 4  
of your gender?  
orientation?

(1) Not useful (2) Somewhat useful (3) Useful (4) Very useful

29. Does your sexual orientation.....1 2 3 4  
or sexual behavior conflict with  
your traditional cultural, ethnic and/or spiritual identity?
30. In your own words how would.....1 2 3 4  
you describe your symptoms or  
condition?
31. Are there any cultural or.....1 2 3 4  
spiritual/religious terms you use  
to describe your condition?
32. Are these kind of symptoms.....1 2 3 4  
common in your family or  
within your cultural or  
religious group?
33. How do you or your family.....1 2 3 4  
explain the symptoms you are  
experiencing?
34. How do others from your.....1 2 3 4  
cultural and or religious/  
spiritual background explain  
the symptoms you are  
experiencing?
35. What treatments have you.....1 2 3 4  
tried in the past either pro-  
fessionally, culturally (folk  
remedies), or spiritually/  
religiously to eliminate these  
symptoms?
36. What kind of difficulties have.....1 2 3 4  
you had with your primary  
sources of support (e.g., family  
separations, disruptions, etc.)?
37. What kind of difficulties have.....1 2 3 4  
you had related to your social  
environment (e.g., no social  
support, difficulty with  
acculturation, etc.)?

	(1) Not useful	(2) Somewhat useful	(3) Useful	(4) Very useful
38. What kind of educational.....1 2 3 4 problems have you had if any (e.g., illiteracy, academic problems, etc.)?				
39. What kind of occupational.....1 2 3 4 problems have you had if any e.g., unemployment, discord with boss or co-workers, etc.)?				
40. What kind of housing problems.....1 2 3 4 have you had if any (e.g., home- lessness, unsafe neighborhood, inadequate housing, etc.)?				
41. What kind of economic problems.....1 2 3 4 have you had (e.g., extreme poverty, inadequate finances, etc.)?				
42. What kind of problems have you.....1 2 3 4 had gaining access to health or mental care services (e.g., no transportation to health care facility, inadequate services, etc.)?				
43. What kind of problems have you.....1 2 3 4 had with the legal system (e.g., arrest, victim of crime, etc.)?				
44. I have family support (e.g., family.....1 2 3 4 visits, phone calls, letters, etc.)?				
45. I have supportive friends from.....1 2 3 4 my cultural and religious community (e.g., visits, letter, phone calls)?				
46. I have contact with people from.....1 2 3 4 my religious community (e.g., visits, letters, phone calls)?				
47. I feel I can trust my treatment.....1 2 3 4				

(1) Not useful    (2) Somewhat useful    (3) Useful    (4) Very useful

team or individuals on the team  
even if they are ethnically, racially,  
culturally, or religiously different  
from me.

48. I feel that the treatment team or.....1    2    3    4  
biased towards me because of my  
ethnicity, race, social class, or  
religious beliefs.
49. I feel that the treatment team.....1    2    3    4  
or individuals on the team may  
misunderstand me or my  
behavior because I am ethnically,  
racially, culturally, linguistically,  
or religiously different from them.
50. What are the differences between.....1    2    3    4  
the patient's culture and the  
organizational culture that the  
treatment team represents?
51. Given the limitations of assess-.....1    2    3    4  
ment tools and methods what  
steps have been taken to acquire  
more culturally appropriate  
measures sensitive to the needs  
of the patient?
52. Have you made adjustments in.....1    2    3    4  
your interpretations of the  
findings and noted this in the  
appropriate documents (e.g.,  
court reports, integrated treatment  
plans, and psychological  
assessments, etc.)?
53. What are the possible diagnostic.....1    2    3    4  
biases and rule outs that exist  
for the ethnic, racial, religious,  
cultural group this patient  
represents?
54. What kind of consultations.....1    2    3    4

(1) Not useful    (2) Somewhat useful    (3) Useful    (4) Very useful

would be appropriate to consider  
to assist in the assessment  
diagnostic, and treatment  
planning process (e.g., cultural,  
linguistic, religious/spiritual)?

55. Are there any possible ethno-.....1   2   3   4  
psychopharmacological  
considerations as it relates to  
varying metabolism rates by  
ethnicity and race for this  
patient)?

APPENDIX G

MARLOWE-CROWNE SOCIAL DESIRABILITY SCALE

# MARLOWE-CROWNE SOCIAL DESIRABILITY SCALE

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is True or False as it pertains to you. Please answer questions by circling T if your answer is true or F if your answer is false. THERE ARE NO RIGHT OR WRONG ANSWERS,

	True	False
1. It is sometimes hard for me to go on with my work if I am not encouraged.	T	F
2. I sometimes feel resentful when I don't get my way.	T	F
3. On a few occasions, I have given up doing something because I thought too little of my ability.	T	F
4. There have been times when I felt like rebelling against people in authority even though I knew they were right.	T	F
5. No matter who I'm talking to, I'm always a good listener.	T	F
6. There have been occasions when I took advantage of someone.	T	F
7. I'm always willing to admit when I make a mistake.	T	F
8. I sometimes try to get even rather than forgive and forget.	T	F
9. I am always courteous, even to people who are disagreeable.	T	F
10. I have never been irked when people expressed ideas very different from my own.	T	F
11. There have been times when I was quite jealous of the good fortune of others.	T	F
12. I am sometimes irritated by people who ask favors of me.	T	F
13. I have never deliberately said some-	T	F

thing that hurt someone's feelings.



APPENDIX H  
CALIFORNIA RESEARCH PARTICIPANT'S  
BILL OF RIGHTS

CALIFORNIA RESEARCH PARTICIPANT'S  
BILL OF RIGHTS

Any person who is asked to participate as a human subject in a research project, or who is asked to consent on behalf of another, has the following rights:

- a) Be informed of the nature and purpose of the project.
- b) Be given an explanation of the procedures to be followed in the project, and any drug or device to be utilized.
- c) Be given a description of any attendant discomforts and risks reasonably to be expected from the project
- d) Be given an explanation of any benefits to the subject reasonably to be expected from the project, if applicable.
- e) Be given a disclosure of any appropriate alternative procedures, drugs or devices that might be advantageous to the subject, and their relative risks and benefits.
- f) Be informed of the avenues of medical treatment, if any, available to the subject after the project if complications should arise.
- g) Be given an opportunity to ask any questions concerning the project or the procedures involved.
- h) Be instructed that consent to participate in the project may be withdrawn at any time and the subject may discontinue participation in the project without prejudice.
- i) Be given a copy of the signed and dated written consent form.
- j) Be given the opportunity to decide to consent or not to consent to a project without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on the subject's decision.

*(Adapted for a research project from Health & Safety Code Chapter 1.3, Section 24172)*

APPENDIX I  
PATIENT INFORMED CONSENT

## PATIENT INFORMED CONSENT

### **1. Purpose, Participation, and Procedures:**

Here at Patton State Hospital we are committed to improving the quality of care and treatment that we provide to the culturally diverse patients we serve. In an effort to do this we have developed an interview tool that we believe will help our clinical staff (e.g. Psychiatrist,

Psychologist, and Social Worker) improve the way in which they assess for cultural and spiritual factors that may impact your treatment. Because you are a patient here at Patton State Hospital you are eligible to participate in this study. Your participation will assist us in determining whether this tool is useful in identifying cultural and spiritual information that will help our staff improve their ability to develop culturally and spiritually informed diagnoses and treatment plans for patients like yourself.

Information will be collected on two hundred male and female patients currently hospitalized at Patton State Hospital. Participation will require approximately an hour of your time. You will be interviewed by one of the following staff: Psychiatrist, Psychologist, or a Social Worker. They will ask you questions about your background, culture, spiritual beliefs and practices.

Your participation is voluntary. However, in an effort to show our appreciation for your cooperation and completion of the interview you will receive an invitation to participate in a celebration with all the other volunteers in this study. Should you decide to participate and then choose not to complete the interview any information you provided would not be used in the study. You would have also given up your eligibility to participate in the volunteer celebration.

### **2. Description of Risks:**

There are no negative consequences if you decide not to participate in this study. That is, if you refuse to participate, there will be no penalty of loss of benefits to which you may otherwise be entitled to (For Example: grounds privileges if you have them). At any time, you may also choose to withdraw from the study without loss of any regular benefits to which you were otherwise entitled.

While medical services are not expected to be needed in this study, should any need for them occur, you will be referred to the medical doctor on your unit. As a result of your inpatient status, you are likely to be diagnosed with severe psychiatric disorders that may have cultural influences that may require professional assistance. Thus, should any need for psychological/psychiatric, or cultural services arise you will be referred to your treatment team. No other risks are likely.

### **3. Description of Benefits:**

Your contribution to this research may help future patients by providing information that may help in the development of culturally appropriate treatment planning. Additionally, as a sign of appreciation you will receive an invitation to attend a celebration with all other volunteers in the study.

**4. Alternative Procedures:**

The interview used in this study should not cause more than a small amount of discomfort (e.g. boredom, and fatigue). Given the nature of this study is to validate a new tool designed specifically to assess Patton State Hospital's patients for the influence of cultural factors on the quality of service delivery, there were no comparable alternative procedures found upon review of the literature.

**5. Confidentiality of Records:**

Participation in this study is voluntary and the information obtained will be kept strictly confidential. Useful information for treatment purposes may become available from the results. You will be the one to decide whether this information will be released, following consultation with the research team. Should you desire to share the results from the interview with your treatment team you will have to provide written consent to release interview information. While the findings from the interview are confidential your participation in the volunteer celebration would be an admission of your participation in the study and you would forfeit your anonymity.

**6. Compensation:**

Participants will receive an invitation to take part in a celebration coordinated by research staff to show appreciation for their participation in the research project.

**7. Injury:**

Injuries from responding to the interview are not expected. However, should you become physically ill while involved in the interview process, the interview will be halted and medical attention sought from nursing and medical staff on the unit.

**8. Questions:**

Should I wish to obtain additional information or answers to questions I may have concerning this study, I may direct my inquiry to the researchers or the current Chairperson of the IRB, Dr. Robert Welsh, Department of Psychology, Patton State Hospital, 3102 E. Highland Ave, Patton, California 92369.

**9. Voluntary Participation:**

As noted, participation is completely voluntary and no loss of any privileges or treatment will Occur for not participating in this study.

**10. Other information:**

I have also been provided a Participant's Bill of Rights outlining my right's for participating and withdrawing participation from this study.

**11. Consent:**

My signature on this form indicates I have been informed of the purpose of this study, any risks or discomforts, any benefits expected from the research, and alternative procedures or courses of treatment that might be more helpful for me.

I may direct further questions to the current Chairperson of the IRB, Dr. Robert Welsh,  
Department of Psychology, Patton State Hospital, 3102 E. Highland Ave, Patton, California  
92369.

Patient Signature/Date: \_\_\_\_\_

Witness Signature/Date: \_\_\_\_\_

APPENDIX J  
CLINICIAN RECRUITMENT SCRIPT

## CLINICIAN RECRUITMENT SCRIPT

Hello my name is \_\_\_\_\_. I am a staff member of the Multicultural Education and Training Program here at Patton State Hospital. The hospital has made a commitment to improve the quality of care and treatment that we provide to the culturally diverse patients we serve here at Patton. In an effort to do this we have developed an interview tool that we believe will help clinical staff (e.g. Psychiatrist, Psychologist, and Social Worker) improve the way in which cultural factors are elicited and assessed for. Because you are a clinician here at Patton State Hospital you are eligible to participate in this study. Your participation will assist us in determining whether this tool is useful in eliciting cultural information that will help to improve diagnostic accuracy and culturally appropriate treatment plans.

We will require approximately 20 hours of your time. Initially, you will complete a cultural competence survey, which will take approximately 20 minutes. Then you will be randomly assigned three to four patients to interview focusing on topics related to background, culture, spiritual beliefs and practices. Upon completion of each interview, you will write a cultural formulation using the information elicited from the patients.

Your participation is voluntary. However, in an effort to show our appreciation for your cooperation and completion of the interview and written cultural formulation, you will be sponsored to attend a local 1-day conference not to exceed \$100.00. Should you decide to participate and then choose not to complete the cultural competence survey, interviews and/or the written cultural formulations, the information you obtained would not be used in the study. You will also forfeit your eligibility to be sponsored to a conference.

I would now like to give you an opportunity to review the rest of the consent form and allow you an opportunity to decide if you would like to participate. Please let me know if you have any questions. Thank you



APPENDIX K  
CLINICIAN RECRUITMENT LETTER

## CLINICIAN RECRUITMENT LETTER

Date:

Name:

Address:

Subject:

Dear \_\_\_\_\_:

My name is Dione Johnson. I am the Graduate Student Assistant to Dr. Robbin Huff-Musgrove, the Director of the Multicultural Education and Training Program (M.C.E.T.). The Hospital, and the M.C.E.T program, is committed to provide culturally competent services to the patients hospitalized at Patton. As a result, the Clinical Quality Improvement Committee at Patton State Hospital identified a need to improve the quality of services delivered to ethnic minority patients at Patton. This need led to the development of the Multicultural Education and Training Structured Interview for Cultural Formulations (METSICF). The M.C.E.T. program is currently in the process of validating the utility of the METSICF, however we need your assistance.

In order to validate the METSICF volunteers are needed to conduct interviews with patients at Patton State Hospital. Your participation will benefit the field of Cultural Competence and mental health practice, and vastly improve the level of culturally appropriate diagnosis, assessment and treatment planning provided to the patients. Further, the Executive Director, Medical Director, Clinical Administrator, and all Service Chiefs are in full support of this study and encourage your participation.

If you are interested in participating, please contact me at 7639 or 6260. I want to take this opportunity to thank-you in advance for your consideration of this request.

Sincerely

Dione Johnson  
Graduate Student Assistant to the  
Director of the Multicultural Education and Training Program

APPENDIX L  
PATIENT RECRUITMENT SCRIPT

## PATIENT RECRUITMENT SCRIPT

Hello My name is \_\_\_\_\_ I am a staff member of the Multicultural Education and Training Program here at Patton State Hospital. The hospital has made a significant commitment to improve the quality of care and treatment that we provide to the culturally diverse patients we serve here at Patton. In an effort to do this we have developed an interview tool that we believe will help our clinical staff (e.g. Psychiatrist, Psychologist, and Social Worker) improve the way in which they assess for cultural and spiritual factors that may impact your treatment. Because you are a patient here at Patton State Hospital you have been selected to participate in this study. Your participation will assist us in determining whether this tool is useful in identifying cultural and spiritual information that will help our staff improve their ability to diagnose and treat you more effectively.

We will require approximately an hour of your time. You will be interviewed by one of the following staff: Psychiatrist, Psychologist, or a Social Worker. They will ask you questions about your background, culture, spiritual beliefs and practices.

Your participation is voluntary. However, in an effort to show our appreciation for your cooperation and completion of the interview you will receive an invitation to participate in a celebration with all the other volunteers in this study. Should you decide to participate and then choose not to complete the interview any information you provided would not be used in the study. You would have also given up your eligibility to participate in the volunteer celebration. While the findings from the interview are confidential your participation in the volunteer celebration would be an admission of your participation in the study and you would forfeit your anonymity.

I would now like to give you an opportunity to review the rest of the consent form and allow you an opportunity to decide if you would like to participate. Please let me know if you would like me to read it over with you or if you have any questions. Thank you.

APPENDIX M  
CLINICIAN INFORMED CONSENT

## CLINICIAN INFORMED CONSENT

### **1. Purpose, Participation, and Procedures:**

Here at Patton State Hospital we are committed to improving the quality of care and treatment that we provide to the culturally diverse patients we serve. In an effort to do this we have developed an interview tool that we believe will help our clinical staff (e.g. Psychiatrist, Psychologist, and Social Worker) improve the way in which they assess for cultural factors that may impact treatment. We will also be looking at the relationship between information obtained during the interview and your level of cultural competence. So we will ask you to complete a brief survey to assess for cultural competence. Because you are a member of the clinical staff here at Patton State Hospital you are eligible to participate in this study. Your participation will assist us in determining whether this tool is useful in identifying cultural information that will help our clinical staff improve their ability to develop culturally informed diagnoses and treatment plans for the culturally diverse patient population we serve.

Information will be collected on two hundred culturally diverse male and female patients and 52 culturally diverse male and female clinicians at Patton State Hospital. Your participation will require approximately 20 hours of your time. You will interview 3-4 patients focusing on their background, cultural, beliefs and practices. Upon completion of each interview, you will write a cultural formulation using the information elicited from the patients.

Your participation is voluntary. However, in an effort to show our appreciation for your cooperation and completion of the interview and written cultural formulation, you will be sponsored to attend a local 1-day conference not to exceed \$100.00. Should you decide to participate and then choose not to complete the survey, interviews and/or the written cultural formulations, the information you obtained would not be used in the study. You will also forfeit your eligibility to be sponsored to a conference.

### **2. Description of Risks**

There are no negative consequences if you decide not to participate in this study. If you refuse to participate there will be no penalty or negative repercussions. If you decide to withdraw from the study during the course of the project there will be no negative consequences, with the exception of your forfeiture for sponsorship to a conference of your choice

### **3. Description of Benefits:**

You will be offered a reduced workload commensurate with the number of hours you spend participating in the study. In addition, you will be sponsored to attend a local 1-day conference (not to exceed \$100.00) of your choice. We believe your participation will serve as an educational experience that will further your level of cultural awareness and competence. Additionally, we believe your contribution to this research project will help clinical staff improve the quality of service delivery they provide to the culturally diverse patient population we serve.

**4. Alternative Procedures:**

Given the nature of this study is to validate a new tool designed specifically to assess Patton State Hospital's patients for the influence of cultural factors on the quality of service delivery, there were no comparable alternative procedures found upon review of the literature.

**5. Confidentiality of Records:**

Participation in this study is voluntary for both the patient and the clinician and any information obtained will be kept confidential. We asked that you not share any information about the results of the patient interview with other staff members. Any results obtained from the cultural competence survey will be kept strictly confidential unless you choose to share the information.

**6. Compensation:**

Your participation in the study will be compensated by your ability to attend a 1-day local conference (not to exceed \$100.00) of your choice. However, as stated previously you will be offered a reduced workload commensurate with the number of hours that you spend participating in the study.

**7. Injury:**

We expect no physical injuries as a result of your participation. However, if you become physically ill, or are physical injured during the clinical interview the testing will be halted and medical attention will be sought from medical personal in the employee clinic.

**8. Questions:**

Should I wish to obtain additional information or answers to questions I may have concerning this study, I may direct my inquiry to the researchers or the current Chairperson of the IRB, Dr. Robert Welsh, Department of Psychology, Patton State Hospital, 3102 E. Highland Ave, Patton, California 92369.

**9. Voluntary Participation:**

As noted, participation is completely voluntary and no loss of any benefits will occur for not participating in this study.

**10. Other information:**

I have also been provided a Participant's Bill of Rights outlining my right's for participating and withdrawing participation from this study.

**11. Consent:**

My signature on this form indicates I have been informed of the purpose of this study, any risks or discomforts, any benefits expected from the research, and alternative procedures or courses of treatment that might be more helpful for me.

I may direct further questions to the current Chairperson of the IRB, Dr. Robert Welsh,  
Department of Psychology, Patton State Hospital, 3102 E. Highland Ave, Patton, California  
92369.

Clinician Signature/Date: \_\_\_\_\_



APPENDIX N

MANUAL FOR ADMINISTRATION OF THE

MULTICULTURAL EDUCATION AND TRAINING

STRUCTURED INTERVIEW FOR CULTURAL

FORMULATIONS

MANUAL FOR ADMINISTRATION OF THE  
MULTICULTURAL EDUCATION AND TRAINING  
STRUCTURED INTERVIEW FOR CULTURAL  
FORMULATIONS

**Introduction:**

*This structured interview is proposed as a supplement to the other biopsychosocial instruments in an attempt to address the role culture and spirituality play in the expression and evaluation of symptoms and dysfunction, as well as the effect cultural and spiritual differences may have on relationships between the individual and the clinician (Diagnostic and Statistical Manual IV, 1994, pg. 843).*

**A CULTURAL IDENTITY:**

**1. Patient's Ethnic/Racial Identity (reference group)**

The person administering the interview will need to ask the patient which ethnic or cultural identity best identifies him/her. The interviewer may need to clarify the exact criteria for inclusion in the various categories with the patient when administering the interview. Below are the descriptions of the ethnic or cultural groups contained in the interview.

- a. Black or African-American: A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."
- b. Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South of Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."
- c. Asian or Pacific Islander: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- d. Native-American or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachments.
- e. White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- f. Other: If a person considers himself/herself biracial then this would be an appropriate category to check. However, the interviewer must identify which ethnic or cultural groups the patient considers himself/herself to be representative of.

**2. Patients Spiritual/Religious Identity**

Ask the patient how he/she identifies herself/himself in regards to spiritual/religious orientation or affiliation, and note the response.

The person administering the interview will need to read the categories and ask the patient which spiritual or religious identity best identifies him/her.

### **3. Place of Birth**

- a. Write where the patient was born and reared. If the patient was born outside the United States, designate how he/she arrived in the United States. The following are definitions of the terms used in this question:
  - (i) Immigrant refers to a person who came to the United States for other reasons which do not include fleeing their native country due to war, political or religious persecution.
  - (ii) Refugee refers to a person who came to the United States to flee from war or political or religious persecution in their native country.
  - (iii.) Other refers to any other manner, besides those listed above, which the patient used to arrive in the United States.
- b. Designate what year the patient came to the United States if he/she was not born in the United States.

### **4. Language Capacity**

- a. Ask the patient which language his primary caretaker spoke to him/her when he/she was a child, and note the answer.
- b. Note which language the patient prefers to speak, read, understand and write. If the patient reports no preference, then note which languages he is referring to.
- c. The examiner will need to incorporate the patient's response to question (a) and his/her observations of the patient's expressive and written language to rate the amount language will be a barrier to treatment.
- d. Ask the patient if he/she speaks more than one language, and write what the language is. Make sure to include other non-standard English Dialects.

### **5. Acculturation/Family Organization and Relational Roles**

Questions (a) through (k) need to be asked by the interviewer to the patient and the response of the patient needs to be noted on the interview form. The interviewer can use the previously listed explanations for ethnic or cultural identity to help answer the questions in this section.

### **6. Current Religious Beliefs and Practices**

Questions #a and #b need to be asked by the interviewer to the patient and the responses noted on the interview form. Questions c - f are open-ended, and the patient's response needs to be noted as he/she gives it.

- 1) Treatment Team Considerations Related to the Patients Culture and Spirituality: **This section needs to be completed by the interviewer as it pertains to the patient.**

- (i) In the opinion of the treatment team, do the patients reported spiritual/religious experiences fall within the culture of the religion they practice.
- (ii) Also note how the beliefs deviate if this is true for the patient.
- (iii) Note the response to the question as perceived by the treatment team.
- (iv) For the purpose of this question, utilize the following to help define the concepts:
  - a) Open: Ability to listen to other opinions, flexible, and open to other ideas or spiritual/religious perspectives.
  - b) Closed: Rigid, inflexible, and unable to tolerate any spiritual/religious ideas that may challenge their own.
  - c) Religion used for its benefits: He/She uses religion for a specific reason and purpose (e.g. prosperity, success, healing).
  - d) Religion is meaningful in and of itself: He/She practices religion because of its inherent value independent of any tangible benefits .

## **7. Gender Identity and Sexual Orientation**

Questions (a) through (d) need to be asked by the interviewer to the patient and the responses noted on the interview form. It is important to ask the patient is he/she is comfortable enough to share their sexual orientation, and respect there response.

## **B. Cultural Expressions and Explanations of Mental Illness**

### **1. Idioms of Distress**

- a. Ask the patient the question, in terms he/she would understand, and note the answer.
- b. Ask the patient the question and note the answer.
- c. Ask the patient the question, in terms he/she would understand, and note the answer.

### **2. Cultural Explanation of Mental Illness**

- a. Ask the patient how he/she or their family explains the symptoms that he/she is currently experiencing.
- b. Ask the patient how other people from the same cultural background explain the symptoms, which he/she is currently experiencing.
- c. This question it trying to ascertain what types of healing practices are utilized by people from the same ethnic or cultural background to treat symptoms like his. Ask the patient the question, and write the answer he/she gives.

**C. Culturally Related Psychosocial Environmental Stressors and Supports**

**1. Cultural and Psychosocial Stressors**

Questions a through h are attempting to ascertain the different stressors the patient feels he/she has experienced. Ask the questions and note the response.

**2. Culturally Related Supports**

Questions a through c are attempting to ascertain the various supports the patient feels he/she currently has. Ask the questions and note the response.

**D. Cultural Elements of the Relationship Between the Patient and the Treatment Team Providers**

This next section is divided into questions that the patient needs to answer, and questions that the treatment team will need to answer as they pertain to the patient. It is understood that differences usually exist among patients and treatment teams. However, these questions are attempting to assess how these differences influence the patient and the relationship he/she has with her/his treatment team.

**1. Cultural and Spiritual Factors Impacting the Patient and Provider Relationship**

a-c These questions need to be asked of the patient, and there response noted on the interview form. It is important to inform the patient that the questions are from his/her perspective, and that no negative consequences will occur as result his/her answer.

**2. Culturally Relevant Factors Pertaining to the Treatment Team That Can Impact the Provider Relationship**

The following question needs to be answered by the treatment team as it pertains to the relationship between the treatment team and the patient.

- a. This question is attempting to assess if there exists a difference between the culture of the patient and the culture of the, organizational system, which the treatment team represents. If the team answers yes to the existence of differences between the culture of the patient and the system/treatment team, then check the areas where the differences lie.

**E Implications for Different Diagnosis and Treatment Planning**

This next section consists of questions which the Treatment Team needs to answer as they pertain to the patient. Please incorporate the information gathered from the previous sections and the clinical opinion of the treatment team to answer questions #1 and #2.

**SUMMARY OF PERTINENT  
ETHNIC/CULTURAL, SPIRITUAL/RELIGIOUS FINDINGS  
IMPACTING DIFFENTIAL DIAGNOSIS, AND TREATMENT PLANNING**

In this section, include a brief summary of any pertinent issues covered in the interview. **For example:** the patient speaks Spanish and has received differential treatment in terms of access to services due to a language barrier, or the patient does attend weekly religious services, but adheres to some rigid and strange beliefs which are not common within his/her religious culture.

## REFERENCES

- Adebimpe, V. (1981). Overview: White norms and psychiatric diagnosis of Black patients. *American Journal of Psychiatry*, 138, 279-285.
- Alvidrez, J. (1999). Ethnic variations in mental health attitudes and service use among low-income African American, Latina, and European American young women. *Community Mental Health Journal*, 35(6), 515-530.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders*, Text Revision (4<sup>th</sup> ed.). Washington, DC: Author.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4<sup>th</sup> ed.). Washington, DC: Author.
- Barnhouse, R. T. (1986). How to evaluate patients' religious ideation. In L. Robinson (Ed.), *Psychiatry and religion: Overlapping concerns*. Washington, D.C: American Psychiatric Press.
- Bergin, A. (1991). Values and religious issues in psychotherapy and mental health. *American Psychologist*, 46, 394-403.
- Bergin, A., & Jensen, J. (1990). Religiosity of psychotherapists: A national survey. *Psychotherapy*, 27, 3-7.
- Bradford, D. (1985). A therapy of religious imagery for paranoid schizophrenic psychosis. In M. Spero (Ed.), *Psychotherapy of the religious patient*. Springfield, IL: Charles C. Thomas.
- Browning, D., Gobe, T., & Evison, I. (1990). *Religious and ethical factors in psychiatric practice*. Chicago, IL: Nelson-Hall.
- Capps, D., Rambo, L., & Ransohoff, P. (1976). *Psychology of religion*. Detroit, MI: Gale Research.

- Castro, F. G., Furth, P., & Karlow, H. (1985). The health beliefs of Mexican, Mexican-American, and Anglo-American women. *Hispanic Journal of Behavioral Sciences*, 6(4), 365-383.
- Corin, E. (1996). Cultural comments on organic and psychotic disorders. In J.E. Mezzich, A. Kleinman, H. Fabrega, & D.L. Parron (Eds.), *Culture & psychiatric diagnosis: A DSM-IV perspective*. Washington, DC: American Psychiatric Press.
- Dana, R.H. (1996). Culturally competent assessment practice in the United States. *Journal of Personality Assessment*, 66(3), 472-487.
- Dana, R.H., Behn, J.D., & Gonwa, T. (1992). A checklist for the examination of cultural competence in social services agencies. *Research on Social Work Practice*, 2(2), 220-233.
- Dana, R.H. & Matheson, L. (1992). An application of the Agency Cultural Competence Checklist to a program serving small and diverse ethnic communities. *Psychosocial Rehabilitation Journal*, 15(4), 101-105.
- D'andrea, M., Daniels, J., & Heck, R. (1991). Evaluating the impact of multicultural counseling training. *Journal of Counseling and Development*, 70, 143-148.
- Dragnus, J.G. (1981). Counseling across cultures: Common themes and distinct approaches. In P.B. Pedersen, J.G. Dragnus, W.J. Lonner, & S.E. Trimble (Eds.), *Counseling across cultures* (2<sup>nd</sup> ed., pp. 3-21). Honolulu: University of Hawaii Press.
- Egeland, J.A., Hostetter, A.M., & Eshleman, S.K. (1983). Amish study III: The impact of cultural factors on diagnosis of bipolar illness. *American Journal of Psychiatry*, 140, 67-71.
- Fabrega, H. (1988). Black-white differences in psychopathology in an urban psychiatric population. *Comparative Psychiatry*, 29, 285-297.
- Hogan-Garcia, M. (1999). *The four skills of cultural*



- diversity competence*. Belmont: Wadsworth Publishing Company.
- Holcomb-McCoy, C.C., & Myers, E. (1999). Multicultural competence and counselor training: A national survey. *Journal of Counseling & Development*, 77, 294-302.
- Gallup, G. (1985). Fifty years of Gallup surveys on religion. *The Gallup Report*. Report No. 226.
- Glock, C.Y., & Stark, R. (1965). *Religion and society in tension*. Chicago: Rand McNally.
- Goldstein, A.P. (1981). Evaluating expectancy effects in cross-cultural counseling and psychotherapy. In A.J. Marsella and P.B. Pederson (Eds.), *Cross-Cultural Counseling and Psychotherapy* (pp. 85-101). New York: Pergamon Press.
- Good, B., & Good, M.J. (1986). The cultural context of diagnosis and therapy: A view from medical anthropology. In M. Miranda and HHL Kitano (Eds.), *Mental Health Research in Minority Communities: Development of Culturally Sensitive Training Programs* (pp. 1-27). Rockville: National Institute of Mental Health.
- Goodwin, F., & Jamison, K. (1990). *Manic-depressive illness*. Oxford: Oxford University Press.
- Gopaul-McNicol, S. A. (1997). The role of religion in psychotherapy: A cross-cultural examination. *Journal of Contemporary Psychotherapy*, 27(1), 37-48.
- Graham, S. (1992). Most of the subjects were White and middle class; Trends in published research on African Americans in selected APA journals, 1970-1989. *American Psychologist*, 47, 629-639.
- Greenberg, D., & Witzum, E. (1991). Problems in the treatment of religious patients. *American Journal of Psychotherapy*, 45, 554-565.

- Greyson, B., & Harris, B. (1987). Clinical approaches to the near-death experience. *Journal of Near-Death Studies*, 6, 41-52.
- Guarnaccia, P. J., & Rogler, L. H. (1999). Research on culture-bound syndromes: New directions. *American Journal of Psychiatry*, 156(9), 1322-1327.
- Gurung, R.A.R., & Mehta, V. (2001). Relating ethnic identity, acculturation, and attitudes toward treating minority clients. *Cultural Diversity and Ethnic Minority Psychology*, 7(2), 139-151.
- Holcomb-McCoy & Myers, J.E. (1999). Multicultural competence and counselor training: A national survey. *Journal of Counseling & Development*, 77, 294-302.
- Howard, G.S. (1991). Culture tales: A narrative approach to thinking, cross-cultural psychology, and psychotherapy. *American Psychologist*, 46(3), 187-197.
- Iijima Hall, D.C. (1997). Cultural malpractice: The growing obsolescence of psychology with the changing U.S. population. *American Psychologist*, 52(6), 642-651.
- Ivey, A. (1980). A person-environment view of counseling and psychotherapy: Implication for social policy. In T. Marsella & P. Pedersen (Eds.), *Cross-cultural counseling and psychotherapy*. New York: Pergamon.
- Ivey, A.E., & Simek-Downing, L. (1980). *Counseling and psychotherapy: skills, theories, and practice*. Englewood: Prentice-Hall.
- Iwamsa, G. Y., & Smith, S. K. (1996). Ethnic diversity in behavioral psychology: A review of the literature. *Behavior Modification*, 20, 45-59.

- Kagehiro, D. K., Jejia, J.A., & Garcia, J.E. (1985). Value of cultural pluralism to the generalizability of psychological theories: A reexamination. *Professional Psychology: Research and Practice*, 16(4), 481-494.
- Katz, J.H. (1985). The sociopolitical nature of counseling. *The Counseling Psychologist*, 13(4), 615-624.
- Kleinman, A. (1988). *Rethinking psychiatry: From cultural category to personal experience*. New York: Free Press.
- Kleinman, A. (1980). *Patients and Healers in the Context of Culture*. Berkeley, CA: University of California Press.
- Kroll, J., Sheehan, W. (1989). Religious beliefs and practices among 52 psychiatric inpatients in Minnesota. *American Journal of Psychiatry*, 146, 67-72.
- Kurtz, E. (1999). The historical context. In W.R. Miller (Ed.), *Integrating Spirituality Into Treatment*, (pp. 19-46). Washington, DC: American Psychological Association.
- LaFromboise, T.D., Coleman, H.K.K., & Hernandez, A. (1991). Development and factor structure of the Cross-Cultural Counseling Inventory -Revised. *Professional Psychology: Research & Practice*, 22, 380-388.
- Landrine, H. & Klonoff, E. A. (1992). Culture and health-related schemas: A review and proposal for interdisciplinary integration. *Health Psychology*, 11(4), 267-276.
- Landrine, H. & Klonoff, E. A. (1994). Cultural diversity in causal attributions for illness: The role of the supernatural. *Journal of Behavioral Medicine*, 17(2), 181-193.

- Lannert, J. (1991). Countertransference and spirituality. *Journal of Humanistic Psychology*, 31, 68-76.
- Li-Repac, D. (1980). Cultural influences on clinical perceptions: A comparison between Caucasian and Chinese-American therapists. *Journal of Cross-Cultural Psychology*, 11(3), 327-342.
- Lopez, S. R., Grover, P., Holland, D., Johnson, M.J., Kain, C.D., Kanel, K., et al. (1989). Development of culturally sensitive psychotherapists. *Professional Psychology: Research and Practice*, 20(6), 369-376.
- Lowenthal, K. M., & Cinnirella, M. (1999). Beliefs about the efficacy of religious, medical, and psychotherapeutic interventions for depression and schizophrenia among women from different cultural-religious groups in Great Britain. *Transcultural Psychiatry*, 36(4), 491-504.
- Lovinger, R. (1984). *Working with religious issues in therapy*. New York: Aronson.
- Lu, F. G., Lim, R. F., & Mezzich, J. E. (1999). Issues in the assessment and diagnosis of culturally diverse individuals. In J. M. Oldham & M. B. Riba (Eds.), *American Psychiatric Press Review of Psychiatry*, Volume 14 (pp. 477-506). Washington, DC: American Psychiatric Press.
- Lukoff, D., Lu, F., & Turner, R. (1992). Toward a more culturally sensitive DSM-IV: Psychoreligious and psychospiritual problems. *The Journal of Nervous and Mental Disease*, 180(11), 673-682.
- Lukoff, D., Lu, F., & Turner, R. (1995). Cultural considerations in the assessment and treatment of religious and spiritual problems. *The Psychiatric Clinics of North America*, 18(3), 467-485.
- Mezzich, J.E., Kirmayer, L.J., Kleinman, A.M., Fabrega, H., Parron, D.L., Good, B.J., et al. (1999). The place of culture in DSM-IV. *Journal of Nervous and Mental Disease*, 187, 457-464.

- Mezzich, J. E., Kleinman, A., Fabrega, H. Jr., & Parron, D. L. (1996). *Culture & psychiatric diagnosis: A DSM-IV perspective*. Washington, DC: American Psychological Association.
- Miller, W. R., & Thorseen, C.E. (1999). Spirituality and health. In W.R. Miller (Ed.), *Integrating Spirituality Into Treatment*, (pp. 3-20). Washington, DC: American Psychological Association.
- Milstein, G., Guarnaccia, P., & Midlarsky, E. (1995). Ethnic differences in the interpretation of mental illness: Perspective of caregivers. *Research in Community and Mental Health*, 8, 155-178.
- Mock, M.R. (1999). Cultural competency: Acts of justice in community mental health. *The Community Psychologist*, 1-3.
- Murkherjee, S., Shukla, S., Woodle, J., Rosen, A.M., & Olarte, S. (1983). Misdiagnosis of schizophrenia in bipolar patients: A multiethnic comparison. *American Journal of Psychiatry*, 140, 1571-1574.
- Neeleman, J., & Persaud, R. (1995). Why do psychiatrists neglect religion? *British Journal of Medical Psychology*, 68(2), 169-178.
- Neighbors, H. (1990). The prevention of psychopathology in African Americans: An epidemiological perspective. *Community Mental Health Journal*, 26, 167-179.
- Neighbors, H.W., Jackson, J.S., Campbell, L., & Williams, D. (1989). The influence of racial factors on psychiatric diagnosis: A review and suggestions for research. *Community Mental Health Journal*, 25(4), 301-311.
- Padilla, A.M. (1981). Pluralistic Counseling and Psychotherapy for Hispanic Americans. In A.J. Marsella, & P.B. Pederson, (Eds.), *Cross-Cultural Counseling and Psychotherapy* (pp. 195-227). New York: Pergamon Press.

- Parham, T.A., & Helms, J.E. (1981). The influence of black students' racial identity attitudes on preferences for counselor's race. *Journal of Counseling Psychology*, 28(3), 250-257.
- Pederson, P.B. (1988). *A handbook for developing multicultural awareness*. Alexandria, VA: American Association for Counseling and Development.
- Ponterotto, J.G., Rieger, B.P., Barrett, A., Harris, G., Sparks, R., Sanchez, C.M., & Madigs, D. (1993). Development and initial validation of the Multicultural Counseling Awareness Scale (Manuscript submitted for publication)
- Ponterotto, J.G., & Casas, J.M. (1991). *Handbook of racial/ethnic minority counseling research*. Springfield, Illinois: Charles C. Thomas Publisher.
- Propst, L.R., Ostrom, R., Watkins, P., Dean, T., & Mashburn, D. (1992). Comparative efficacy of religious and nonreligious cognitive-behavioral therapy for the treatment of clinical depression in religious individuals. *Journal of Consulting and Clinical Psychology*, 60, 94-103.
- Pruyser, P. W. (1984). Religion in the psychiatric hospital: A reassessment. *Journal of Pastoral Care*, 38, 5-17.
- Ragan, C., Maloney, H. N., & Bent-Hallahmi, B. (1980). Psychologists and religion: Professional factors and personal beliefs. *Rev Religious Res*, 21, 208- 217.
- Reynolds, W. M. (1982). Development of reliable and valid short forms of the Marlowe-Crowne social desirability scale. *Journal of Clinical Psychology*, 38 (1), 119-123.
- Russell, G. L., Fujino, D. C., Sue, S., Cheung, M. K., & Snowden, L. R. (1996). The effects of therapist-client ethnic match in the assessment of mental health functioning. *Journal of Cross-Cultural Psychology*, 27(5), 598-615.

- Salzman, L. (1986). Religion as metaphor in mental illness. In L. Robinson (Ed.), *Psychiatry and religion: Overlapping concerns*. Washington, DC: American Psychiatric Press.
- Schnittker, J., Freese, J., & Powell, B. (2000). Nature, nurture, neither, nor: Black- White differences in beliefs about the causes and appropriate treatment of mental illness. *Social Forces*, 78(4), 1101-1130.
- Shafranske, E., & Mahoney, H. N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy*, 27, 72-78.
- Shams, M., & Jackson, P. R. (1993). Religiosity as a predictor of well-being and moderator of the psychological impact of unemployment. *British Journal of Medical Psychology*, 66, 341-352.
- Simon, R.J., Fleiss, J.L., Garlans, B.J., et al. (1973). Depression and schizophrenia in black and white mental patients. *Archives of General Psychiatry*, 28, 509-512.
- Sodowsky, G.R., Taffe, R.C., Gutkin, T.B., & Wise, S.L. (1994). Development of the Multicultural Counseling Inventory: A self-report measure of multicultural competencies. *Journal of Counseling Psychology*, 41(2), 137-148.
- Spitzer, R. L., Gibbon, M., Skodol, A., Williams, J. B. W., & Hyoler, S. (1980). The heavenly vision of a poor woman: A down to earth discussion of DSM-III differential diagnosis. *Journal of Operational Psychiatry*, 11, 169-172.
- Stander, V., Piercy, F.P., MacKlinnon, D., & Helemke, K. (1994). Spirituality, religion, and family therapy: Competing or complementary worlds: *The American Journal of Family Therapy*, 22, 27-41.
- Sue, S. (1999). Science, ethnicity, and bias: Where have we gone wrong? *American Psychologist*, 54(12),

1070-1077.

- Sue, S. (1998). In search of cultural competency in psychotherapy and counseling. *American Psychologist*, 53(4), 440-448.
- Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist*, 37-45.
- Sue, D.W. (1981). *Counseling the culturally different: Theory and practice*. New York: John Wiley.
- Szasz, T. (1974). *The myth of mental illness*. New York: Harper & Row.
- Taylor, R.J., Ellison, C.G., Chatters, L.M., Levin, J.S., & Lincoln, K.D. (2000). Mental Health Services in Faith Communities: The Role of Clergy in Black Churches. *Social Forces*, 5(1), 73-87.
- Thomas, A., & Sillen, A. (1972). *Racism and psychiatry*. New York: Brunner/Mazel.
- Thoresen, C.E. (1998). Spirituality, health, and science: The coming revival? In S. Roth-Roemer, S. Kurpius Ribubsibm & C.Carmin (Eds.), *The emerging role of counseling psychology in health care* (pp. 409-431). New York: Norton.
- Torrey, E.F. (1972). *The mind game: Witchdoctors and psychiatrists*. New York: Emerson Hall.
- Turner, R. P., Lukoff, D ., Barnhouse, R. T., & Lu, F.G. (1995). Religious or spiritual problem: A culturally sensitive diagnostic category in the DSM-IV. *The Journal of Nervous and Mental Disease*, 183(7), 435-444.
- U.S. Department of Health and Human Services. (2001). *Mental health: Culture, Race, and Ethnicity*. Rockville, MD: Author.
- Vega, W. A., & Murphy, J. W. (1990). *Culture and the restructuring of community mental health*. Greenwood Press.



- Weiss, M. (1997). Explanatory Model Interview Catalogue: Framework for comparative study of illness. *Transcultural Psychiatry*, 43(2), 235-263.
- Weitzel, W.D., Morgan, D.W., Guyden, T.E. et.al. (1973). Toward a more efficient mental status examination. *Archives of General Psychiatry*, 28, 215-218.
- Whaley, A.L. (1998). Racism in the provision of mental health services: A social-cognitive analysis. *American Journal of Orthopsychiatry*, 68(1), 47-57.
- Worthington, E.L. (1988). Understanding the values of religious clients: A model and its application to counseling. *Journal of Counseling Psychology*, 35, 166-174.
- Wrenn, C.G. (1985). Afterward: The culturally encapsulated counselor revisited. In P.B. Pedersen (Ed.), *Handbook of cross-cultural counseling and therapy* (pp.323-329). Westport, CT: Greenwood Press.