ITEM DEVELOPMENT OF A PROVIDER-LEVEL CULTURAL COMPETENCY INSTRUMENT USING THE CULTURE ASSIMILATOR FORMAT

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ABSTRACT

A provider-level cultural competency instrument based on the culture assimilator method is an innovative approach to measuring cultural competency that may more accurately assess the behaviors of mental health professionals. The goal of this project was to develop and establish the content validity of critical incidents to be used in a theory-based culture assimilator instrument based on the Multicultural Counseling Competencies Theory (MCC). The first phase of the study involved the development of 30 critical incidents based on semi-structured interviews and a review of the cultural competency and MCC literature. The second phase involved the systematic reduction of the 30 critical incidents based on multicultural experts’ opinions and the Kendall’s Coefficient of concordance W. The project resulted in 10 critical incidents representing different cultural misunderstandings that are primarily representative of MCC Theory Domain 2, “Understanding the Worldview of the Culturally Different Client.” Future directions are provided.
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CHAPTER ONE
INTRODUCTION

A “culturally competent mental health practitioner is someone whose behaviors and attitudes promote effective resolution of a mental health issue for someone who is different, culturally, from him/herself” (Jackson, 2002, p. 22). The importance of providing culturally competent services to diverse consumers with divergent beliefs, norms, and values is a major concern for organizations, providers, and policy makers (American Psychological Association, APA, 2003; Kobylars, Heath, & Like, 2002; New York State Office of Mental Health, NYOMH, 1998; Ronnau, 1994; Sowers-Hoag & Sandau-Beckler, 1996; Weaver, 1999). Research indicates that the cultural and ethnic background of people influences their views of illness and well-being, as well as their willingness to seek out, participate in, and complete mental health treatment (Kundhal & Kundhal, 2003; Warren, 2002). While these findings are noted in the literature, not all providers have been trained in cultural competency nor do they consistently incorporate these standards into daily practice (Sherer, 2003).

A challenge facing psychologists and other mental health practitioners is finding ways to provide culturally competent services to consumers (D’Andrea & Daniels, 1995). This is a difficult issue because the majority of mental health providers and administrative leaders have been trained and taught in a culture deeply rooted in Western beliefs, norms, and values, while the clientele seeking services are becoming increasingly diverse (Jackson, 2002, p. 22). There are various ways to increase clinicians’ ability to provide mental health services, and it is useful to measure changes in cultural competency levels. Measuring current levels of cultural competency may assist providers
as they receive the necessary training and implement change so that they can eventually improve their overall treatment practices. Therefore, it is essential to develop an efficient, objective, and accurate assessment instrument to measure the level of cultural competency currently delivered by mental health providers.

**Important Definitions**

Defining core concepts, such as culture, race, ethnicity, and cultural competency, is a crucial step in accurately measuring a construct. Although various definitions of the following concepts are found in the literature, the following definitions have been utilized for the current study:

**Culture** is defined as “the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs and values that are unique to race, ethnicity, sexual orientation, religious background or social group” (US Department of Health and Human Services, USDHHS, 2001).

**Race** is defined as “the category to which others assign individuals on the basis of physical characteristics, such as skin color or hair type, and the generalizations and stereotypes made as a result” (APA, 2003, p. 380).

**Ethnicity** refers “to a common heritage shared by a particular group (Zenner, 1996). Heritage includes similar history, language, rituals, and preferences for music and foods” (USDHHS, 2001, p. 9).

**Cultural competency** is defined as “the set of congruent behaviors, attitudes and skills, policies and procedures that come together in a system, agency, or individuals, to enable mental health caregivers to work effectively and efficiently in cross/multicultural
situations” (New York State Office of Mental Health, 1998, p.4; Cross, Bazron, Dennis, & Isaacs, 1989).

**History of Multicultural Movement**

An important event in the multicultural movement was the landmark case of Brown vs. the Board of Education in 1954. During the court proceedings, psychological research based on African American children’s perceptions of black or white dolls dramatically influenced a Supreme Court decision and the eventual desegregation of the American public school system (APA, 2003). These plastic, diaper-clad dolls were identical except for their skin color and were used by psychologists, Kenneth and Mamie Phipps Clark, in studies examining African American children’s racial identification (Benjamin & Crouse, 2002). Although the children, ranging in age from three to seven, were able to accurately identify the race of the dolls, the majority of them preferred the white doll and attributed positive characteristics to it (Library of Congress, 2004). When asked to outline the drawings of a boy and girl and to color them the same color as themselves, children with dark complexions tended to use a white or yellow crayon (Library of Congress, 2004). The Clarks suggested that these results proved that “prejudice, discrimination, and segregation” caused a sense of inferiority and self-hatred in African American children (Library of Congress, 2004).

The case of Brown vs. the Board of Education was introduced in Topeka, Kansas when an African American girl was forced to walk to a “black only” school a mile from her home because the principal of the “white only” school, located only seven blocks away, refused to allow her to matriculate (Knappman, 1994). This case was addressed at both the district court and Supreme Court levels before it was unanimously decided that
segregation would be outlawed in the public school system. This was the first time that psychological research was used to support a case at the Supreme Court level (Benjamin and Crouse, 2002; APA, 2003).

Ten years later, the Civil Rights Act was a legislative attempt to improve the quality of life for African Americans and other culturally diverse groups at the national and state level (APA, 2003; NYOMH, 1998). The Act barred discrimination based on race, color, or national origin in any federal program (APA, 2003). The Act was intended to decrease discrimination prevalent in public domains, increase occupational opportunities, strengthen voting laws, and limit available funding for programs that promoted discriminatory practices (The Drisken Congressional Center, 2006). Not only were the benefits of the Civil Rights Act reaped by society as a whole, but it also dramatically influenced the multicultural movement in psychology. Specifically, the Civil Rights Act opened the dialogue about the importance of acknowledging race, ethnicity, culture, prejudice, and discrimination in the therapeutic relationship (D’Andrea & Daniels, 1995). In addition, it started the multicultural movement in psychology, which magnified the importance of providing clinical interventions that address the needs of all people served (D’Andrea & Daniels, 1995).

Traditionally, Western psychology has been dominated by cultural norms and values that highlight cultural superiority, secularism, individualism, and egalitarianism. In addition, it is based on the assumption that human behaviors are governed by universal principles (Highlen, 1994, 1996; Katz, 1985; Sue & Sue, 1990; Sue et al., 1998). Western psychology assumes that people who are mentally healthy are autonomous and independent, have control over their lives and the universe, and are interested in
achieving self-awareness and personal growth (Highlen, 1994, 1996; Katz, 1985; Sue & Sue, 1990; Sue et al., 1998). Unfortunately, these principles are not necessarily appropriate or relevant for all people (Sue et al., 1998). On the contrary, many racial and ethnic groups consider principles of "interdependence and collectivism, being in harmony with the universe rather than mastering it, and a concern with group rather than self-development and growth" to be characteristic of healthy functioning (Sue et al., 1998, p. 22). Because of these profound differences, many behaviors appropriate to other ethnically and racially diverse groups may appear pathological to therapists trained in Western beliefs (Sue et al., 1998, p. 22). For instance, hearing voices or seeing things that are not there may be a common aspect of a particular religion among some cultural groups, but they are usually indicative of a psychotic disorder in Western culture (USDHHS, 2001). Unfortunately, culture and race were not considered to be salient variables in the therapeutic relationship until the 1950s and 1960s (Sue et al., 1998).

In 1973, the Vail Conference marked the first attempt to create ethical guidelines related to culture in psychology (APA, 2003). This was the first time that the National Institute of Mental Health and the American Psychological Association held a conference in which a substantial number of women, culturally diverse group members, and consumers of psychological services were represented (Ivey & Leppaluoto, 1975). A major conclusion of the Vail Conference was:

"the provision of professional services to persons of culturally diverse backgrounds by persons not competent in understanding and providing professional services to such groups shall be considered unethical...It shall be equally unethical to deny such persons professional services because the present
staff is inadequately prepared... It shall be the obligation of all service agencies to employ competent persons or to provide continuing education for the present staff to meet the service needs of the culturally diverse populations it serves.” (a direct quote from the conference; Ivey & Leppaluoto, 1975, p.749).

This profound statement recommended that all psychologists, clinicians, teachers, and professors develop the skills and expertise necessary to address both the personal and institutional oppression of culturally diverse populations (Ivey & Leppaluoto, 1975). This statement also emphasized culture as a direct practical concern for practicing psychologists (Casas, Ponterotto, & Guiterrez, 1986). Because of this conference, cultural diversity training is now a mandatory component of all APA accredited doctoral programs and is a top priority for continuing education (APA, 2003).

Following these major events was the development of many diversity-related committees within the American Psychological Association (APA). These committees included the APA Office of Cultural and Ethnic Affairs in 1978; the Board of Ethnic Minority Affairs in 1980; the Task Force on Minority Education and Training in 1981; the Task Force on Communication with Minority Constituents in 1984; the Society of Psychological Study of Ethnic Minority Issues (Division 45) in 1987; the Board for the Advancement of Psychology in the Public Interest in 1990; and the Commission on Ethnic Minority Recruitment, Retention, and Training in 1994 (APA, 2003).

Along with the development of these major committees and task forces, several important articles and reports were written between 1990 and 2003 further emphasizing the importance of cultural factors in the therapeutic relationship. One such report, the APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic and
Culturally Diverse Populations, is among the first guidelines developed to increase awareness about the psychological needs of culturally and ethnically diverse groups (APA, 1990). These guidelines were intended for all psychologists, not only those practicing in clinical settings (APA, 1990). Although not mandated rules, the guidelines were designed to provide psychologists with suggestions for working efficiently and effectively with culturally diverse populations (APA, 2003).

Mental Health: A Report of the Surgeon General was a critical report out of the Surgeon General’s office that addressed mental health issues (USDHHS, 1999). This report acknowledged the tendency for mental health to be ignored and misunderstood, although it affects people of all ages (USDHHS, 1999). The Supplement to the Surgeon General’s Report on Culture, Race, and Ethnicity recognized the importance of culture in addressing mental health issues commonly faced by the four largest racial and ethnic groups in the United States (USDHHS, 2001). This document emphasizes the importance of gaining the appropriate knowledge and skills to provide culturally competent services to culturally diverse groups regardless of their age, race, sexual orientation, religion, etc. (USDHHS, 2001). As a result of the federal acknowledgement of culture and mental illness, funding opportunities became available to support research in this area.

Along with these three major publications came the National Standards for Culturally and Linguistically Appropriate Services in Healthcare: Final Report (CLAS; Office of Minority Health, 2001). These standards were a response by the United States Department of Health and Human Services (HHS) Office of Minority Health (OMH) to ensure that all people would receive equitable and effective health care treatment that is culturally and linguistically appropriate (OMH, 2001). The CLAS is made up of 14
different standards that are organized into three different themes: 1) culturally competent care, 2) language access services, and 3) organizational supports for cultural competence (OMH, 2001).

The publication of the *Guidelines for Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists* asserted that there is a multicultural focus in all that psychologists do, including research, training, clinical work, supervision and consultation (APA, 2003). These guidelines provide psychologists with a framework for meeting the needs of culturally diverse populations (APA, 2003).

Thus, the aforementioned conferences, committees, commissions and publications support the idea that provider level cultural competency is important. Some now believe that the inability of service providers to effectively serve culturally diverse populations is unethical (APA, 1993; Ivey & Leppaluoto, 1975; Korman, 1974; President’s Commission on Mental Health, 1980; Sue et al., 1998). Therefore, it is essential for providers to obtain the knowledge and skills to assist them in addressing cultural issues in clinical settings.

**Multicultural Counseling Competencies Theory**

The majority of the cultural competency literature has been grounded in the Multicultural Counseling Competencies (MCC) model that was initially developed by Sue and colleagues in 1982 (Sue et al., 1982). Since its development, the MCC model has been modified (e.g., Sue, Arredondo, & McDavis, 1992; Sue et al., 1998) and used as the basis of several cultural competency measures (e.g., D’Andrea, Daniels, & Heck, 1991; Sodowsky, Taffe, Gutkin, & Wise, 1994). Ponterotto, Fuertes, and Chen (2000) conducted a comprehensive review of the multicultural counseling models in the literature and found that the MCC model demonstrated content validity. The literature
suggests that there are three primary types of support available for the MCC model, which include “widespread acceptance among professional organizations, training programs, and prominent multicultural scholars; scale-specific MCC research; and research on the effects of culturally responsive counselor behavior” (Worthington, Soth-McNett, & Moreno, 2007, p. 357).

The basic assumption underlying this model is that all people have their own worldviews that have been developed by their “cultural upbringing, sociopolitical history, and life experiences” and that therapists and clients bring these worldviews to the therapeutic relationship (Ivey, Ivey, & Simek-Morgan, 1993; Sue et al., 1998, p. 18). Because all worldviews represent important perspectives that affect how individuals’ think, feel, and behave, it is crucial for providers not only to understand their own worldviews but also to understand the worldviews of individuals served as a means of enhancing clinical encounters (Christopher, 1996; Sue et al., 1998). The model developed by Sue and colleagues includes three domains that describe a culturally competent counselor including: (1) Becoming Aware of Own Worldview; (2) Understanding the Worldview of the Culturally Different Client/Respecting Client’s Worldview; and (3) Developing Appropriate Intervention Strategies and Techniques. Sue and Sue (1998) stated:

These three goals stress the fact that becoming culturally skilled is an *active process*, that it is ongoing, and that it is a process that *never reaches an end point*. Implicit is recognition of the complexity and diversity of the client and client populations, and acknowledgments of our own personal limitations and the need to always improve. (p. 146)
These multicultural counseling domains have been subdivided into the following dimensions: (1) attitudes and beliefs, (2) knowledge, and (3) skills (Sue, Arredondo, & McDavis, 1992).

**Becoming Aware of Own Worldview.** It is necessary for providers to be aware of how their own cultural background and experiences impact their attitudes, values, and biases, and to recognize that this may impact their ability to work effectively with culturally different clients. Understanding and acquiring specific knowledge about their own cultural heritage will aid in realizing how similarities or differences in worldviews may directly affect the therapeutic relationship (Abu Baker, 1999; APA, 2003; Solomon, 2001).

Potential harm may result if providers are unable to appreciate, recognize, and account for their own personal biases (Burn, 1992; Tsiu & Schultz, 1988). In addition to being aware of their own worldviews, providers also need to realize the social, cultural, psychological and circumstantial environments related to their professional activities (VanZandt, 1990). Failure to take these essential steps may affect the therapeutic relationship and result in biases and stereotypic beliefs about other ethnic groups (APA, 2003; Weaver, 1999). Sue (1998) noted that culturally skilled clinicians must be willing to acknowledge their professional limits and seek out the consultation necessary to enrich their ability to address the needs of culturally different clients. Therefore, providers need to understand their own worldviews before they will be able to understand the perspectives and beliefs of their clients (Sue et al., 1998).

One of the examples of the attitudes and beliefs necessary for this domain is that "culturally skilled counselors are comfortable with differences that exist between
themselves and clients in terms of race, ethnicity, culture, and beliefs” (Sue, Arredondo, & McDavis, 1992, p. 633). One of the examples from the knowledge dimension is “culturally skilled counselors possess knowledge about their social impact upon others. They are knowledgeable about communication style differences, how their style may clash or facilitate the counseling process with minority clients, and how to anticipate the impact it may have on others” (Sue, Arredondo, & McDavis, 1992, p. 634). An example from the skills dimension is that “culturally skilled counselors are constantly seeking to understand themselves as racial and cultural beings and are actively seeking a nonracist identity” (Sue, Arredondo, & McDavis, 1992, p. 634).

**Understanding the Worldview of the Culturally Different Client/Respecting Client’s Worldview.** Culturally competent providers must also be willing to learn about their clients’ life experiences, cultural heritages, and historical backgrounds in an attempt to provide more effective and culturally competent services (APA, 2003; Kundhal & Kundhal, 2003; Okazaki, 1998). With this knowledge, providers will be able to compare and contrast their values and beliefs with those of their clients. In addition, providers should be willing to become actively involved in community events, such as social and political functions as a means of gaining more information about the populations they serve (Sue et al., 1998).

An example of an attitude and belief required within this domain is “culturally skilled counselors are aware of their stereotypes and preconceived notions that they may hold toward other racial and ethnic minority groups” (Sue, Arredondo, & McDavis, 1992, p. 634). An example from the knowledge dimension is “culturally skilled counselors understand and have knowledge about sociopolitical influences that impinge upon the life
of racial and ethnic minorities. Integration issues, poverty, racism, stereotyping and powerlessness all leave major scars that may influence the counseling process.” (Sue, Arredondo, & McDavis, 1992, p. 635) An example from the skills dimension is “culturally skilled counselors should familiarize themselves with relevant research and the latest findings regarding mental health and mental disorders or various ethnic and racial groups. They should actively seek out educational experiences that enrich their knowledge, understanding, and cross-cultural skills.” (Sue, Arredondo, & McDavis, 1992, p. 635).

Developing Appropriate Intervention Strategies and Techniques. For providers to develop appropriate intervention strategies and techniques, it is important to respect and take into account the religious beliefs and values, indigenous helping practices, and bilingualism of their clients. It is also valuable for providers to be knowledgeable about institutional barriers, potential biases evident in assessment instruments, community characteristics and resources, discriminatory practices, and stages of identity development experienced by culturally different clients. Not only is it essential to be knowledgeable about appropriate intervention strategies, but it is also critical to be able to engage in a variety of helping styles and approaches, exercise intervention skills on behalf of their clients, seek consultation with community leaders and practitioners when necessary, and educate their clients about the processes of the psychological intervention (Sue et al., 1998).

An example of an attitude and belief required in this domain is that “culturally skilled counselors respect indigenous helping practices and respect minority community intrinsic help-giving networks” (Sue, Arredondo, & McDavis, 1992, p. 635). One
example from the knowledge dimension is “culturally skilled counselors are aware of institutional barriers that prevent minorities from using mental health services” (Sue, Arredondo, & McDavis, 1992, p. 635). An example from the skills dimension is “culturally skilled counselors are not averse to seeking consultation with traditional healers or religious and spiritual leaders and practitioners in the treatment of culturally different clients when appropriate” (Sue, Arredondo, & McDavis, 1992, p. 636).

**Importance of Cultural Competency in Mental Health Practice**

The demographics of the United States are one of the strongest indicators for the need for clinicians, systems, and agencies to provide culturally competent services. Asian American and Pacific Islander, Hispanic/Latino, American Indian and Alaskan Native, and African American populations are the most recognized ethnic and racial minority groups in the United States (U. S. Department of Health and Human Services, USDHHS, 2001). According to the U.S. 2000 Census, there has been a tremendous increase over the past decade in the number of Asian American/ Pacific Islander and Latino populations such that Caucasians no longer comprise the majority in some regions (U.S. Census, 2000). Approximately 28% of the population in urban centers consists of ethnically and racially diverse populations (New York State Office of Mental Health, 1998). In addition, the number of immigrants to the United States has almost tripled, from 9.6 million in 1970 to 26 million in 2000 (Kundhal & Kundhal, 2003). The 2000 census data indicate 67% of the U.S. population identified themselves as Caucasian, either alone or with another race, 13% as African American, 1.5% as American Indian or Alaskan Native, 4.5% as Asian or Pacific Islander, 13% as Hispanic, and approximately 7% identified as some other race with some overlap between ethnic groups (APA, 2003, p.378). If these
trends persist, it is estimated that ethnic groups will comprise the majority of the United States population between 2030 and 2050 (New York State Office of Mental Health, 1998; Sherer, 2003; Sue & Sue, 1990). Within the service delivery system itself, it is estimated that 40 percent of the population will be comprised of people of color (Cross, Bazron, Dennis, & Isaacs, 1989). The change in demographics magnifies and supports the need to provide culturally appropriate mental health services.

Although it is evident that progress has been made regarding the knowledge and awareness of providing culturally competent services, research indicates that implementation and practical application are still lacking (Antshel, 2002; Knox, Burkard, Johnson, Suzuki & Ponterotto, 2003). Evidence demonstrates that ethnically and racially diverse groups continue to experience disparities in their access, utilization, quality and outcomes of mental health services (Jackson, 2002; Kobylars, Heath, & Like, 2002; New York State Office of Mental Health, 1998; Okasha, 1999; USDHHS, 2001). Culturally diverse groups, for instance, continue to face significant barriers to health care, including the inability to afford health insurance, living in isolated and rural areas, lack of appropriate transportation, and linguistic and/or literacy barriers (Fox, 2002). Even when individuals of various racial and ethnic backgrounds are insured to the same degree and are equal in other access-related factors, they tend to receive lower quality health care than their Caucasian counterparts (Institute of Medicine, 2002).

A major indicator of accessibility to mental health care is health insurance coverage (USDHHS, 2001). Unfortunately, culturally diverse populations are less likely to have health insurance coverage than Caucasians. For example, although the Federal Government is responsible for providing health care to all federally recognized tribal
members through the Indian Health Service, only 1 in 5 American Indians actually have coverage (USDHHS, 2001). The number of members served continues to decrease for American Indians who do not live on reservations (USDHHS, 2001). In fact, a recent national report found that only about half of American Indians and Alaskan Natives have employer-based insurance coverage compared to 72% of Caucasians (USDHHS, 2001). It is estimated that approximately 21% of Asian Americans and Pacific Islanders also lack health insurance coverage, although rates differ across subgroups (USDHHS, 2001).

Another example of disparities in accessibility to health care services is demonstrated by the Hispanic population. Although Hispanic individuals comprise 12% of the U.S. population, one of every four uninsured Americans is Hispanic and approximately 37% are uninsured (USDHHS, 2001).

Not only do these groups experience disparities in access to services, but they also utilize mental health services at significantly lower rates. Research indicates that only 16% of African Americans diagnosed with a mood disorder and 13% with an anxiety disorder actually receive mental health services, and less than a third obtain any type of medical or mental health consultation (USDHHS, 2001). African American individuals are also more likely to prematurely terminate services once they enter care and obtain emergency care when they are in need of assistance (USDHHS, 2001). Asian Americans and Pacific Islanders also demonstrate differential utilization rates. For instance, a large scale study examining outpatient and inpatient utilization rates of Asian Americans and Pacific Islanders in Hawaii found lower inpatient service utilization than would be expected given their population size (Leong, 1994). With regards to outpatient utilization rates, although Chinese and Japanese Americans used less outpatient care than expected,
Filipino Americans used them at rates that would be expected (Leong, 1994). Studies have demonstrated that Asian Americans who receive mental health services are often more severely ill than their White counterparts and attribute these differences to two possible explanations. One explanation is that Asian Americans seek care only after their symptoms have become increasingly severe, and another is that they are often discouraged from seeking care by family members until they reach a point when their family views them as unmanageable (USDHHS, 2001).

Not only are disparities in access to and utilization of mental health care apparent across different ethnic groups but misdiagnosis, as a result of misconceptions, misunderstandings, and misinterpretation of cultural factors by providers also significantly impact individuals from various racial and ethnic groups (Hollar, 2001; USDHHS, 1999, 2001; Warren, 2002). Previous studies, for example, have found that there are differences in the rates of various diagnoses across ethnic groups. Some studies have found that African Americans are more likely than Caucasians to be diagnosed with psychotic disorders than with affective disorders, whereas Latinos are more likely to be diagnosed with affective disorders (Matthews, Glidden, & Hargreaves, 2002). Studies looking specifically at diagnostic rates among Asian populations are varied with some suggesting a higher rate of depression than Caucasians and some supporting elevated rates of psychosis (Matthews, Glidden, & Hargreaves, 2002). These differences may be due to a number of factors including differences in treatment and referral methods, as well as misdiagnosis (Matthews, Glidden, & Hargreaves, 2002).

Thus, the changes in demographics, disparities in access to and utilization of mental health services, and possible rates of misdiagnosis across different ethnic groups
clearly point to the importance of and need to study cultural competency in relation to mental health practice.

**Why Measuring Cultural Competency is Important?**

Measuring cultural competency is a challenge faced by many researchers. This is because the most common definition of cultural competency is difficult to operationalize in terms that can be identified, observed, or measured behaviorally (Geron, 2000). In addition, there are conflicts about what it means, and how it should be measured (Switzer, Scholle, Johnson, & Kelleher, 1998). The purpose of cultural competency is to “help practitioners choose appropriate and effective interventions, to hold practitioners accountable for their professional behavior, and to hold organizations accountable for the services they provide” (Geron, 2000, p. 40). With improved measurement, providers may determine whether an increase in cultural competency leads to positive results, such as a reduction in drop out rates and/or an increase in treatment outcomes, consumer satisfaction, and utilization of mental health services by culturally diverse populations (Brach & Fraser, 2000). If cultural competency is found to positively affect outcomes, the profession can work toward developing culturally appropriate and effective care through education and training (Geron, 2000). There is support for the need to accurately measure the degree to which providers integrate cultural awareness, knowledge, and skills into the therapeutic relationship, but only a few instruments measuring this phenomenon are currently available (Pope-Davis & Dings, 1994).

**Existing Cultural Competency Instruments**

Different instruments measuring provider cultural competency have been developed in order to aid in both, research and training. However, some of these
instruments are still in relatively early stages of development and need to undergo further psychometric testing. (Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002). It has also been suggested that the self-report format of these instruments needs to be revised to enhance accuracy (Ponterotto et al., 2002). Some examples of instruments currently available are the *Cross-Cultural Counseling Inventory-Revised* (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991); the *Cultural Competence Self-Assessment Questionnaire-Provider Version* (Mason, 1995); the *Multicultural Awareness-Knowledge-Skills Survey-Counselor Edition-Revised* (MAKSS-CE-R; Kim, Cartwright, Asay, & D'Andrea, 2003); the *Multicultural Counseling Inventory* (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994); and the *Multicultural Counseling Knowledge and Awareness Scale* (MCKAS; Ponterotto et al., 2002).

A majority of these instruments were created in order to address the importance of multicultural issues in counseling, research, education, and organizations by measuring competency through various subscales (Kocarek, Talbot, Batka & Anderson, 2001). As noted earlier, multicultural researchers have suggested that there are three broad areas of competency, which include the MCC dimensions of knowledge, attitudes and beliefs, and skills (Sue et al., 1982), that represent cognitive, affective, and behavioral domains, respectively (LaFromboise, Coleman, & Hernandez, 1991; Sodowsky, Taffe, Gutkin, & Wise, 1994). Unfortunately, these three dimensions are difficult to empirically isolate and therefore, may represent correlated constructs that may influence each other (Sodowsky, Taffe, Gutkin, & Wise, 1994). Therefore, critical incidents developed for the current study were based on the three MCC domains of: (1) *Becoming Aware of Own Worldview*, (2) *Understanding the Worldview of the Culturally Different Client/Respecting Client's*
Worldview, and (3) Developing Appropriate Intervention Strategies and Techniques. In order to gain a picture of the currently available instruments, previous instruments are discussed in detail.

Cross-Cultural Counseling Inventory-Revised (CCCI-R, LaFromboise, Coleman, & Hernandez, 1991). The CCCI-R is a revision of the CCCI, which was based on the APA Division 17 report that assessed the effectiveness of counseling culturally diverse clients (LaFromboise, Coleman, & Hernandez, 1991). Twenty-two items were created based on the characteristics of a culturally skilled counseling psychologist and subsequently reduced to 18 with the removal of overlapping items (LaFromboise, Coleman, & Hernandez, 1991). Each item was placed on a Likert-type scale ranging from 1 to 5 indicating the strength of agreement with each statement (LaFromboise, Coleman, & Hernandez, 1991). Based on suggestions and information gathered from pilot tests, preliminary scaling research, and a study conducted by Pomales, Claiborn, & LaFromboise (1986), minor adjustments were made (LaFromboise, Coleman, & Hernandez, 1991).

The CCCI-R includes 18 items from the original CCCI and two additional items that address an individual’s basic understanding of the counseling process, resulting in a 20-item behavioral checklist that is completed by an evaluator who observes a counselor as he or she works with a racially/ethnically different client (LaFromboise, Coleman, & Hernandez, 1991). The Likert-type scale for the revised version was changed and ranges from 1 (strongly disagree) to 6 (strongly agree), resulting in a composite score, which ranges from 20 to 120. Sample behaviors noted in the CCCI-R include (La Fromboise, Coleman, & Hernandez, 1991, p. 385): (1) Cross-Cultural Counseling Skill: (e.g.,
“Comfortable with differences,” “Aware of own cultural heritage,” “Aware of professional responsibilities”); (2) Socio-Political Awareness: (e.g., “Willing to suggest referral for extensive cultural differences,” “Aware of how own values might affect client,” “Perceives problem within the client’s cultural context”); and (3) Cultural Sensitivity: (e.g., “Demonstrates knowledge about client’s culture,” “Aware of institutional barriers that affect the client”).

Various studies were conducted to test the reliability and validity and to interpret the factorial structure of the CCCI-R (LaFromboise, Coleman, & Hernandez, 1991). The results of these studies demonstrated varied inter-rater reliability (.39-.69), adequate content validity (i.e., three factor model of Awareness, Knowledge, and Skills), adequate criterion validity (i.e., differences in scores between individuals with and without multicultural training), good internal consistency (.95) and varied inter-item correlations (.18-.73; LaFromboise, Coleman, & Hernandez, 1991; Hays, 2008). However, this instrument has questionable test-retest reliability (Kumas-Tan, 2007). The benefit of the CCCI-R is the inclusion of a supervisory rating rather than a self-report method of obtaining information; however, it is based on only one dimension and the psychometrics are not particularly strong (La Fromboise, Coleman, & Hernandez, 1991; Pope-Davis & Dings, 1995).

Cultural Competence Self-Assessment Questionnaire-Provider Version (CCSAQ; Mason, 1995). The CCSAQ was created for use in the child and adolescent mental health system to identify cultural competence training needs and evaluate the degree to which participants were exhibiting culturally competent behaviors (Mason, 1995). It has also been used in other human services systems such as juvenile justice, public health, and
alcohol and drug abuse treatment services (Mason, 1995). There are two versions of the CCSAQ that were created to identify the needs of either direct service providers or administrative staff (Mason, 1995). The 79-item self-report measure is based on the review of literature related to the delivery of health and human services (Mason, 1995). A general score is obtained based on five different subscales, including: (1) knowledge of the community; (2) personal involvement; (3) resources and linkages; (4) staffing; (5) organizational policies and procedures; and (6) reaching out to communities (Mason, 1995). Items included on this instrument use a Likert-type scaling ranging from 1 (not at all) to 4 (very well). Item averages and subscale means can be calculated in order to identify the areas that need the most improvement (Mason, 1995). This instrument has been found to be most useful as a pre- and post-test measure of cultural competency in order to determine the needs of the staff, as well as the usefulness of a specific training intervention (Mason, 1995).

Sample items from each of the subscales include: (1) Knowledge of Communities: (e.g., “How well are you able to describe the communities of color in your service area?”; “Do you know the social service needs within groups of color that go unaddressed by the formal social service system?”); (2) Personal Involvement: (e.g., “Do you attend cultural or racial group holidays or functions within communities of color?”; “Do you patronize businesses owned by people of color in your service area?”); (3) Resources and Linkages: (e.g., “Does your agency have linkages with civil rights, human rights, or human relations groups that provide accurate information concerning populations of color?”; “Does staff utilize cultural consultants who can help them work more effectively within a cultural context?”); (4) Staffing: (e.g., “Does your agency
prepare new staff to work with people of color?"; “How well has your agency been able to retain people of color on staff?”; (5) Service Delivery and Practice (For Direct Service Staff Only): (e.g., “Do you share some of your personal feelings with clients?”; “How well do you use cultural strengths and resources when planning services to clients of color?”); (6) Organizational Policy and Procedures: (e.g., “In general, how well are policies communicated to agency staff?”); and (7) Reaching Out to Communities: (e.g., “Are people of color depicted on agency brochures or other print media?”; “Does your agency participate in cultural, political, religious, or other events or festivals sponsored by communities of color?”).

Various studies have been conducted to look at the reliability of the instrument. A study by Mason (1995) found that all of the subscales yielded a coefficient alpha of .80, with the exception of the personal involvement subscale that had a coefficient alpha of .60 (Mason, 1995). The strengths of this instrument are that it is the only scale that has been utilized in the public health domain; it is literature-based; and it attempts to integrate a wide range of concepts. Conversely, this instrument is extremely long, has a high susceptibility to social desirability, and has limited psychometric testing, as there is no evidence of inter-item correlations available in the literature at this time.

_Multicultural Awareness-Knowledge-Skills Survey- Counselor Edition- Revised_ (MAKSS-CE-R; Kim, Cartwright, Asay, & D’Andrea, 2003). The MAKSS-CE-R is a 33-item self-report instrument that is comprised of three subscales (i.e., awareness, knowledge, and skills). The MAKSS is intended to measure a provider’s self-reported multicultural competency (Hays, 2008). Each item is placed on three different 4-point Likert-type scales ranging from 1 (very limited/strongly disagree) to 4 (very aware/very
good/strongly agree), with scores ranging from 72 to 138 (with higher scores representing greater multicultural competence). It was developed in response to criticisms of the original version of this instrument (Kim, Cartwright, Asay, & D’Andrea, 2003), the MAKSS (D’Andrea, Daniels, & Heck, 1991), which was a 60-item self-report measure that consisted of three scales; awareness, knowledge, and skills (20 items each). The MAKSS was intended to be used to estimate the effectiveness of various multicultural counseling trainings (Constantine, Gloria, & Ladany, 2002). The MAKSS items were rated on a 4-point Likert-type scale with responses ranging from 1 (very limited/strongly disagree) to 4 (very good/very aware/strongly agree). Reverse scoring is used for seven negatively worded awareness scale items (Pope-Davis & Dings, 1995). It also includes eight additional items to identify participants’ demographic information (Pope-Davis & Dings, 1995). Some of the criticisms include the lack of psychometric support for the validity of the instrument, use of a small sample of an intact group to establish the criterion related validity of the scores, questionable generalizability, and susceptibility to social desirability (i.e., correlation of .20 [p < .05] between a social desirability measure and the Skills subscale). Kim, Cartwright, Asay, & D’Andrea (2003) conducted two studies in an attempt to improve the MAKSS. The purpose of the first study was to investigate the adequacy of the three-factor structure that was proposed by D’Andrea, Daniels, and Heck in 1991 through the use of exploratory and confirmatory factor analyses (Kim, Cartwright, Asay, & D’Andrea, 2003). Three hundred thirty-eight graduate students enrolled in counseling courses at various United States universities were administered the MAKSS (D’Andrea, Daniels, & Heck, 1991), the MCKAS (Ponterotto et al., 2002), the Rosenberg Self-Esteem Inventory (RSEI), the Crowne and
Marlowe Social Desirability Scale- Form XX (SDS, 1960), and a demographic information sheet (Kim, Cartwright, Asay, & D’Andrea, 2003). The authors decided that they would “retain items that clearly represented only one factor, and retain items that were conceptually consistent with each other” (Kim, Cartwright, Asay, & D’Andrea, 2003, p. 166). Ten Awareness, 10 Knowledge, and 13 Skills items were retained for the final instrument.

Sample items include (Kim, Cartwright, Asay, & D’Andrea, 2003, p. 166-168): (1) Skills: (e.g., “How well would you rate your ability to accurately assess the mental health needs of lesbian women?”); (2) Awareness: (e.g., “The human service professions, especially counseling and clinical psychology have failed to meet the mental health needs of ethnic minorities.”); and (3) Knowledge: (e.g., “At the present time, how would you rate your understanding of the following term? ‘pluralism’”). The items are rated on a 4-point likert-type scale with responses ranging from 1 (very limited/unaware/strongly disagree) to 4 (very good/very aware/strongly agree; Pope-Davis & Dings, 1995). A confirmatory factor analysis was conducted and a Comparative Fit Index of .96, Bentler-Bonnett Non-Normed Fit Index of .96, and Incremental Fit Index of .96 were obtained suggesting further support for the construct validity of the three-factor model proposed (Kim, Cartwright, Asay, & D’Andrea, 2003).

Coefficient alphas of .71, .85, .87, and .82 were obtained for the Awareness items, Knowledge items, Skills items, and the entire instrument, respectively (Kim, Cartwright, Asay, & D’Andrea, 2003). Correlations of .67 and .35 were obtained between the Awareness subscale and the MCKAS- Awareness and MCKAS- Knowledge subscales, respectively (Kim, Cartwright, Asay, & D’Andrea, 2003). A correlation of .48 was
observed between the Knowledge subscale and the MCKAS-Knowledge subscale, .31
between the Skills subscale and the MCKAS-Knowledge subscale, .59 between the
entire instrument and the MCKAS-Knowledge subscale, and .24 between the entire
instrument and the MCKAS-Awareness subscale (Kim, Cartwright, Asay, & D’Andrea,
2003). The results also demonstrated no or small correlations between the subscales and
the RSEI and SDS (Kim, Cartwright, Asay, & D’Andrea, 2003). The instrument provided
some evidence for criterion-related validity in that participants who completed at least
one multicultural counseling course scored higher on the Awareness and Knowledge
subscales and on the entire instrument when compared to those students who did not take
a multicultural course (Kim, Cartwright, Asay, & D’Andrea, 2003).

The second study was conducted with a different set of 137 graduate students who
were enrolled in counseling courses across the United States (Kim, Cartwright, Asay, &
D’Andrea, 2003). The participants were administered the MAKSS-CE-R, the MCI
(Sodowsky, Taffe, Gutkin, & Wise, 1994), the Cognitive Flexibility Scale (CFS) and a
demographic questionnaire (Kim, Cartwright, Asay, & D’Andrea, 2003). Coefficient
alphas of .80, .87, .85, and .81 were found for the Awareness subscale, Knowledge
subscale, Skills subscale, and entire instrument, respectively (Kim, Cartwright, Asay, &
D’Andrea, 2003). The results demonstrated varied correlations of .19 to .60 between the
Knowledge and Skills subscales and the MCI total and subscale scores (Kim, Cartwright,
Asay, & D’Andrea, 2003). A correlation of -.20 was found between the Awareness
subscale and the MCI Counseling Relationship subscale (Kim, Cartwright, Asay, &
D’Andrea, 2003). Small to moderate correlations were expected between the MAKSS-
CE-R and the CFS because cognitive flexibility is expected to be positively related to the
attainment of cultural competency (Kim, Cartwright, Asay, & D'Andrea, 2003). Correlation coefficients between .21 and .30 were obtained for the Knowledge and Skills subscales and the total score, but no relationship was identified for the Awareness subscale (Kim, Cartwright, Asay, & D’Andrea, 2003).

A major limitation to the generalizability of the instrument is the use of graduate students as opposed to practicing professionals as sources during its development (Kim, Cartwright, Asay, & D’Andrea, 2003). There were also a proportionately larger number of female participants, which may suggest potential bias (Kim, Cartwright, Asay, & D’Andrea, 2003). The self-report format employed by the MAKSS-CE-R also lends itself to social desirability. Finally, the results demonstrated that the revised instrument accounted for only 29.80% of the variance that the original 60-item MAKSS accounted for (Kim, Cartwright, Asay, & D’Andrea, 2003).

Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al., 2002). The MCKAS is the third revision of the original Multicultural Counseling Awareness Scale (MCAS; Constantine, Gloria, & Ladany, 2002), which was intended to measure multicultural competency. The development of the original MCAS was based on a literature review and the rational-empirical approach (Ponterotto et al., 2002). The initial item pool consisted of 135 items and was subsequently reduced to 45 (Ponterotto et al., 2002). The instrument was created based on a three-factor model, Awareness, Knowledge, and Skills; however, after extensive analysis, the items were better explained by a two-factor model, Knowledge-Skills and Awareness (Ponterotto et al., 2002).

The MCKAS is a 32-item self-report measure that uses a 7-point Likert type scale ranging from 1 (not at all true) to 7 (totally true; Pope-Davis & Dings, 1994; Ponterotto et
This instrument is comprised of two subscales, Knowledge (20 items) and Awareness (12 items). Scale items are added to obtain scores with ten of twelve Awareness items reverse-scored (Ponterotto et al., 2002). The scores range from 92 to 150, with higher scores suggesting greater multicultural competence. Revisions were prompted by three major criticisms: (1) conceptual and practical considerations of items related to an individual’s familiarity with scholars within the multicultural field; (2) the utility of the three social desirability items; and (3) lengthy items that include multiple clauses (Ponterotto et al., 2002).

Some examples of MCKAS items (Ponterotto et al., 2002, p. 178-180) are: (1) Knowledge: (e.g., “I am aware some research indicates that minority clients receive ‘less preferred’ forms of counseling treatment than majority clients;” “I am aware of both the initial barriers and benefits related to the cross-cultural counseling relationship;” “I am aware of the value assumptions inherent in major schools of counseling and understand how these assumptions may conflict with values of culturally diverse clients”); and (2) Awareness: (e.g., “I believe all clients should maintain direct eye contact during counseling;” “I think that being highly competitive and achievement oriented are traits that all clients should work towards;” “I believe that all clients must view themselves as their number one responsibility.”)

After conducting a study of 525 counseling and counseling psychology students and professionals who were primarily Caucasian women, the authors concluded that items determining a person’s familiarity with the field, level of social desirability, and items with high factor loading or multiple loadings should be eliminated leading them to the two final subscales: Knowledge and Awareness (Ponterotto, et al., 2002).
Another study used a sample of students who were enrolled in master-level programs at five Northeastern universities to test for reliability and construct, convergent, criterion and discriminant validity (Pontentotto et al., 2002). In addition to the MCKAS, the students also completed the Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994), the Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992); and the Social Desirability Scale (SDS; Crowne & Marlowe, 1960). In summary, there were moderate indices of convergent validity between the MCKAS and MCI, but the operationalization of the awareness construct varied across these measures suggesting the need for clarity (Pontentotto et al., 2002). These findings suggest that the awareness construct is being measured differently by these two instruments; however, the moderate levels of convergent validity suggest that they are probably measuring the same overall construct of cultural competency (Pontentotto et al., 2002). A significant correlation was obtained between the MCKAS Knowledge subscale and the MEIM Ethnic Identity subscale, and the MCKAS Knowledge subscale and the SDS (Pontentotto et al., 2002). Discriminant validity was established between the MCKAS Awareness subscale and the SDS (Pontentotto et al., 2002). The coefficient alphas ranged from .75 to .91 for the Knowledge and Awareness subscale scores (Pontentotto et al., 2002; Constantine, Gloria, & Ladany, 2002).

The MCKAS has limitations. One limitation is that there is little empirical evidence linking scores with actual levels of provider cultural competency, suggesting minimal validity for this instrument (Pontentotto et al., 2002). Recent studies have not examined the stability estimates of this instrument. Other limitations include the inability of the items to fit nicely into the tripartite model used in other instruments (i.e.,
knowledge, awareness, and skills) and the lack of reliability and validity evidence on the MCKAS’ most recent version. The tendency for the instrument to be less behaviorally focused and more attitude and thought focused may also be considered a drawback, because of possible incongruities between attitudes/thoughts and actual behaviors in clinical practice (Pope-Davis & Dings, 1995).

Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994). Finally, the MCI is a 40-item self-report measure that was developed to operationally measure providers’ abilities to provide multiculturally competent services to culturally diverse clientele (Pope-Davis & Dings, 1995; Sodowsky, Taffe, Gutkin, & Wise, 1994). Based on a thorough review of the literature, an initial pool of 87 behavioral items that address both multicultural and general counseling competencies were generated and administered to a sample of psychology students, psychologists, and counselors from a Midwestern state (Sodowsky, Taffe, Gutkin, & Wise, 1994). Participants were asked to rate each item on a scale from 1 (very accurate) to 4 (very inaccurate). Some items were reverse-scored in order to reduce the likelihood of obtaining a skewed response set (Sodowsky, Taffe, Gutkin, & Wise, 1994). A “do not know” option was also included as a possible response to identify items that should be excluded (Sodowsky, Taffe, Gutkin, & Wise, 1994). The participants were also asked to describe their multicultural counseling strengths and weaknesses as well as their comments about the instrument (Pope-Davis & Dings, 1995).

Four specific factors, including Multicultural Counseling Skills, Multicultural Awareness, Multicultural Counseling Knowledge and Multicultural Counseling Relationship were identified after extensive statistical analyses (Sodowsky, Taffe,
Gutkin, & Wise, 1994). One item was eliminated based on a 20% response rate of “do not know” and other items were removed if they failed to load on one of the four factors at .33 or higher (Pope-Davis & Dings, 1995). Scoring procedures included computing the average of each scale.

Sample items include (Sodowsky, Taffe, Gutkin, & Wise, 1994, p. 141-142; Pope-Davis & Dings, 1995, p. 297): (1) Skills: (e.g., “I monitor and correct my defensiveness [e.g., anxiety, denial, minimizing, overconfidence];” “I use several methods of assessment [including free response questions, observations, and varied sources of information and excluding standardized tests]”); (2) Awareness: (e.g., “When working with international students or immigrants, I have knowledge of the legalities of visa, passport, green card, and naturalization”; “I enjoy multicultural interactions as much as interactions with people of my own culture.”); (3) Knowledge: (e.g., “I include such issues as age, gender roles, and socioeconomic status in my understanding of different minority cultures”; “I make referrals or seek consultations based on the clients’ minority identity development”); and (4) Relationship: (e.g., “I perceive that my race causes the person to mistrust me”; “I have feelings of overcompensation, oversolicitation, and guilt that I do not have when working with majority clients”).

This instrument is considered to have strong psychometric properties and has been used in a number of studies and several doctoral dissertations (Ponterotto et al., 2002). One study concluded that the internal consistency reliabilities were .80, .81, .80, and .67 for the Knowledge, Skill, Awareness, and Relationship scales, respectively (Sodowsky, Taffe, Gutkin & Wise, 1994; Pope-Davis & Dings, 1995). Other studies have demonstrated that the MCI has good face and content validity, acceptable criterion
validity, unknown test-retest reliability, and a moderate relationship among the subscales (Kumas-Tan et al., 2007).

The MCI focuses on behaviors rather than thoughts and attitudes, making it more amenable to the self-report method (Pope-Davis & Dings, 1995). Although the MCI represents a positive step in the measurement of multicultural competency, there are some limitations. One limitation, as with the others mentioned previously, is the possibility of scores being affected by social desirability (Sodowsky, Taffe, Gutkin, & Wise, 1994). Another weakness is the range between the two highest scores on the rating scale, somewhat accurate and very accurate (Pope-Davis & Dings, 1995). For most clinicians, it seems as if a rating lower than 3 would be unlikely if the behaviors referenced have been used or experienced by the clinician at any time (Pope-Davis & Dings, 1995).

A majority of the aforementioned instruments are used with great frequency because of their low costs and convenient self-report format (Ponterotto et al., 2002). All of the instruments, with the exception of the CCSAQ (Mason, 1995), were initially based on the tripartite model (knowledge, awareness, and skills) of cultural competency that has been largely endorsed in the multicultural counseling field (Constantine, Gloria, & Ladany, 2002). However, despite similar objectives, these instruments lack consensus in terms of the number of factors that constitute the assessment instruments (Constantine, Gloria, & Ladany, 2002).

Although these instruments represent an attempt to measure cultural competency, they are all relatively new and have limited psychometric properties. Some major limitations of these instruments are: (1) the tendency to provide unclear descriptions and
definitions of what each subscale is purported to measure; (2) the possibility of participants assessing anticipated rather than actual attitudes, thoughts, or behaviors; (3) the lack of social desirability items inherent in each of the measures; (4) the development of instruments without input from consumers; and (5) the sample that the instruments were normed on were predominantly white, middle-class, educated populations (Pope-Davis & Dings, 1995; Kocarek, Talbot, Batka & Anderson, 2001; Constantine, Gloria, & Ladany, 2002; Kumas-Tan, et al., 2007). The inclusion of social desirability items in these instruments would allow assessors to differentiate between respondents who are responding honestly and those who are answering according to what they perceive is expected of them. It has been suggested that content-related multiple-choice or essay achievement tests are more appropriate methods of measuring an individual’s cultural knowledge, and performance assessment is better at estimating an individual’s cultural skill level because they would be more objective and less reliant on a provider’s level of self-understanding (Pope-Davis & Dings, 1995). However, there are no instruments that employ a content-related multiple-choice or essay achievement method at this time, and the CCCI-R is the closest example of a performance assessment. There is also a need for an instrument to measure levels of provider cultural competency with all culturally diverse populations, not only racially and ethnically diverse people (Constantine, Gloria, & Ladany, 2002). The proposed culture assimilator method is an innovative approach to assessing provider cultural competency.

An Innovative Approach to Cultural Competency

The culture assimilator, also known as the intercultural sensitizer was developed in the early 1960s by Fiedler, Osgood, Stolurow, and Triandis. It is based on the
“attribution theory,” which theorizes how people perceive and explain their own as well as other people’s behaviors (Heider, 1958). The cultural assimilator is a programmed cultural training approach that compares and contrasts individuals’ knowledge and understanding of cultural differences, and the impact of these differences on cross-cultural interactions (Bennet, 1986; Bhawuk & Brislin, 2000; Cushner, 1989; Harrison, 1992; Lonner, 1997). Cultural assimilators can also be used as an aid to teach individuals how to recognize and interpret situations from another cultural perspective, as well as a self-learning tool (Albert, 1986; Bhawuk & Brislin, 2000). As individuals engage in the training process, their understanding of another group’s values, norms, beliefs and roles are expected to subsequently increase (Triandis, 1972; Cushner, 1989). Individuals should also be able to better identify appropriate behaviors of their own culture and learn to acknowledge appropriate behaviors, attitudes, and values of other cultures (Bhawuk, 2001). An important component of this training technique is that participants are not necessarily learning the right way to respond to a cross-cultural conflict, but instead, are unlearning the wrong behaviors that are perpetuated by people who hold certain values, stereotypes, biases, and perceptions. (Bhawuk, 2001).

The culture assimilator training program consists of approximately 37 to 100 short real-life critical incidents that describe a cross-cultural interaction between two or more culturally diverse people with conflicting values and/or attitudes (Bhawuk & Brislin, 2000; Lonner, 1997; Harrison, 1992). After each incident, four or five explanations for the behaviors are included (Bhawuk & Brislin, 2000; Lonner, 1997). These explanations generally represent differing views from each culture as well as other alternatives that may be explained by individual differences (Bhawuk & Brislin, 2000).
The trainee is asked to choose the best explanation based on his or her own perception and verify it with the “correct” answer located at the end of all of the critical incidents (Lonner, 1997). Feedback about the positives and negatives of each alternative is also included (Bhawuk & Brislin, 2000). Culture assimilators can be used in various ways, including the facilitation of personal growth, as a teaching tool in group training programs, or as the basis for group discussions or role playing sessions (Brislin, Cushner, Cherrie, & Yong, 1986).

Previous research demonstrates a beneficial effect of culture assimilator training on the cognitive, affective, and behavioral processes of individuals (Bhawuk & Brislin, 2000; Cushner, 1989). In fact, the use of culture assimilators in cross-cultural training has been studied in laboratory and field settings, has ample empirical support, and is one of the most researched training methods (Albert, 1986; Barrett & Bass, 1976; Cushner, 1989; Bhawuk, 1998; Bhawuk, 2001; Brislin, 1986; Harrison, 1992). The culture assimilator has been proven to be effective as a programmed learning technique above other cross-cultural training approaches (Harrison, 1992; Lonner, 1997).

Despite sufficient evidence for the effectiveness of culture assimilators on increasing individuals' understanding of various cultural perspectives, it has not been used to address the increasingly diverse cultural populations receiving services from mental health professionals in the fields of counseling, psychology, or other helping professions (Lonner, 1997). In addition, it has not been used as a measure of cultural competency. In fact, the purpose of this study is to develop appropriate critical incidents that can be used for cultural assimilator training and for determining provider-level cultural competency in mental health professions.
Culture-Specific Assimilator.

Culture assimilators were initially created for specific cultures, such as individuals from the Middle East, Iran, Honduras, Greece, Thailand, China, Indonesia, Venezuela and Japan (Albert, 1986; Bhawuk, 1998; Bhawuk, 2001). They were intended to address practical problems frequently experienced by individuals visiting, working, or migrating to other countries (Bhawuk, 2001). Not only were culture-specific assimilators created to be used across countries, but they were also created to deal with cultural interactions that occur within the United States (Albert, 1986). An example of a critical incident from the Venezuelan Culture Assimilator (Tolbert & Mc Lean, 1995) is available in Appendix A.

During the 1970’s, evidence for the usefulness of the culture-specific assimilators as a training tool increased substantially (Bhawuk & Brislin, 2000). For example, a study conducted by Mitchell and Foa (1969) evaluated the effectiveness of the Thai culture assimilator against a training program that consisted of lectures and films about the culture of interest. The impact of these types of training approaches on interpersonal relations and task performance were subsequently measured (Bhawuk & Brislin, 2000). Although the group using the Thai culture assimilator approach performed better than the comparison group on the effectiveness of interpersonal relations, no difference was observed in task performance.

A field study conducted by O’Brien and colleagues in 1970 compared the Honduras culture-specific assimilator to a geography-area training approach with
adolescent students (Bhawuk & Brislin, 2000). These students were going to spend three weeks in Honduras as “health care and community development workers,” and their performances were subsequently evaluated by program staff members (Bhawuk & Brislin, 2000, p. 172). The students who were motivated and read the assimilator tended to perform better than the other groups, whereas those who were not motivated and/or did not read the materials did not perform as well (Bhawuk & Brislin, 2000).

Yet, another field study was conducted in Greece in 1972 by Worchel and Mitchell who compared the United States military and civilian advisors and a control group who received no training (Bhawuk & Brislin, 2000). Similar results were found, in that, those trained with the Greek culture assimilator showed greater productivity, adjustment, enjoyment and better interpersonal relations than the control group (Bhawuk & Brislin, 2000).

In addition to the substantial impact the culture-specific assimilator approach had on individuals going to live or work in other countries, it also influenced the training of people within a country (Bhawuk & Brislin, 2000). For instance, in 1975, Weldon and colleagues conducted a study that used a culture assimilator that was developed to train both African American and Caucasian individuals about cultural beliefs and values in the United States (Bhawuk & Brislin, 2000). Results found that individuals trained in the culture assimilator approach held less stereotypical beliefs, perceived less social distance between the two cultures, handled conflicts between the two cultural groups more effectively, and perceived behaviors of the other cultural group as rational and intentional (Bhawuk & Brislin, 2000, p. 173).
Another study, which supported the effectiveness of the culture-specific assimilator technique was conducted with 50 exchange students from 14 different countries who were going to spend a year in New Zealand (Bhawuk & Brislin, 2000). The treatment group received training using 18 critical incidents while the control group received another type of cross-cultural training (Bhawuk & Brislin, 2000). Results indicated that the treatment group was better able to explain misunderstandings, apply the concepts learned to personal experiences, and initiate more attempts to deal with cross-cultural problems than the control group (Bhawuk & Brislin, 2000).

Given the evidence to support the use of the culture-specific assimilator training approach, these studies suggest that they may be effectively used across various cultural groups and populations in the measurement of training effectiveness, the comparison of different groups, and the assessment of training methods and content (Bhawuk, 2001). Unfortunately, many of the culture-specific assimilators, such as those developed for Thailand, Iran, and Honduras need to be updated to include more recent cultural issues faced by people who are moving to or working in these areas (Bhawuk & Brislin, 2000). In addition, the approach looks at a specific culture’s perceptions of “right” and “wrong” behaviors for practical problems rather than providing underlying explanations for cross-cultural differences (Bhawuk, 2001). Finally, although beneficial for specific cultures, culture-specific assimilators have not been used by many people because of their specificity to a particular population (Cushner, 1987; Cushner, 1989).

*Culture-General Assimilator.*

In an effort to expand the utilization of the culture-specific assimilator training method, the first culture-general assimilator method was developed in the 1980’s. This
was a major contribution to the field of cross-cultural training (Bhawuk, 1998; Bhawuk & Brislin, 2000; Cushner, 1989) because the culture-general assimilator training method addressed issues such as self-awareness and sensitivity in cross-cultural interactions (Brislin & Pedersen, 1976). In addition, the training was a means to provide people with the appropriate tools to deal with cross-cultural differences (Bhawuk, 2001). In 1986, Brislin, Cushner, Cherrie, and Yong created a culture-general assimilator that consisted of 100 episodes, which were approximately 200 words in length, and covered 18 general themes (e.g., anxiety, disconfirmed expectancies, roles, categorization; Bhawuk, 1998; Lonner, 1997). The authors created the culture-general assimilator based on the critical incident approach that originated from the work of the industrial psychologist, J. C. Flanagan. (Lonner, 1997). Flanagan defined a critical incident as an experience or incident that was critical in making an important decision (Lonner, 1997). Brislin and colleagues believed that individuals would benefit more from understanding the impact and dynamics of culture in general than information about a specific culture, as there are common themes and experiences that may be generalized across interactions between culturally different individuals (Brislin, 1986; Gannon & Poon, 1997). The culture-general assimilator was used in a variety of settings including: Anchorage, Alaska, for health workers assigned to rural Alaskan villages; Manila, Philippines, for workers and Peace Corps trainers in a refugee resettlement camp; Honolulu, Hawaii, during a 10-day program for cross-cultural trainers wanting skills improvement and for educational administrators of international schools; Vancouver, British Columbia, for cross-cultural counselors; and San Diego, California, for interpreters for the deaf (Brislin, Cushner,
Cherrie, & Yong, 1986, p. 50). An example of a culture-general assimilator (Brislin, Cushner, Cherrie, & Yong, 1986) can be found in Appendix B.

The culture-general assimilator has been useful in and across different training situations. Brislin (1986) also reported that the culture-general assimilator may be appropriate in various settings, such as: (1) when a culture-specific assimilator is unavailable or feasible, (2) when an occupation requires competency across culturally diverse groups of consumers, (3) to expose college students to general cultural issues, and 4) as a follow-up after returning from studying abroad (Brislin, 1986).

Although there are notable strengths of a culture-general assimilator, such as its basis on theoretical concepts and greater applicability, there are also weaknesses of this approach. The weaknesses include: (1) the use of a large number of categories which may make it difficult for trainees to remember each component, (2) the incompatibility of this approach with an integrated theoretical cross-cultural framework, and (3) the inclusion of concepts covered by a large number of categories that may be addressed better through the overarching theory of individualism and collectivism (Bhawuk, 2001).

Theory-Based Culture Assimilator.

In an attempt to address the weaknesses of the culture-specific and culture-general assimilators, a theory-based culture assimilator called the Individualism and Collectivism Assimilator was developed in the 1990's (Bhawuk, 2001; Bhawuk & Brislin, 2000). Bhawuk and Triandis (1995) suggested that experts differ from novices in that they use theories during cross-cultural training to enhance knowledge organization, improve the information retrieval process for problem solving, and further develop intercultural expertise (Bhawuk, 1998). Therefore, culture-theory assimilators are expected to result in
the enhancement of an individual’s cognitive complexity and ability to coherently explain
behavioral differences, which are missing in the other types of cultural assimilators
(Bhawuk, 1998).

This specific type of culture assimilator is based on the theory of Individualism
and Collectivism. (Bhawuk & Brislin, 2000; Bhawuk, 2001) It also attempts to provide a
conceptual framework that is useful for examining the potential reasons for cross-cultural
differences in interpersonal relationships (Bhawuk & Brislin, 2000; Bhawuk, 2001). The
theory of Individualism and Collectivism has four defining attributes including: (1)
Concept of self; (2) Relationship between self and groups of people; (3) How the self
interacts with the society; and (4) The nature of social exchange between self and others
(Bhawuk, 2001). Triandis (1995) suggested that there are vertical and horizontal
individualism and collectivism, which depends on people’s views of themselves in
relation to others of the same cultural group or different cultural groups (Bhawuk, 2001).
An example of a critical incident from the Individualism and Collectivism Assimilator
(Bhawuk, 1995) can be found in Appendix C.

Bhawuk (1998) conducted a study that evaluated the performances of 102
exchange students from a Midwestern university on a variety of measures after they
received cross-cultural training. The participants were randomly assigned to one of four
groups (i.e., three treatment groups and one control group), in which they either reviewed
critical incidents from the Japanese culture-specific assimilator, the culture-general
assimilator, the culture-theory assimilator (i.e., Individualism and Collectivism
Assimilator), or 48 pages of reading material from a book (Bhawuk, 1998). Thirty-six
critical incidents were used for each treatment group to ensure consistency in training
time and depth (Bhawuk, 1998). Each participant was sent home with a reading packet and an instruction sheet and asked to return the material the following week (Bhawuk, 1998). When the participants returned, they were asked to complete the Intercultural Sensitivity Inventory, which measures the intent to engage in behavior change when living in an individualistic society versus a collectivistic society; the Category Width Scale, which measures individual cognitive differences; and other reaction, learning, and behavioral measures (Bhawuk, 1998). The author also obtained demographic information (i.e., age, gender, ethnicity), scores on a measure of learning effort, and information about overseas experiences (i.e., countries visited, duration of stay, and number of different foods tried; Bhawuk, 1998) from the study participants.

The results indicated that participants who received the Individualism and Collectivism Assimilator performed significantly better than the other groups on a number of outcome measures, but the differences were largely dependent on the comparison group (Bhawuk, 1998). Specifically, they performed better than the other three groups on the Intercultural Sensitivity Inventory, the culture-specific and culture-general assimilators group on the Category Width Scale, the culture-specific group on the attribution making measure, and the control group on the reaction measures (Bhawuk, 1998). However, significant differences were not obtained on the recall or face-to-face cross-cultural interaction measures (Bhawuk, 1998). This study suggests that the Individualism-Collectivism Assimilator may have some advantages over the other assimilators in cross-cultural training; however, there are some limitations to this study. For instance, the homogeneity of the sample used and small sample size limits the
generalizability of these findings. Another limitation is the method of administration (i.e., participants were encouraged to read the materials at their own pace).

The Use of Critical Incidents Using the Cultural Assimilator Model for Cultural Competency Training

Critical incidents have been used as educational and training cultural competency tools across disciplines, including education, nursing, human resources, and crisis management (Collins & Pieterse, 2007); however, culture assimilator based training is limited in psychology. Critical incidents typically briefly describe a situation of interest and offer opportunities for reflective examination (Collins & Pieterse, 2007). The reflective component is viewed as essential to the training process. The goal of the reflective component is an increase in and transformation of the trainees’ understanding of the experience. In fact, the literature suggests that the analysis of critical incidents during training is a strategy, which leads to a subsequent increase in the cultural awareness of faculty and students in counselor training programs (Collins & Pieterse, 2007). Specifically, several researchers have applied critical incident analysis to counselor training (e.g., Furr & Carroll, 2003; Fukuyama, 1994) and found that critical incidents resulted in increased attention to, understanding of, and insight about the ways race and culture influence counseling and supervision (Collins & Pieterse, 2007).

An example of critical incidents, which highlight essential issues that may arise in multicultural situations, was presented by Sue and Sue (1990). These critical incidents shared three characteristics including: (1) incidents that represent a cultural conflict; (2) a solution that is not obvious or may arouse controversy among respondents; and (3) the specification of the conditions under which the cultural misunderstanding occurred (Sue
Sue, 1990). The intention of these critical incidents was to help trainees become more culturally aware of their own values, expand their awareness of other individuals’ worldview, learn about ways to anticipate cultural barriers that may arise in mental health settings, and generate and suggest other strategies that may be more culturally appropriate (Sue & Sue, 1990). These three characteristics were incorporated into the critical incidents developed for the current study. An example of a critical incident presented by Sue and Sue (1990) can be found in Appendix D.

Although the aforementioned evidence supports the use of critical incidents based on the culture assimilator approach as a training method, teaching aide, and self-learning tool, the use of the culture assimilator as an objective measure of provider-level cultural competency is non-existent in the published literature. In an attempt to create the first provider-level cultural competency assessment instrument based on the culture-theory assimilator approach, there is a need to develop content-valid critical incidents to be used for a provider-level cultural competency instrument.

Establishing Content Validity

Content Validity

Content validity is essential in that it affects clinical judgments and is one component of construct validity (Haynes, Richard, & Kubany, 1995). Although there are many definitions of content validity in the literature, the definition provided by Haynes, Richard, & Kubany (1995) was used in this study. “Content validity is the degree to which elements of an assessment instrument are relevant to and representative of the targeted construct for a particular assessment purpose” (Haynes, Richard, & Kubany, 1995, p. 238).
"Content validation is a multimethod, quantitative and qualitative process that is applicable to all elements of an assessment instrument" (Haynes, Richard, & Kubany, 1995, p. 243). Haynes, Richard, & Kubany (1995, p. 247) suggest several guidelines in the establishment of content validity, which include: (1) specify the construct targeted by the instrument; (2) specify the intended functions of the instrument; (3) select an assessment method to match targeted construct and function of assessment; (4) initial selection and generation of items; (5) match items to facets and dimensions; (6) examine structure, form, topography and content of each item; (7) have experts review the results; and (8) have experts and target population review the modified assessment instrument. The first six are related to developing the items and the last two are related to piloting these items. The first six guidelines were used in this study to develop critical incidents and ensure their content validity. The goal is to create critical incidents that will be used as the items for a more objective provider-level cultural competency assessment instrument.

Purpose of Project

The literature presented suggests that there have been instrumental and valuable attempts to measure provider level cultural competency through observation or self-report; however, a measure of cultural competency based on the idea of a theory-based culture assimilator approach is non-existent in the published literature. Cultural assimilators have been used successfully as a cross-cultural training technique, so it is also expected to be beneficial as a technique used to measure other behavioral constructs. Additionally, the use of the culture assimilator technique may reduce the likelihood of bias and social desirability, which usually accompany self-report formats, as well as
enhance the probability of accurately assessing the behaviors of mental health professionals.

The purpose of this project was to develop critical incidents that have content validity and represent cultural misunderstandings that may occur between a provider and consumer in a treatment setting. The development of the critical incidents or items progressed through two phases. The first phase involved the creation of critical incidents based on interviews conducted with both providers and consumers, a review of the cultural competency and MCC literature, and other assessment instruments that could potentially be used as items on a provider-level cultural competency assessment instrument. The collected information was condensed based on the three MCC domains, including: (1) Becoming Aware of Own Worldview; (2) Understanding the Worldview of the Culturally Different Client/Respecting Client’s Worldview; and (3) Developing Appropriate Intervention Strategies and Techniques. The second phase involved a systematic reduction in the number of critical incidents or items based on multicultural experts’ opinions about whether or not the incident involved a cultural misunderstanding and determination of each critical incident’s corresponding MCC theoretical domains. Participants were also asked to provide qualitative information about how each critical incident could be improved. This project resulted in the development of a set of critical incidents, which have demonstrated content validity. These critical incidents can then be used in the development of a provider-level cultural competency instrument using the cultural assimilator format. The next step in the development of the instrument will be the creation of alternative responses to each critical incident and the examination of the reliability and validity of the completed assessment instrument.
CHAPTER TWO

PHASE ONE

Method

Sample

A total of 22 culturally diverse mental health providers and consumers were recruited for participation in this study. Twelve participants were consumers (i.e., individuals who have been diagnosed with a serious mental illness and were eligible for Adult Mental Health Division services) and 10 were mental health service providers (i.e., individuals employed at Community Mental Health Centers or the university counseling center). The providers included two (20%) psychologists, two (20%) psychiatric nurses, five (50%) social workers, and one (10%) clinical psychology intern. Thirteen (59.1%) of the participants were males and nine (40.9%) were female. The ages of participants ranged from 21 to 60 years old or older. The majority (40.9% and 31.8%) of participants were between the ages of 31-40 and 51-60, respectively. The participants were from various ethnic groups, including Caucasian (31.8%), Mixed (3 or more ethnicities; 27.3%), Two Ethnicities (13.6%), Other White (9.1%), Hawaiian (4.5%), Filipino (4.5%), and Other Asian American (4.5%). However, when asked about the ethnicity they identified with the most, the responses were: Hawaiian (27.3%), Other (22.7%), Caucasian (13.6%), Japanese (9.1%) and one of several other ethnic categories including American Indian, Chinese, Filipino, Other Asian American, Other White, and not applicable (4.5%). A more detailed description of the participants’ demographic characteristics is presented in Appendix E.
The participating providers and staff members were recruited through phone calls and flyers (see Appendix F) posted at community mental health centers (CMHCs) and counseling centers. Specifically, the flyers were posted for approximately two months at six different sites (i.e., five O‘ahu CMHCs and one university counseling center), informational meetings were provided to three different sites (i.e., two CMHCs and a university counseling center), and contact was made with a CMHC administrator who declined participation in the study until further information could be provided. The participants either contacted the primary investigator or were contacted by the primary investigator (i.e., community mental health centers’ primary phone numbers and e-mail addresses), if they expressed interest in participating in this study after viewing the flyer or speaking with other staff members who were familiar with the study. Interest was generated individually or through question and answer sessions conducted with multiple staff members at various community mental health centers. Consumers were contacted if they responded to the flyer or notified clinical staff of their willingness to participate. If consumers expressed an interest in participating to clinical staff members, these staff members contacted the primary investigator who then contacted the consumers.

The providers and consumers who were recruited through this process came from four different CMHCs and a university counseling center, which were all located on the island of O‘ahu. Specifically, eighteen (81.8%) of the 22 participants came from two CMHCs, while the other four (18.2%) participants came from the other two CMHCs and one university counseling center. Four (40%) of the 10 providers and six (50%) of the 12 consumers came from one CMHC, six (50%) consumers came from another CMHC, and six (60%) providers came from the other three CMHCs and one university counseling
center. After consenting to participate in the study, individuals were asked to share several examples of their experiences with culturally diverse clinical interactions.

Data Collection Procedures

The primary investigator conducted one-on-one semi-structured interviews with providers and consumers that were approximately a half hour to an hour in duration. Each interview began with an introduction, review of the purpose of the study, and verbal and written explanations of informed consent (see Appendix G). The informed consent form also solicited agreement for audiotape recording of the interview. All informed consent forms contained the names and contact information of the primary investigator and her supervisor for questions, comments, or concerns regarding the research study. Participants were advised that their participation was completely voluntary; they could skip any questions that made them feel uncomfortable; and they could terminate their participation at anytime. They were also advised that the information provided would be kept confidential, and answers provided would not be associated with any identifying information. Participants who agreed to the terms of the informed consent were asked to sign the form prior to the beginning of the interview and were given copies for their records.

Consumers and providers were then asked to generate at least two examples of personal experiences that resulted in a cross-cultural conflict in the therapeutic relationship based on a set of standard interview questions (see Appendix H). The purpose of these questions was to prompt the participants to: (1) think of cultural issues that may arise in a therapeutic setting; (2) discuss the way the issue was handled; and (3) problem solve ways that issue could have been handled differently. Participants were
also given copies of the interview questions (see Appendix H) and two sample critical incidents (see Appendix I) to refer to as needed while the interviewer read aloud. The interviewer asked for examples of cultural interactions from their own experiences. The researcher wrote down the key elements of each story so that they could be used to construct the critical incidents. The interviews were also audiotape recorded so that the researcher could refer to the tapes as needed. Providers and consumers were given a $10.00 gift certificate to a grocery store as a thank you for their participation.

Other incidents were created based on the domains of the MCC Theory (i.e., Becoming Aware of Own Worldview; Understanding the Worldview of the Culturally Different Client; and Developing Appropriate Strategies and Techniques), literature relevant to the construct, and assessment instruments. These critical incidents were created to cover issues not discussed during the interviews but highlighted in the literature review (e.g., clinician’s inability to recognize limits of his/her competencies and expertise, clinician’s unwillingness to work with an indigenous healer).

The information gathered was synthesized into 37 critical incidents that followed standards suggested in the critical incident literature (e.g., portrayal of a problem, conflict/misunderstanding that resulted from a cultural difference, 200 to 300 word incidents). Thirty critical incidents were developed in order to ensure the creation of 15 critical incidents by the end of the study. This is consistent with Allen & Yen (1979) who suggest the generation of one and a half to three times as many items as is ultimately needed. Characteristics of diverse cultures, such as age, disability, sexual orientation, or religious affiliation were used in each critical incident to emphasize the importance of
cultural diversity and the impact it may have in mental health settings (e.g., access to, utilization of, and compliance with mental health services).

It was necessary to include an equal number of initial items (i.e., at least 10 critical incidents for each MCC domain) addressing conflicts that resulted from the clinician's lack of awareness of his/her own worldview, understanding of the culturally different client's worldview, and implementation of intervention strategies and techniques. In addition to a cultural conflict, all of the critical incidents also included the possibility of a solution(s) that is not obvious and the specific conditions under which the cultural misunderstanding occurred (Sue & Sue, 1990). It was also important for the critical incidents to be no more than 200 to 300 words in length and to demonstrate some consistency in style and content. For example, if the therapist's occupation and consumer's diagnosis were mentioned in one critical incident, these characteristics were mentioned in all of the critical incidents. A table was created to ensure that at least one of the cultural variables (e.g., age, ethnicity, gender, and sexual orientation) was represented in each critical incident and that all of the necessary and consistent variables were covered within each domain (see Appendix J).

Participants were also required to complete a demographic questionnaire (see Appendix K), which included the following variables: gender, age, ethnicity, marital status, religious affiliation, sexual orientation, education level, diagnosis and types of treatment (if appropriate), professional role, cultural competency workshops and courses taught or attended, and experience with multicultural clients. The demographic information gathered was used to describe the participants. Each participant was assigned a number code, and personal identifying information was kept separately from the data.
All the information was kept in a locked file cabinet accessible only to the primary investigator.

Results

A total of 37 cultural misunderstandings were obtained from participant interviews, MCC theory, other literature related to the construct of cultural competency, and other cultural competency assessment instruments. However, the main ideas of seven of the obtained scenarios overlapped; therefore, the 37 scenarios were condensed and revised, resulting in 30 critical incidents. Specifically, the primary investigator: (1) read through the cultural misunderstandings obtained; (2) grouped the misunderstandings into themes based on the MCC domains (e.g., issues involving the clinician’s: lack of awareness of his/her own worldview; reduced understanding of the culturally different client; or inability to use appropriate intervention strategies and techniques); (3) used comparative judgment to decide which issues were similar; and (4) condensed the cultural misunderstandings into one critical incident when more than one participant discussed a similar cultural issue that impacted the therapeutic relationship. Ten critical incidents were created for each of the Multicultural Counseling Competencies domains (i.e., Becoming Aware of Own Worldview, Understanding the Worldview of the Culturally Different Client/Respecting the Client’s Worldview, and Developing Appropriate Intervention Strategies and Techniques). Demographic information for the critical incidents generated through interviews was slightly modified or altered to protect the privacy and confidentiality of the participants.

The critical incidents were adapted to present various cultural misunderstandings around age, race, ethnicity, disability, sexual orientation, gender, or religious affiliation...
such that one cultural issue was addressed in each critical incident. Although the critical incidents were distinctly different based on the cultural issue addressed, all of the critical incidents covered similar components, which included diagnosis and/or symptoms, setting, identification of clinician and client, provider’s occupation, and most importantly, a cultural conflict. The 30 critical incidents used in the Cultural Competency Critical Incident Evaluation Form can be found in Appendix L.
CHAPTER THREE

PHASE TWO

Method

Sample

Twenty-five experts were recommended and solicited for their involvement, and a total of 11 participated in this phase of the study. These cultural competency experts were identified through the opinions of cultural experts using the snowball sampling method. The snowball sampling method is a nonprobability method used when the preferred sample is limited (StatPac Inc., 1997-2005). This method is characterized by a researcher's use of participants' referrals in the identification of other qualified participants (StatPac Inc., 1997-2005). The experts were mental health professionals (e.g., psychologists, counselor educators, social workers), researchers, or academicians who have demonstrated expertise in the area of cultural competency (e.g., presentations, publications, etc.) and were identified by other experts. Initially, local cultural experts were contacted by phone or e-mail and asked for the contact information of other local or national experts who they thought would be interested in participating in this study. Once identified, they were recruited by phone or e-mail for their participation in this phase of the study.

The sample of experts was comprised of six males (54.5%) and five females (45.5%). A total of six cultural competency experts (54.5%) were currently living and working in the state of Hawai‘i, while the other five were living in the continental United States. The ethnic breakdown of the experts was: Caucasian (27.3%; n=3), Japanese (18.2%; n=2), Two Ethnic Identities (18.2%; n=2), Other Hispanic/Latino (18.2%; n=2),
Hawaiian (9.1%; n=1), and Other Asian American (9.1%; n=1). When asked to identify the ethnicity they identify with most, the responses were: Other (36.4%; n=4), Japanese (18.2%; n=2), Other Hispanic/ Latino (18.2%; n=2), Hawaiian (9.1%; n=1), Other Asian American (9.1%; n=1), and No Answer (9.1%; n=1). All of the experts completed their graduate school degrees. Five (45.5%) identified themselves as psychologists, four (36.4%) as a professional with multiple roles (e.g., professor/academician and psychologist), one (9.1%) as a researcher, and one (9.1%) as a clinical psychology fellow. Additional demographic information can be found in Table 1.
Table 1. Experts' Demographic Characteristics and Descriptive Statistics

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<td>No</td>
<td>2</td>
</tr>
<tr>
<td>No Answer</td>
<td>3</td>
</tr>
<tr>
<td>Multicultural Workshops Taken</td>
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</tr>
<tr>
<td>Yes</td>
<td>7</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>No Answer</td>
<td>3</td>
</tr>
<tr>
<td>Taught Multicultural Workshops</td>
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<tr>
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<td>7</td>
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<tr>
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<td>1</td>
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<td>Years of Working Experience with</td>
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<tr>
<td>Multicultural Clients</td>
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<tr>
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</tr>
<tr>
<td>8-11 years</td>
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<td>12-15 years</td>
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<td>16+ years</td>
<td>3</td>
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<tr>
<td>No Answer</td>
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</tbody>
</table>
Data Collection Procedures

Once the experts were identified through the snowball sampling method, the participants were asked through e-mail or mail to read an electronic version of the informed consent form (see Appendix M). The names and contact information of the primary investigator and her supervisor were provided on all consent forms so that the participants could contact them regarding questions, comments, or suggestions about the research study. Participants were advised of their rights, which included voluntary participation, freedom to refrain from answering questions that make them feel uncomfortable, and liberty to terminate participation at any time. Participants were also informed about the confidentiality of all information provided during the session and guaranteed that the answers provided would not be associated with any identifying information. Participants were offered an option to print a copy of the consent form for their records. Participants were assigned numbers to assure confidentiality.

If the participants agreed to the terms of the consent form, they either completed a Word or PDF-form fillable document or a hard copy of the Cultural Competency Critical Incident Evaluation Form (see Appendix L) along with the demographic questionnaire (see Appendix K), which were e-mailed or mailed, respectively. The experts had two months from the time of notification of the study until the time that data collection was terminated. The Cultural Competency Critical Incident Evaluation Form incorporated the critical incidents gathered and identified during Phase One. The same three questions were asked for each critical incident. The experts were asked to rate the first statement, “This critical incident represents a cultural misunderstanding,” on a 5-point Likert-type scale, ranging from 1 = Strongly Disagree to 5 = Strongly Agree. Participants were also
asked to allocate a specific percentage to each domain of cultural competency in the second question: “What percent of this critical incident would you attribute to each of these 3 domains?” The three domains were: 1) Clinician’s lack of awareness of his/her own worldview; 2) Clinician’s reduced understanding of the consumer’s worldview; and 3) Clinician’s inability to develop/utilize appropriate intervention strategies and techniques. The third question was an open-ended question, “How could this critical incident be improved?”, which solicited qualitative feedback from participants.

The demographic questionnaire (see Appendix K) included information about the participants’ gender, age, ethnicity, ethnic group they identify with most, marital status, religious affiliation, sexual orientation, highest level of education completed, years of residence in Hawai‘i, psychiatric diagnosis and types of treatment, if appropriate, current professional roles, multicultural workshops or courses taught or taken, and years of experience with multicultural clients. The participants were given approximately two months to respond to the evaluation form. Upon the completion of this questionnaire, the participants were thanked for their participation and mailed a $20 gift certificate for a bookstore located nationwide. All of the completed questionnaires were printed and placed in a locked file cabinet only accessible to the primary investigator.

Data Analysis Procedures

The means and standard deviations were calculated for Questions 1 for all 30 critical incidents. In an effort to obtain items that accurately portrayed a cultural misunderstanding, an a priori decision was made to retain only critical incidents with a mean rating of four or higher (five-point scale) on Question 1 across all respondents. These items that did not meet this criterion would not be included in the final instrument.
The means, standard deviations, and ranges were also calculated for each of the three domains identified in Question 2.

In addition to the means, standard deviations, and ranges calculated for each of the three domains identified in Question 2, the Kendall Coefficient of Concordance $W$ was also calculated after the percentages were converted to their respective ranks. The Kendall Coefficient of Concordance $W$ is used to determine the association among $k$ sets of rankings, which is applicable to studies investigating interrater reliability and variable clusters (Siegel & Castellan, 1988). The computation of $W$, the coefficient of concordance, generates a linear relation to the average $r_t$ taken over all groups (Siegel & Castellan, 1988). Therefore, the degree of interrater agreement among a specified number ($k$) of judges results from the degree of variation among the number of objects, or in this case, critical incidents ($N$) being ranked (Siegel & Castellan, 1988). In other words, $W$ is an index, which indicates the divergence between the actual agreement demonstrated in the data and the maximum possible or perfect agreement (Siegel & Castellan, 1988).

The computation of $W$ involves: 1) organizing the data into a $k \times N$ table with the rankings obtained from each expert to the $N$ critical incidents located in the rows; 2) summing the ranks $R_i$ in each column and dividing each by $k$ to calculate the average rank $\bar{R}_i$; and 3) expressing $R_i$ as a deviation from the grand mean (Siegel & Castellan, 1988). Larger deviations suggest a greater degree of association among the $k$ sets of ranks, thus, the sum of squares of these deviations is calculated (Siegel & Castellan, 1988). The value of $W$ is computed using the following equation:

$$W = \frac{\frac{1}{N} \sum_{i=1}^{N} (R_i - \bar{R})^2}{\frac{N(N^2 - 1)}{12}}$$
where \( k \) = number of sets of rankings, e.g., the number of judges

\( N \) = number of objects (or individuals) being ranked

\( \bar{R}_i \) = average of the ranks assigned to the \( i \)th object or subject

\( \bar{R} \) = the average (or grand mean) of the ranks assigned across all objects or subjects

\( N(N^2 - 1)/12 \) = maximum possible sum of the squared deviations, i.e., the numerator which would occur if there were perfect agreement among the \( k \) rankings, and the average rankings were 1, 2, ..., \( N \) (Siegel & Castellan, 1988, p.264)

The method used to determine whether the Kendall coefficient of concordance is significant is largely dependent upon the sample size or the number of objects (i.e., MCC domains) being ranked (Siegel & Castellan, 1988). The significance of an observed value of \( W \) can be established by determining the probability associated with the occurrence when \( H_0 \) is true of a value as large as the observed value (Siegel & Castellan, 1988).

When the sampling distribution of \( W \) for all permutations in the \( N \) ranks in all possible ways among the \( k \) rankings is computed, \((N!)^k\) equals all the sets of possible ranks (Siegel & Castellan, 1988). These sets are used to test the null hypothesis (i.e., \( k \) sets of ranking are independent) by identifying “the probability associated with the occurrence under \( H_0 \) of a value as large as an observed \( W \)” (Siegel & Castellan, 1988, p. 269). The critical values of \( W \) for the \( \alpha = .05 \) and \( \alpha = .01 \) significance levels when \( k = 11 \) and \( N = 3 \) are .275 and .392, respectively (Siegel & Castellan, 1988). A significant \( W \) value suggests that the \( k \) experts or judges are applying the same or similar standards in ranking the \( N \) critical incidents (Siegel & Castellan, 1988). When there is no relevant criterion used for
ordering the critical incidents, the pooled ordering is used as the "standard" (Siegel & Castellan, 1988). Even though a significant value of $W$ is obtained, it does not necessarily mean that the rankings are correct, which suggests the utilization of the wrong criteria by some of the judges (Siegel & Castellan, 1988). Therefore, $W$ can be defined as the best estimate of the "true" ranking of $N$ objects (Siegel & Castellan, 1988). The information gathered from both the means and standard deviations of the allocated percentages and the Kendall coefficient of concordance $W$ would subsequently be used to categorize or match each critical incident to their corresponding domains.

The qualitative information obtained from Question 3 was intended to be used to improve various aspects of the critical incident, such as grammatical errors, language simplification, or communication of a cultural misunderstanding. Specifically, this information was intended to be used to examine the structure, form, and content of each critical incident. An a priori decision was made to use only suggestions made by a majority of the participants to improve the critical incidents. If a majority of the experts made similar suggestions, the primary investigator would use these suggestions to modify the items retained.

*Results*

**Question 1:** This critical incident represents a cultural misunderstanding.

The means and standard deviations for all 30 critical incidents were calculated to determine which critical incidents would be retained. These values are indicated in Table 2. The data suggested that 16 critical incidents [i.e., 3, 4, 6, 10, 11, 13, 16, 17, 20, 21, 23, 24, 25, 27, 29, 30 – as indicated with an asterisk (*)] should be retained for the final instrument because they had a mean greater than or equal to 4 (see Appendix N). The
items that were retained were renumbered from one to 16 based the aforementioned order. The remaining items were discarded.
Table 2. Descriptive Statistics for Question 1: This critical incident represents a cultural misunderstanding.

<table>
<thead>
<tr>
<th>Question 1: This critical incident represents a cultural misunderstanding.</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
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<tr>
<td>Critical Incident #3</td>
<td>*4.91</td>
<td>.302</td>
</tr>
<tr>
<td>Critical Incident #4</td>
<td>*4.64</td>
<td>1.206</td>
</tr>
<tr>
<td>Critical Incident #5</td>
<td>3.82</td>
<td>1.168</td>
</tr>
<tr>
<td>Critical Incident #6</td>
<td>*4.82</td>
<td>.405</td>
</tr>
<tr>
<td>Critical Incident #7</td>
<td>3.18</td>
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</tr>
<tr>
<td>Critical Incident #8</td>
<td>3.20</td>
<td>1.317</td>
</tr>
<tr>
<td>Critical Incident #9</td>
<td>3.73</td>
<td>1.421</td>
</tr>
<tr>
<td>Critical Incident #10</td>
<td>*4.45</td>
<td>.522</td>
</tr>
<tr>
<td>Critical Incident #11</td>
<td>*4.82</td>
<td>.405</td>
</tr>
<tr>
<td>Critical Incident #12</td>
<td>3.27</td>
<td>1.272</td>
</tr>
<tr>
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<td>*4.55</td>
<td>.688</td>
</tr>
<tr>
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</tr>
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<tr>
<td>Critical Incident #30</td>
<td>*4.09</td>
<td>1.300</td>
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</table>

* = Critical incidents with a mean rating of 4 or higher were retained.
Question 2: What percent of this critical incident would you attribute to each of these 3 domains?

The means, standard deviations, and ranges were also calculated for each of the domains identified in Question 2 based on the responses of the 11 experts. These means and standard deviations were intended to be used to match each item or critical incident to one or more of the three domains of the MCC theory. Table 3 presents the means, standard deviations, and ranges of each domain for only the critical incidents that were retained.
<table>
<thead>
<tr>
<th>Critical Incident</th>
<th>Lack of Awareness of His/Her Own Worldview</th>
<th>Reduced Understanding of the Consumer’s Worldview</th>
<th>Inability to Develop/Utilize Appropriate Intervention Strategies</th>
<th>Mean</th>
<th>Range</th>
<th>Standard Deviation</th>
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<td>25.00</td>
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<td>20.549</td>
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<td>Standard Deviation</td>
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<td>24.55</td>
<td>0-50</td>
<td>16.348</td>
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<td>31.82</td>
<td>0-70</td>
<td>21.826</td>
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<td>Inability to Develop/Utilize Appropriate Intervention Strategies</td>
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<td>17.73</td>
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<td>40-100</td>
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<td>Inability to Develop/Utilize Appropriate Intervention Strategies</td>
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<th>Standard Deviation</th>
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<tr>
<td>Lack of Awareness of His/Her Own Worldview</td>
<td>25.45</td>
<td>0-80</td>
<td>23.712</td>
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<td>41.82</td>
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<td>28.572</td>
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<td>10-100</td>
<td>29.611</td>
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<th>Standard Deviation</th>
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<td>Lack of Awareness of His/Her Own Worldview</td>
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<td>0-20</td>
<td>8.312</td>
</tr>
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<td>47.27</td>
<td>20-100</td>
<td>31.013</td>
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<td>Inability to Develop/Utilize Appropriate Intervention Strategies</td>
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<td>0-80</td>
<td>28.731</td>
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<table>
<thead>
<tr>
<th>Critical Incident #12</th>
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<th>Range</th>
<th>Standard Deviation</th>
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</thead>
<tbody>
<tr>
<td>Lack of Awareness of His/Her Own Worldview</td>
<td>19.55</td>
<td>0-50</td>
<td>17.096</td>
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<td>Reduced Understanding of the Consumer's Worldview</td>
<td>46.82</td>
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<td>33.64</td>
<td>0-80</td>
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### Table 3 (Continued)

**Question 2: What percent of this critical incident would attribute to each of these 3 domains?**

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<td>15.883</td>
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<td>20.505</td>
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<td>Inability to Develop/Utilize Appropriate Intervention Strategies</td>
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<td>0-100</td>
<td>28.881</td>
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<table>
<thead>
<tr>
<th>Critical Incident #14</th>
<th>Mean</th>
<th>Range</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of Awareness of His/Her Own Worldview</td>
<td>28.64</td>
<td>0-60</td>
<td>19.117</td>
</tr>
<tr>
<td>Reduced Understanding of the Consumer's Worldview</td>
<td>37.27</td>
<td>0-80</td>
<td>26.773</td>
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<td>Inability to Develop/Utilize Appropriate Intervention Strategies</td>
<td>34.09</td>
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<td>33.972</td>
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<table>
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<tr>
<th>Critical Incident #15</th>
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<th>Range</th>
<th>Standard Deviation</th>
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<tbody>
<tr>
<td>Lack of Awareness of His/Her Own Worldview</td>
<td>20.00</td>
<td>0-50</td>
<td>17.464</td>
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<td>Reduced Understanding of the Consumer's Worldview</td>
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<td>30.451</td>
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<td>Inability to Develop/Utilize Appropriate Intervention Strategies</td>
<td>16.36</td>
<td>0-50</td>
<td>17.334</td>
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</table>

<table>
<thead>
<tr>
<th>Critical Incident #16</th>
<th>Mean</th>
<th>Range</th>
<th>Standard Deviation</th>
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</thead>
<tbody>
<tr>
<td>Lack of Awareness of His/Her Own Worldview</td>
<td>13.64</td>
<td>0-30</td>
<td>11.201</td>
</tr>
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<tr>
<td>Inability to Develop/Utilize Appropriate Intervention Strategies</td>
<td>45.00</td>
<td>0-100</td>
<td>33.838</td>
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</table>

Although the percentages differed, the critical incidents could not be confidently assigned to a specific MCC domain after factoring in the standard deviations obtained.

The data suggest variable responses across the expert participants for the majority of the 16 critical incidents. However, the calculation of the *Kendall Coefficient of Concordance W* for each MCC domain for each individual critical incident helped to determine how each of the critical incidents should be categorized according to this particular panel of experts. The number of rankings, means, standard deviations, and Kendall’s Coefficient
of Concordance $W$ are presented in Table 4. The significant values of $W$ are indicated with an asterisk (*), suggesting that the 11 experts (with the exception of Critical Incidents #15 and #16, which were evaluated by only nine of the 11 experts) were applying similar standards in ranking the three MCC domains for each critical incident. One of the experts did not allocate percentages to Critical Incidents #15 and #16 for two different reasons. Specifically, this expert stated that he believed one of the situations was handled correctly and that the clinician in the other situation should not be responsible for resource shortages in the clinic. Another expert did not answer Question 2 for critical incident #15 because she believed the scenario raised an ethnical dilemma that would supersede cultural differences. Finally, another expert did not respond to Question 2 for critical incident #16 because he felt that none of the domains were pertinent to the scenario as the lack of cultural competency portrayed in the critical incident was an agency issue.
Table 4. Descriptive Statistics and Kendall's Coefficient of Concordance by Multicultural Counseling Competencies Theory Domains

(Question 2)

<table>
<thead>
<tr>
<th>Critical Incident</th>
<th>Lack of Awareness of His/Her Own Worldview</th>
<th>Reduced Understanding of the Consumer's Worldview</th>
<th>Inability to Develop/Utilize Appropriate Intervention</th>
<th>Number of Rankings</th>
<th>Mean</th>
<th>Standard Deviation</th>
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Table 4 suggests that the experts who rated each critical incident applied similar standards of ranking for critical incidents 3, 4, 5, 8, 9, 11, 12, 13, 15, and 16 (see Appendix N). The means and standard deviations of the percentages and Kendall Coefficient of Concordance $W$ provide information regarding how each of the critical incidents should be categorized according to the MCC theory. Since the standard deviations are relatively large for almost all of the mean percentages, the data need to be carefully interpreted. Specifically, Critical Incidents 3, 4, and 5 primarily represent characteristics from MCC Domain 2 (i.e., Understanding the Worldview of the Culturally Different Client/Respecting Client’s Worldview), but exhibit less characteristics from both MCC Domain 1 (i.e., Becoming Aware of Own Worldview) and MCC Domain 3 (i.e., Developing Appropriate Intervention Strategies and Techniques), respectively. The data suggest that Critical Incidents 8 and 12 mostly represent MCC Domain 2 but also exhibit characteristics from MCC Domains 3 and 1, respectively. Critical Incidents 9, 13, and 15 predominantly represent MCC Domain 2 but also demonstrate a relatively equivalent amount of characteristics from MCC Domains 1 and 3. Critical Incident 11 shows a large number of characteristics from MCC Domains 2 and 3, and a minimal amount from MCC Domain 1. Finally, Critical Incident 16 exhibits characteristics primarily from MCC Domain 3 followed by characteristics from MCC Domains 2 and 1, respectively. The 11 cultural competency experts attributed eight of the 10 remaining critical incidents largely to MCC Domain 2, Understanding the Worldview of the Culturally Different Client/Respecting the Client’s Worldview.

Notwithstanding the substantial overlap between the domains the remaining 10 critical incidents represented, there were some consistencies between this matching data
and Table 2, which indicate the domain each critical incident was intended to predominantly represent. In fact, four (40%) of the 10 critical incidents were accurately matched to their respective domains. Specifically, Critical Incidents 8, 9, 11, and 13 were accurately matched to Domain 2, Understanding the Worldview of the Culturally Different Client/Respecting the Client’s Worldview (based on Appendix J), even though the experts indicated that they also represented the other two domains. The experts indicated that Critical Incidents 3, 4, 5, 12, and 15 were most representative of Domain 2, although Critical Incidents 3 and 5 were intended to portray a cultural misunderstanding around Domain 1 and Critical Incidents 4, 12, and 15 were intended to be representative of Domain 3. Although Critical Incident 16 was intended to exemplify Domain 2, the experts agreed that it was most representative of Domain 3.

The remaining 10 critical incidents were representative of cultural misunderstandings, which involved differences in race, ethnicity, sexual orientation, religious affiliation, and disability and/or impairments. Specifically, Critical Incident 3 presented a sexual orientation issue; Critical Incidents 4, 8, and 13 focused on ethnic differences; Critical Incidents 5 and 12 portrayed racial differences; Critical Incidents 9 and 15 presented issues around religious affiliation; and Critical Incidents 11 and 16 focused on the impact of disabilities and/or impairments (e.g., an inability to speak or understand English). However, none of the remaining 10 items focused on cultural misunderstandings, which involved age and gender differences.

**Question 3: How could this critical incident be improved?**

The qualitative information provided by the experts regarding the remaining critical incidents was not conclusive or significant because it was misunderstood by
majority of the participants. Only five (45.5%) of the 11 experts provided valid answers (e.g., suggestions about grammatical errors, simplification of language) to Question 3; however, there were no significant trends in the information provided. For example, approximately three to four experts provided feedback, suggestions, or comments for each critical incident. The feedback generally ranged from “good” to “no recommendations” to suggestions about simplifying words and sentences. Specific feedback for each of the remaining 10 critical incidents is available in Appendix O. Three of the five experts also provided general comments about the critical incidents. These comments included questioning the broad definition of cultural competency that was used for this study, removing the letters A and B from Clinician and Client, respectively, as to enhance clarity, and simplifying critical incidents by using simpler words and shortening sentences. The other six (54.5%) experts provided invalid responses such as: 1) “Use open questions to explore relationship dynamics;” and 2) “Clinician gain more knowledge re: LGBT issues.” These responses were invalid because they involved ways the clinician could be more culturally competent in a multicultural therapeutic situation, rather than ways to improve the actual critical incident. This information can be used for the future development of the Provider-Level Cultural Competency Questionnaire.
CHAPTER FOUR

DISCUSSION

The purpose of this study was to develop critical incidents with good content validity for a provider-level cultural competency instrument based on the Multicultural Counseling Competencies Theory. These incidents are intended to be used in the development of a provider-level cultural competency instrument using the theory-based culture assimilator format. The 10 items that were retained are comprised of two Multicultural Counseling Competencies Theory domains: Understanding the Worldview of the Culturally Different Client/Respecting Client's Worldview and Developing Appropriate Intervention Strategies and Techniques. In general, the methodology employed by this study illustrates the multimethod, quantitative, and qualitative process of content validity proposed by Haynes, Richard, & Kubany (1995). Specifically, the methodology followed these guidelines for establishing content validity.

First, the construct was specified by defining the construct of cultural competency according to Cross, Bazron, Dennis, and Isaacs (1989). It was defined as “the set of congruent behaviors, attitudes and skills, policies and procedures that come together in a system, agency, or individuals to enable mental health caregivers to work effectively and efficiently in cross/multicultural situations.” Then, the intended function of the instrument was specified (i.e., the development of a more objective measurement of the cultural competency levels of providers working with individuals with serious mental illnesses). Third, the selection of the assessment method (i.e., use of the theory-based culture assimilator format) to match the targeted construct (i.e., provider-level cultural competency) and function (i.e., a more objective measurement) of the assessment.
occurred. The fourth guideline involved the generation and initial selection of the items or critical incidents for the assessment instrument. Specifically, critical incidents were generated based on interviews conducted with both providers and consumers from a state mental health system and university counseling center, the Multicultural Counseling Competencies theory, the literature related to cultural competency, and other cultural competency assessment instruments. The identified experts were then asked to identify the critical incidents, which accurately represented cultural misunderstandings. Fifth, the panel of experts were asked to match the items to facets and dimensions (i.e., matching each critical incident to its corresponding domains based on the Multicultural Counseling Competencies theory; using percentage means, standard deviations, ranges, and the Kendall Coefficient of Concordance $W$ from data provided from the experts to match the items to their corresponding domains). Finally, the panel of experts were asked to examine the structure, form, topography and content of each item (i.e., have the panel of experts provide qualitative information about the structure, form, topography, and content of each critical incident). This study highlights a number of concerns and limitations that can arise when designing items or critical incidents, which exemplify a complex, multifaceted construct such as cultural competency. The results and limitations of each phase of this study are summarized and discussed more completely below.

*Phase One*

An initial pool of 30 critical incidents representing cultural misunderstandings was generated through information obtained from participant interviews, Multicultural Counseling Competencies theory, literature related to the construct of cultural competency, and other assessment instruments. Ten critical incidents were created based
on each of the domains (i.e., Becoming Aware of Own Worldview, Understanding the Worldview of the Culturally Different Client/Respecting Client's Worldview, and Developing Appropriate Intervention Strategies and Techniques) of the Multicultural Counseling Competencies theory. In an attempt to protect the identity of the individuals who shared their personal cultural experiences, the interview-based information used in each critical incident was slightly modified or altered.

The critical incidents were also tailored to present various cultural misunderstandings around age, race, ethnicity, disability, sexual orientation, gender, or religious affiliation such that one cultural issue was addressed in each critical incident. Although the critical incidents were distinctly different based on the cultural issue addressed, all of the critical incidents covered similar components.

The process used to generate these critical incidents involved the use of multiple informants. Specifically, not only was the literature thoroughly reviewed, but interviews were also conducted with mental health providers and consumers increasing the probability that real-life cultural issues were created and portrayed in the critical incidents. Although it is impossible to generate critical incidents that capture all the possible cultural misunderstandings that may occur in a mental health setting, the data collection procedure was able to capture several significant cultural issues as presented in the literature and indicated by the participants. Another strength of this study involved grounding the critical incidents in the Multicultural Counseling Competencies theory. The MCC theory is a widely used and accepted theory that has been adopted by the American Psychological Association as guidelines for psychological practice (APA, 2003). Its competencies are often presented as specific and measurable capacities (Collins
& Pieterse, 2007), which are congruent with the development of an objective provider-level cultural competency assessment instrument.

A couple of key challenges to developing these critical incidents were the complex definition of cultural competency and lack of independence between the domains of the Multicultural Counseling Competencies theory upon which they were based. Specifically, although cultural competency has been found to be an essential component in psychology and other disciplines, it is difficult to operationalize and has been defined differently by various people and organizations. There may also be other existing cultural competency theories that may better explain this multifaceted construct. The definitional and theoretical variations are also evident in the literature, other cultural competency assessment instruments, and personal experiences shared by the providers and consumers who were interviewed.

The classification of each critical incident into its respective MCC domain by the cultural competency experts demonstrated a lack of independence between the three domains. Evidence of the lack of independence between the MCC domains is also evident in the MCI (Sodowsky, Taffe, Gutkin, & Wise, 1994), MAKSS-CE-R (Kim, Cartwright, Asay, & D’Andrea, 2003), MCKAS (Ponterotto et al., 2002), and CCI-R (LaFromboise, Coleman, & Hernandez, 1991), which demonstrated four, three, two, and one factor of multicultural counseling competency, respectively. The three different factor structures may be indicative of several things, which include: (1) the possibility that the three domains are intercorrelated and difficult to separate; (2) it may be better explained with a two-factor model; (3) there are factors of multicultural counseling competency that the MCC theory does not explore (e.g., a four-factor model); (4) the
domains may be manifestations of latent or mediating variables (Kitaoka, 2005); and (5) the theory is inaccurate in that the three domains do not fully explain the construct and/or additional domains exist.

Another limitation to this phase of the study was the sampling procedures. The recruitment procedures involved the solicitation of a sample of people who volunteered for or were referred by other individuals who also participated in or were familiar with the study or primary investigator, which could be representative of a sample of people who are interested or vested in cultural competency. The sample obtained only included providers and consumers from the island of O‘ahu, possibly limiting the variability in cultural experiences obtained by and shared with the primary investigator. Consequently, the participants may represent a relatively small and biased sample that is not necessarily representative of all providers and consumers nationwide who have experienced either a positive or a negative cultural interaction in their therapeutic sessions. Notwithstanding the small sample size, the participants generally represented a diverse cultural group (e.g., sex, age, educational level).

Phase Two

A total of 11 cultural competency and mental health experts who were identified through the cultural competency literature and the snowball sampling method were asked to complete the *Cultural Competency Critical Incident Evaluation Form*. The data obtained were based on the following three questions: 1) This critical incident represents a cultural misunderstanding.; 2) What percent of this critical incident would you attribute to each domain?; and 3) How could this critical incident be improved? The initial 30
critical incidents were reduced to 16 based on the data (i.e., means and standard deviations) obtained from Question 1.

The remaining 16 items were further reduced to 10 critical incidents based on data obtained from Question 2. Specifically, the data included percentage means and standard deviations and Kendall Coefficients of Concordance W that were calculated for each domain within each critical incident and for each critical incident, respectively. If the expert raters did not systematically use the same standards to rate each item as determined by the Kendall Coefficients of Concordance W, they were not included in the final set of critical incidents. The information obtained also allowed for the matching of each critical incident to their corresponding domain(s). The 11 cultural competency experts attributed eight of the 10 remaining critical incidents largely to MCC Domain 2, Understanding the Worldview of the Culturally Different Client/Respecting the Client’s Worldview, but also indicated a substantial amount of overlap between all three MCC domains. Four of the 10 critical incidents were accurately matched by the experts to their respective domains, while six critical incidents were not. The critical incidents that were retained also represented various cultural issues, such as cultural misunderstandings around sexual orientation, ethnicity, race, disability and/or impairments, and religious affiliations. However, none of the remaining critical incidents focused on age and gender differences.

The qualitative information (i.e., Question 3) provided by the experts regarding the remaining critical incidents was not conclusive or significant because it was misunderstood by majority of the participants. Only five (45.5%) of the 11 experts provided valid answers (e.g., suggestions about grammatical errors, simplification of
language) to Question 3; however, there were no significant trends in the information provided. The other six (54.5%) experts provided invalid responses (e.g., ways a clinician could be more culturally competent in a particular situation portraying a cultural misunderstanding or conflict). Despite the lack of significant findings, the valid information that was provided by the five experts will be considered in the future development of the Provider-Level Cultural Competency Questionnaire.

Although the aforementioned information suggests the utilization of a methodical procedure by which an initial pool of items or critical incidents were systematically reduced and the consistent use of similar standards across experts to match the critical incidents to their corresponding domains, there were limitations to this phase of the study. One limitation was the use of the MCC theory as a basis for the generation of these theory-based critical incidents. The MCC theory was selected because each domain appeared to be more distinct than the knowledge, awareness, and skills dimensions commonly used in the establishment of other cultural competency measures (e.g., Multicultural Awareness-Knowledge-Skills Survey- Counselor Edition- Revised; Kim, Cartwright, Asay, & D’Andrea, 2003; and Multicultural Counseling Inventory; Sodowsky, Taffe, Gutkin, & Wise, 1994). However, the data suggest that there is a considerable amount of shared characteristics among the three MCC domains. This may be a result of the awareness, knowledge, and skills domains included within each MCC domain.

Second, notwithstanding an attempt to ascertain an equal number of items for each MCC domain, a majority of the remaining critical incidents were mostly representative of MCC Domain 2 (Understanding the Worldview of the Culturally
Different Client) and largely coincided with the other two MCC domains. This may have resulted from a lack of clarification in the critical incidents themselves. Since all the critical incidents needed to be between 200 and 300 words to meet the criteria, there is a possibility that each critical incident involved an aspect of one of the three MCC domains, which could have lead to the significant amount of overlap. Another possible explanation is that the critical incidents were written in a more knowledge- or cognitive-based manner, which would be more indicative of MCC Domain 2. An additional possibility is that providers may have a tendency to attribute cultural misunderstandings to their reduced understanding of the worldviews of culturally different clients than to a lack of awareness of their own worldviews.

Another existing instrument, which only found one factor, is the CCCI-R (LaFromboise, Coleman, & Hernandez, 1991). The CCCI-R is similar to the critical incidents that were created in this study in that they both attempt to address more objective and behavioral aspects of cultural competency rather than self-perceived knowledge, attitudes and beliefs, and skills. As noted earlier, the CCCI-R is a behavioral checklist that is completed by an evaluator who observes a clinician as he/she works with a culturally different client. Similarly, the critical incidents also portray behavioral aspects of a cultural misunderstanding that may influence the therapeutic relationship. Alternatively, other existing cultural competency instruments (e.g., MAKSS-CE-R; Kim, Cartwright, Asay, & D’Andrea) include short phrases, sentences, or questions, which ask a clinician to rate their perceived level of expertise in the three MCC dimensions of knowledge, attitudes and beliefs, and skills. The differences in factor structures may be
due to differences in how cultural competency is measured (i.e., behavioral checklist and scenarios versus self-report).

The third limitation involved the sampling procedure used during this phase of the study. Although the snowball sampling method is a valid way of identifying a group of experts, the experts often identified people they have worked with and people who may hold similar views as them. In addition, out of the 25 experts who were recruited, only 11 actually participated in the study. Consequently, this sample of experts is not likely to be representative of all cultural competency experts. Despite these limitations, there was a relatively equal distribution of local and national experts in the expert panel.

The fourth limitation involves Question 3 of the Cultural Competency Critical Incident Evaluation Form. Although the instrument was pilot tested with a group of colleagues prior to the actual administration of the instrument, a majority of the experts misinterpreted the meaning of this question. If the question was worded more clearly or if examples were provided with the question, more of the experts may have accurately interpreted the question and provided responses that may have been useful for improving the critical incidents. Although the valid information that was gathered is important, it could not be utilized in the improvement of the critical incidents.

Finally, one of the cultural competency and mental health experts questioned the broad parameters of the cultural issues covered in the critical incidents, although the inclusion of various cultural issues was an attempt to address limitations of existing cultural competency instruments. Previous assessment instruments have been criticized for limiting their assessment instruments to misunderstandings that may arise with racially and ethnically diverse groups; although some experts believe that multicultural
issues have expanded in scope to also include differences in age, gender, sexual
orientation, religion, and disability/impairments (Hays, 2008). In fact, the 10 critical
incidents that were retained included misunderstandings due to differences in ethnicity,
race, sexual orientation, religion, and disability/impairments, but did not include those
related to age and gender. This may be a result of differences in perspectives across
experts about what constitutes a cultural misunderstanding such that age and gender
differences are not considered cultural misunderstandings. This concern highlights the
importance of operationally defining cultural competency and reaching a consensus
among experts about what is meant by this complex and multifaceted concept. Deciding
on an operational definition of this term will help the future development of assessment
instruments used to measure provider and organizational cultural competency levels.

Future Directions

Despite the aforementioned study limitations, the 10 remaining critical incidents
have demonstrated content validity and can be used in the future objective assessment of
provider-level cultural competency based on the theory-based cultural assimilator format.
Specifically, another study could be conducted in which the same or different cultural
experts would devise and designate specific responses to these cultural
misunderstandings based on the cultural competency continuum, which ranges from
culturally destructive to culturally proficient (Cross, Bazron, Dennis & Isaacs, 1989).
After the assessment instrument is developed, it can be pilot-tested with a multiculturally
diverse group of people with various levels of expertise in cultural competency to see if it
can accurately distinguish between these groups. Specifically, the culture assimilator-
based provider-level cultural competency instrument, consumer satisfaction
questionnaires, and treatment outcome (e.g., symptom reduction, low attrition rates) measures can be administered to see if providers who have high levels of cultural competency have higher consumer satisfaction and better treatment outcomes than those with low levels of cultural competency. If it accurately differentiates between these groups and its findings are replicated, it can be confidently administered to providers within state mental health systems to assess their current levels of cultural competency. With increasing demands for providers who are culturally competent, there is a dire need for an objective provider-level cultural competency instrument. It is believed that this theory-based study is an important step in the right direction.
APPENDIX A

Venezuelan Culture Assimilator (Tolbert & McLean, 1995, p. 122-123)

“Edward, a U.S. business professional, was having a business lunch with Carlos, the owner of a printing company. Edward was having his company’s letterhead printed by Carlos. As they were leaving, Edward wanted to share some new ideas for layouts with Carlos. Carlos said he would be happy to see them. Edward asked if he could bring them by his office the next day, and they could go over them in about an hour or so. Carlos said he would be happy to do it and told him to drop by at about 2 p.m.

The next day Edward went to Carlos’ office at 2 p.m., and Carlos was not there. The secretary said that he left at about 1:30, and he would not be returning for the day. Edward said that there must be some mistake as they had made these arrangements yesterday at lunch. The secretary said that she did not have an appointment scheduled and she was sorry. Edward was very angry about the inconvenience. He was debating about whether or not to cancel his agreement with Carlos and take his business somewhere where he could be better served.

How would you explain the fact that Carlos was not there?

a. Carlos was not interested, and he did not know how to let Edward know.

Carlos made the appointment casually hoping that Edward would forget about it.

b. The appointment was agreed upon over a business lunch, and evidently Carlos was not sufficiently organized to remember himself or to call his secretary to tell her to write it down. Thus it was forgotten.
c. Secretaries handle the agenda, and if they are not told about appointments, then they do not exist. Typically, in Venezuela, business professionals do not keep their own schedules. [This is the best answer.]

d. Carlos did not really feel that he committed himself; for Carlos it was only a tentative possibility."
APPENDIX B

Culture-General Assimilator (Brislin, Cushner, Cherrie, & Yong, 1986, p. 120)

“The Trip to the Doctor”

“Huang was the first-born son of a well-to-do family in Hong Kong. He had done well in his undergraduate studies at the University of Hong Kong and had been accepted for graduate studies at a prestigious American university. He made his initial adjustment fairly well, finding housing and joining a supportive group of other students from Hong Kong who lived near his university. After a time, however, he began to be disappointed in his own work and was unhappy with life in America. He had become attracted to an American woman but the relationship broke up because of personality differences. While not failing any of his classes, he was by no means among the best students in his department as shown by both test scores and participation in class seminars. Not wanting his friends from Hong Kong to learn about his problems, Huang went to the student health center complaining about upset stomach, severe headaches, and lower back pain. The doctor at the health center prescribed acetaminophen with codeine. Huang began to take the pills but the problems did not go away.

There is a very common issue in this story that happens frequently as part of people’s sojourns (many types of sojourns, not just foreign students). What is this issue?

(1) The doctor prescribes a placebo to Huang so that Huang will feel that he is getting help.

(2) Huang came from an important family in Hong Kong and expected more deference in the United States from professors and fellow students.
(3) Huang's support group from Hong Kong living near him in America is insensitive to his problem.

(4) Huang describes his personal problems in terms of physical symptoms. The doctor prescribes for physical symptoms. [This is the best answer.]

(5) Huang should volunteer for extra help classes at the university, such as noncredit courses in English as a second language, but his pride prevents him from doing so.”
APPENDIX C

Individualism and Collectivism Assimilator (Bhawuk, 1995, p. 163)

“21. A friend in need…

Dr. Chen and Dr. Norman were faculty at a university in Singapore. Dr. Chen and his wife were devoted to Dr. Norman and his family. The two families got along very well and spent a lot of time together. Both couples enjoyed the opera, exotic food, and traveling abroad. Dr. Norman and his wife appreciated the help the Chens provided them, especially the way Mrs. Chen was like a surrogate mother to their four children ranging from age four to eleven. The Chens did not impose their friendship on the Normans, whereas the Normans seemed to understand and appreciate the Chinese way of life, kinship, and friendship.

One day Dr. Norman casually mentioned to Dr. Chen that he and his wife were separating. Dr. Chen expressed his grief and concern and extended his support should it help the couple mend their relationship. Dr. Norman thanked him for his consideration and suggested that there was really nothing that the Chens could do. When Dr. Chen broke the news to his wife, she was in tears. The very first thing that came to her mind was the future of the four Norman children: “What about the children! Who is going to take care of them!” she exclaimed. After a long deliberation they decided that they would try to help the Normans in view of their long standing friendship.

The Chens talked to the Normans both singly and together on many occasions. As a way of explanation, they mention that there would hardly be any family anywhere in the world that does not go through some misunderstanding or the other, but with a little bit of understanding people can always work out their differences. They also noted how
important it was for the children that the couple stayed together. On one occasion when they talked to Mrs. Norman about this issue, she locked Dr. Norman out of their house and a few days later filed for divorce. Dr. Chen and his wife were stunned by the development and felt responsible for the outcome.

Could you explain what happened?

a. Mrs. Norman though that her husband had violated her trust by telling the Chens about their separation.

b. Mrs. Norman did not want to take help and be indebted to Dr. Chen and his wife.

c. Mrs. Norman though the Chens were trying to take her children away from her.

d. Mrs. Norman resented the Chens' meddling in what she thought was her personal affair. [This is the best answer]"
APPENDIX D

“Culture Conflict” (Sue & Sue, 1990, p. 259)

“David Chan is a 21-year-old student majoring in electrical engineering. He first sought counseling because he was having increasing study problems and was receiving failing grades. These academic difficulties became apparent during the first quarter of his senior year and were accompanied by headaches, indigestion, and insomnia. Since he had been an excellent student in the past, David felt that his lowered academic performance was caused by illness. However, a medical examination failed to reveal any organic disorder.

During the initial interview, David seemed depressed and anxious. He was difficult to counsel because he would respond to inquiries with short, polite statements and would seldom volunteer information about himself. He avoided any statements that involved feelings and presented his problem as strictly an education one. Although he never expressed it directly, David seemed to doubt the value of counseling and needed much reassurance and feedback about his performance in the interview.

After several sessions, the counselor was able to discern one of David’s major concerns. David did not like engineering and felt pressured by his parents to go into this field. Yet, he was unable to take responsibility for any of his own actions, was excessively dependent on his parents, and was afraid to express the anger he felt toward them. Using the Gestalt “empty chair technique,” the counselor had David pretend that his parents were seated in empty chairs opposite him. The counselor encouraged him to express his true feelings toward them. While initially he found it very difficult to do, David was able to ventilate some of his true feelings under constant encouragement by
the counselor. Unfortunately, the following sessions with Dave proved unproductive in that he seemed more withdrawn and guild-ridden than ever.

Questions

1. What cultural forces may be affecting David’s manner of expressing psychological conflicts?

2. What possible unwarranted interpretations are being made about David Chan?

3. What stereotypes do you have about Asian-Americans? How may stereotypes affect the holder of the stereotypes’ attitudes and behaviors? How may they affect the minority individual?

4. How may the counseling techniques used by the counselor clash with the traditional Asian cultural values? With what effect?

5. If you were a counselor, what course of action would you take? Why?"
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PARTICIPANTS NEEDED FOR RESEARCH IN CULTURAL COMPETENCY

We are looking for volunteers to take part in a study of “Item Development of a Provider-Level Cultural Competency Instrument Using the Cultural Assimilator Format.”

As a participant in this study, you will be asked to:
1) Complete a face-to-face interview (i.e., describe 1 or 2 cultural interactions) and
2) Complete a demographic questionnaire

Your participation will involve 1 session, which is approximately 30 to 60 minutes.

In appreciation for your time, you will receive a gift certificate to a grocery store.

For more information about this study, or to volunteer for this study, please contact:
Andrea Nacapoy, B.A.
University of Hawai‘i at Manoa: Psychology Department
at
808-539-3733 or
e-mail: nacapoy@hawaii.edu
This study has been reviewed by, and received ethics clearance through the University of Hawai‘i, Committee on Human Subjects.
APPENDIX G

INFORMED CONSENT: PROVIDER VERSION

Item Development of a Provider Level Cultural Competency Instrument: Phase I
Andrea Nacapoy & John J. Steffen, Ph.D.
UH Department of Psychology/DOH Mental Health Services Research and Evaluation
2800 Woodlawn Drive, Suite 120
Honolulu, Hawaii 96822-1863
nacapoy@hawaii.edu
808-539-3961

Description of Project: This is the first phase of a research project we are conducting to help the Adult Mental Health Division (AMHD) of the Hawaii Department of Health develop a way of measuring and evaluating provider-level cultural competency, using an assessment instrument that is based on the cultural assimilator format. Initially, we need to generate a sample of critical incidents that occurred while working directly with a culturally different client. At least 10 providers are expected to participate in this phase of the study.

Invitation to Participate: You are being invited to take part in this research study because you are currently providing services to culturally diverse populations, and we would like to solicit your practical experiences in culturally diverse interactions.

Description of Procedures: If you decide to participate in this phase of the study, you will be interviewed for a one-half hour to an hour. During this interview, you will be asked to describe clinical interactions where culture influenced your relationship with a client. Notes will be taken while you are describing your short real-life scenarios. The interview will also be audio tape-recorded. You will also be asked to complete a demographic questionnaire, but the information obtained will not be connected in any way to the stories you provide.

Risks and Inconveniences: No risks are expected for study participants. However, some participants may feel distress or embarrassment when sharing personal experiences. If you do feel uncomfortable, you are free to skip to the next question or end the interview at any time.

Benefits: Your participation could benefit you indirectly by helping to improve mental health services and by making services and programs more culturally appropriate. This research may contribute to the existing literature on cultural competency.

Confidentiality: You will not be asked to write your name on the demographic questionnaire nor will you be identified in any way on the tape. Any information obtained from the questionnaire will be kept strictly confidential and will not be linked to any data, which means that you will not be identified in anything published as a result of this project.

Voluntary Participation: Your participation in this study is entirely voluntary. Refusal to participate in any part of the study will not affect you now or in the future. You can terminate your participation at any time without penalty.

Questions: Please feel free to ask any questions about anything that seems unclear to you. You can ask the principal investigator (Andrea Nacapoy, 539-3733) questions about this project at any time. You can also contact John J. Steffen, Ph.D., the supervisor of this project, at any time to ask questions about the research. His phone number is 808-539-3961. You may also contact the Committee on Human Studies, University of Hawaii, 2540 Maile Way, Honolulu, Hawaii, 96822 (808-956-5007) if you feel that you have been treated unfairly in any way relating to this study or have any questions regarding your rights as a participant in this study.
I certify that I have read and that I understand the foregoing, that I have been given satisfactory answers to my inquiries concerning project procedures and other matters and that I have been advised that I am free to withdraw my consent and to discontinue participation in the project or activity at any time without prejudice.

I herewith give my consent to participate in this study with the understanding that such consent does not waive any of my legal rights, nor does it release the principal investigator or the institution or any employee or agent thereof from liability to negligence.

Signature of Individual Participant

Date
INFORMED CONSENT: CONSUMER VERSION

Item Development of a Provider Level Cultural Competency Instrument: Phase I
Andrea Nacapoy & John J. Steffen, Ph.D.
UH Department of Psychology/DOH Mental Health Services Research and Evaluation
2800 Woodlawn Drive, Suite 120
Honolulu, Hawai‘i 96822-1863
nacapoy@hawaii.edu
808-539-3961

Description of Project: This is the first part of a research project. It will help to measure the cultural competency levels of providers within the Adult Mental Health Division (AMHD) of the Hawai‘i Department of Health. We first need to create a sample of cultural interactions to develop the instrument. These interactions will describe situations between you and a mental health service provider. At least 10 mental health consumers are needed in this phase of the study.

Invitation to Participate: You are invited to take part in this research study because your views are important. Your input will help providers to recognize and understand your culture a little better. Your participation will not affect any mental health services that you or a loved one is receiving. Please read and/or listen to the following information carefully. Feel free to ask any questions you have.

Description of Procedures: If you decide to participate in this study, you will be interviewed for one-half hour to one hour. During this interview, a researcher will ask you to describe situations. I am interested in situations where your culture influenced your relationship with a mental health service provider. Notes will be taken during the interview. The interview will also be audiotape-recorded. You will also be asked to complete a demographic questionnaire.

Risks and Inconveniences: No risks are expected for study participants. However, some participants may feel distress or embarrassment when sharing personal experiences. If you do feel uncomfortable, skip to the next question or end the interview at any time.

Benefits: Findings from this study may not help you directly. It may help others in the future by improving services for culturally diverse groups.

Confidentiality: You will not be asked to write your name on the demographic questionnaire. You will not be identified on the audiotape. Any information obtained will be kept private. You will not be identified in any publications.

Incentive: You will receive a $10.00 gift certificate as a thank you for being in the study.

Voluntary Participation: This study is voluntary. You may choose not to participate at any time. Your choice not to participate will not change or influence your services in any way. You can choose to skip a question or end the interview at any time.

Questions: If you have questions about this project, you may contact John J. Steffen, Ph.D., at 808-539-3961. If you feel that you have been treated unfairly in any way related to this study or have any questions about your rights as a participant in this study, you can contact the Committee on Human Studies. You can contact the Committee via mail at 2540 Maili Way, Honolulu, Hawai‘i, 96822, or by telephone at 808-956-5007.

I certify that I have read and that I understand the foregoing, that I have been given satisfactory answers to my inquiries concerning project procedures and other matters and that I have been advised that I am free to withdraw my consent and to discontinue participation in the project or activity at any time without prejudice.
I herewith give my consent to participate in this study with the understanding that such consent does not waive any of my legal rights, nor does it release the principal investigator or the institution or any employee or agent thereof from liability to negligence.

______________________________  ____________________
Signature of Individual Participant  Date
PHASE ONE: AUDIO RECORDING CONSENT FORM

Andrea Nacapoy & John J. Steffen, Ph.D.
UH Department of Psychology/DOH Mental Health Services Research and Evaluation
2800 Woodlawn Drive, Suite 120
Honolulu, Hawai‘i 96822-1863
nacapoy@hawaii.edu
808-539-3961

You are asked to provide consent for an audiotape recording to be made of the interview in which you have agreed to participate. The primary investigator will refer to the audiotape as necessary, as a way of remembering the content of the interview. The audiotape will be kept in a locked file cabinet that is only accessible to the principle investigator, and destroyed within two months of the date that the project is completed, to maintain confidentiality.

Please indicate below the uses of this audiotape that you are willing to consent to. This is completely voluntary. Your name will not be identified in any reporting of the audiotape proceedings.

I have read and understood the information above and give my permission for my individual interview to be audio recorded.

Signature of Individual Participant Date

Signature of Investigator Date

After completing the interview, please indicate how you would like the tape to be used.

The primary investigator can use all data collected on the audiotape for the creation of critical incidents.

Yes _____ No _____

Quotations from the tapes can be used for scientific publication as long as I am not identified individually.

Yes _____ No _____

I have read the above description and give my consent for the use of an audiotape as indicated above.

Signature of Individual Participant Date

Signature of Investigator Date

(If you cannot obtain satisfactory answers to your questions or have comments or complaints about your treatment in the study, contact: Committee on Human Studies, University of Hawaii, 2540 Maile Way, Honolulu, HI 96822. Phone: 808-956-5007.)
cc: Signed copy to participant
APPENDIX H

PHASE I: INTERVIEW QUESTIONS

Greeting: Thank you for agreeing to participate in this interview process. This project is about cultural competency. Research indicates that the cultural and ethnic background of people shapes their views of illness and well-being, as well as their motivation to engage in mental health treatment (Kundhal & Kundhal, 2003; Warren, 2002). Culture includes the age, race, ethnicity, disability, sexual orientation, gender or religious affiliation of an individual. Therefore, cultural competency is the set of matching behaviors, attitudes and skills, policies and procedures that work together in an agency or organization to allow mental health caregivers to work well in multicultural situations (New York State Office of Mental Health, 1998, p.4; Cross, Bazron, Dennis, & Isaacs, 1989).

I am going to read you an example of an interaction between a client and mental health professional where culture was important. When I am finished reading it, I will ask you to describe an incident that happened to you. After you describe the incident, I will ask you a few questions about the incident. You will be given a laminated version of the questions, as well as a sample critical incident, so that you may refer to them as needed.

[Read critical incidents in Appendix I]

1) There are three ways of thinking about cultural issues that may occur between a clinician and a consumer.

   o Clinician’s biases and/or stereotypes
   o Clinician’s knowledge or lack of knowledge about the client’s culture
   o Clinician’s ability or inability to use appropriate treatment techniques

   Please describe an incident where one of these issues occurred.

2) How do you think the situation was handled?

3) How could it be handled differently?

4) Is there anything else related to the topic of culture and mental health that you were hoping we would talk about today that we did not cover yet?

Thank you for your participation in this study.
APPENDIX I

CRITICAL INCIDENT SAMPLE

Dr. Smith who is a heterosexual, female clinician is working with a Mr. Jones who is a homosexual, male client at a community mental health center. Mr. Jones reports experiencing multiple and severe episodes of depression because his life has not ended up the way he planned. Mr. Jones believes that his difficulties are related to feelings of isolation from family members who disagree with his career and homosexual orientation. Mr. Jones reports that his partner is having trouble understanding his point of view because his partner’s family accepts him and the choices he has made. Mr. Jones’ partner goes with him to his sessions and waits in the waiting room for support. During the intake assessment, Mr. Jones notes that he is also interested in couples counseling. With the client’s permission, Dr. Smith invites Mr. Jones’ partner into the session. In her effort to understand the relationship dynamics, Dr. Smith asks who is in the more dominant, or male, role and who is in the more submissive, or female, role. The couple seems shocked and explains to Dr. Smith that these dynamics do not apply to their relationship. Dr. Smith is confused and feels embarrassed about the question she just asked. The clients do not appear to feel comfortable and starts answering questions with one-word answers. They do not return to their next scheduled appointment.

Mr. Chun is a 78-year-old Chinese male who is working with Dr. Ching at a community mental health center. Mr. Chun moved to the United States to be closer to his children who immigrated to California nineteen years prior to his arrival. He had been living with his wife in China, but she had recently passed away from a heart attack. Mr. Chun sought treatment at a community mental health center after his eldest daughter repeatedly asked him to. The daughter went with her father to the intake session. She reported that he appeared to be “losing his mind.” In particular, she noted that her father was angry all the time and had unrealistic expectations of his children. Embarrassed, Mr. Chun reported that he felt disrespected by his children. He also noted that they never came to him for guidance and often did not include him in their lives. His daughter felt that his expectations might be appropriate in China, but were not appropriate in the United States. Dr. Ching recognizes an obvious generational difference, but automatically supports his daughter and encourages Mr. Chun to try to understand his daughter’s point of view. Quite upset at and offended by the doctor’s comments, he no longer participates in the interview and allows his daughter to answer Dr. Ching’s questions. He does not return to his next scheduled appointment.
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Matrix for Organizing Cultural Variables and Necessary
APPENDIX K

CULTURAL COMPETENCY CRITICAL INCIDENT EVALUATION FORM:
DEMOGRAPHIC SECTION

Please put an (X) next to the answer or fill in the blank for each of the questions below.

1. What is your gender?

   ___ Male
   ___ Female

2. What is your age in years?

   ___ 18 - 20
   ___ 21 - 30
   ___ 31 - 40
   ___ 41 - 50
   ___ 51 - 60
   ___ 60+

3. What is your ethnicity? (Mark all that apply)

   ___ Black or African American
   ___ American Indian
   ___ Alaska Native
   ___ Caucasian
   ___ Other White (specify) ________
   ___ Hawaiian
   ___ Samoan
   ___ Tahitian
   ___ Micronesian
   ___ Other Pacific Islander (specify) ________
   ___ Japanese
   ___ Chinese
   ___ Filipino
   ___ Korean
   ___ Other Asian American (specify) ________
   ___ Cuban
   ___ Mexican
   ___ Puerto Rican
   ___ Other Hispanic or Latino (specify) ________
   ___ Unknown

4. Which ethnic group do you identify with the most? ________

5. What is your marital status?

   ___ Single/ Never Married
   ___ Married
   ___ Separated
   ___ Widowed
   ___ Cohabitating/ Not Married
   ___ Other (specify) ________
___ Divorced

6. What is your religious affiliation?

___ Christianity  ___ Islam
___ Hinduism  ___ Chinese traditional religion
___ Buddhism  (e.g., Confucianism)
___ Indigenous  ___ Secular/Nonreligious/Agnostic/Atheist
___ Judaism
___ Other (specify) ___________________________

7. What is your sexual orientation?

___ Heterosexual  ___ Lesbian
___ Gay/Homosexual  ___ Bisexual
___ Transgender  ___ Other (specify) ____________

8. What is the highest level of education that you completed?

___ Some High School  ___ Bachelor’s or 4-Year Degree
___ High School Graduate/ GED  ___ Some Graduate School
___ Some College  ___ Graduate School Degree
___ Associate’s or 2-Year Degree  ___ Other (specify) ____________
___ Technical Training

9. How long have you been living in Hawai‘i?

___ Less than 2 years  ___ 16 to 20 years
___ 2 to 5 years  ___ Greater than 20 years
___ 6 to 10 years  ___ Born and raised in Hawai‘i
___ 11 to 15 years

10. If you have ever been given a psychiatric diagnosis, what is it? (Please list all that apply)

_________________________________________________________________________

11. If applicable, what types of treatment are you currently receiving? (Mark all that apply)

___ Psychotherapy  ___ Peer Mentoring
___ Psychiatric Consultation  ___ Medication Monitoring
___ Case management  ___ Other (specify) ________________
___ Group Therapy
12. Is your current professional role a (Mark all that apply):

___ Student
___ School Counselor
___ Psychiatric Nurse
___ Case Manager
___ Professor/Academician
___ Peer Specialist
___ Advocate
___ Family Member
___ Psychologist
___ Psychiatrist
___ Social Worker
___ Researcher
___ Volunteer
___ Consumer
___ Other (specify) __________

For Providers Only:
13. Did you receive any multicultural course work?

___ Yes      ___ No      ___ Unknown

14. Did you teach any multicultural courses?

___ Yes      ___ No      ___ Unknown

15. Did you attend any multicultural workshops?

___ Yes      ___ No      ___ Unknown

16. Did you teach any multicultural workshops?

___ Yes      ___ No      ___ Unknown

17. How many years have you been working with multicultural clients?

___ 3 years or fewer         ___ 12 to 15 years
___ 4 to 7 years            ___ 16 or more
___ 8 to 11 years
APPENDIX L

CULTURAL COMPETENCY CRITICAL INCIDENT EVALUATION FORM

You are being asked to provide feedback about critical incidents in mental health settings, which were created based on interviews with providers and consumers and from the literature. Please read each incident and respond to three different questions per incident. The first question asks the extent to which you agree or disagree that the critical incident represents a cultural misunderstanding. The second question asks you to indicate the percent of a critical incident that you would attribute to each of the 3 domains of the Multicultural Counseling Competencies Theory. The last question is an open-ended question that asks for suggestions for improving the critical incident.

Some helpful definitions include:

*Culture* is defined as "the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs and values that are unique to race, ethnicity, sexual orientation, religious background or social group" (US Department of Health and Human Services, USDHHS, 2001).

*Cultural competency* is defined as "the set of congruent behaviors, attitudes and skills, policies and procedures that come together in a system, agency, or individuals, to enable mental health caregivers to work effectively and efficiently in cross/multicultural situations" (Cross, Bazron, Dennis, & Isaacs, 1989).

**Critical Incident #1**
Client B is a 25-year-old Polish male who presents with delusions, auditory hallucinations, and difficulties maintaining jobs and interpersonal relationships to the community mental health center. His illness was methamphetamine-induced but has continued for two years post recovery. He indicates that his family was extremely supportive of him but no longer knows how to help him. His parents attend his initial appointment at the community mental health center and indicate that he becomes violent and threatening at times and seems to lack awareness of his environment. Although they want to allow him to continue living with them, they do not want him to endanger the rest of the family. They indicate that if he cannot control his behavior, he needs to find another place to live. His family believes that medication monitoring and praying are the optimal methods for dealing with Client B’s behavioral difficulties. In an attempt to identify Client B’s personal goals, his Mexican American counselor sets up a time to meet with Client B individually. During this meeting, Clinician A notices that Client B simply restates what his family indicated in the previous session. Remembering how his own family tries to make his life choices for him, Clinician A stresses to Client B that he is an adult and can work toward goals, which are different from his parents’. Clinician A states, “For example, if you do not think prayer will help, you are entitled to feel that way and not participate with your family in prayer.” Client B becomes extremely offended by Clinician A’s comment and asks for another person who will listen to him and his family.
(1) This critical incident represents a cultural misunderstanding.

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<tr>
<td>Strongly Agree</td>
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<td>Neutral</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
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(2) What percent of this critical incident would you attribute to each of these 3 domains?

- Clinician’s lack of awareness of his/her own worldview
- Clinician’s reduced understanding of the consumer’s worldview
- Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% *(The percentages should add up to 100%)*

(3) How could this critical incident be improved?

Critical Incident #2
Client B is a 63-year-old female who is diagnosed with diabetes, hypertension, and obesity. She also receives behavioral health services at the community mental health center because she often experiences auditory and visual hallucinations, fear of being watched and followed, disorganized thinking, and impaired occupational and interpersonal functioning. In particular, she suffers from an exacerbation of symptoms when her blood sugar is either extremely high or low, she catches a cold, or she is limited by her ability to move around. She recently transitioned to a new social worker because her old social worker went on maternity leave. Her relationship with her old social worker was very positive because they shared common interests and values, and were able to communicate comfortably with one another. However, her new social worker is 23 years old and does not appear to understand the complexities associated with having both medical and psychological disorders, and is often incapable of providing the support Client B expects. After Client B makes several attempts to educate Clinician A about all of her illnesses with limited success, Client B asks to be assigned to another social worker. Clinician A feels upset and does not understand why it is important to know these things when her primary responsibilities require knowledge about severe and persistent mental illness. She also feels as if the request for transfer is unwarranted since she believes she is very competent in working with individuals with schizophrenia.

(1) This critical incident represents a cultural misunderstanding.
(2) What percent of this critical incident would you attribute to each of these 3 domains?

- Clinician’s lack of awareness of his/her own worldview
- Clinician’s reduced understanding of the consumer’s worldview
- Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)

(3) How could this critical incident be improved?

Critical Incident #3
Clinician A is a Filipino psychiatrist who moved to Hawai‘i when she was a child. She worked hard to adapt to American cultural beliefs as a means to try fit in with the other children in her school. Clinician A also stopped speaking Ilokano, participating in cultural activities, and eating Filipino food. She became very accustomed to the American way of life and identifies herself as “American.” She is now working at a university counseling center and encounters Client B, a Filipino female who was born in the Philippines and also moved to Hawai‘i when she was a child. However, in an attempt to maintain her Filipino culture, Client B devotes a lot of her time to the Filipino community and returns to the Philippines frequently. Client B presents with depressed mood, decreased motivation, and decreased concentration. Clinician A conducts an interview in which she assesses Client B’s background history and presenting problems in order to provide optimal treatment for her mental illness. After Clinician A completes the interview, she assumes that since they are the same age and ethnicity, and both moved to the United States around the same time, they have experienced a lot of the same things. Clinician A discusses how fortunate they both are to have moved to America, noting that she loves the opportunities offered in the States. Client B becomes agitated because she never indicated that she is happy to live in America and actually feels unhappy with her family’s choice to move. She is uncertain whether she wants to continue in treatment, but does not feel comfortable correcting Clinician A.

(1) This critical incident represents a cultural misunderstanding.

☐ 5 Strongly Agree
☐ 4 Agree
☐ 3 Neutral
☐ 2 Disagree
☐ 1 Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

- Clinician’s lack of awareness of his/her own worldview
- Clinician’s reduced understanding of the consumer’s worldview

115
Clinician's inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)

(3) How could this critical incident be improved?

Critical Incident #4
Clinician A is a male community health center social worker who is from a family in which the males work and bring home money and the females usually care for the children and the household. Males also make the majority of family-related decisions. He is providing services to Client B who presents with depressed mood, significant weight loss, fatigue, psychomotor retardation, inappropriate guilt, and recurrent thoughts of death. Client B is also having marital difficulties and often does not want to get out of bed in the morning. Client B expresses frustration because although he works to provide for the family, his wife makes the majority of the family-related decisions. He indicates that he has no say in where his children go to school, how the money he earns is spent, or how to discipline their children. Although this is common in his culture, he recognizes that the males in other cultures are afforded many opportunities to contribute to major family-related decisions. Clinician A does not understand Client B’s family structure, hierarchies, values, and beliefs; and encourages Client B to stand up for himself, stating that, “the man of the house should have a say in these types of decisions.” Client B feels uncomfortable because he knows that this is not the case in his culture but sharing it with Clinician A may undermine his masculinity. Client B outwardly agrees with Clinician A and refrains from discussing the issue in future sessions although it is a major contributor to his high level of depression, stress, and low self-esteem.

(1) This critical incident represents a cultural misunderstanding.

☐ 5 Strongly Agree
☐ 4 Agree
☐ 3 Neutral
☐ 2 Disagree
☐ 1 Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

☐ Clinician’s lack of awareness of his/her own worldview
☐ Clinician’s reduced understanding of the consumer’s worldview
☐ Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)
Critical Incident #5
Client B recently immigrated to Hawai‘i from the Philippines. She is transported by ambulance to the psychiatric hospital after attempting suicide by a medication overdose. Her cousin who discovered the situation accompanies her to the hospital, and reports significant shifts in Client B’s mood. He notes that there are days when Client B is extremely happy, awake all day and night, and more talkative than usual; but there are other days when she is very sad and withdrawn, has difficulty thinking and concentrating, and exhibits suicidal ideation. When Clinician A, the psychiatric nurse, attempts to obtain information from Client B, she does not respond to his questions. Clinician A decides to follow-up with Client B the following morning since it was extremely busy in the emergency room but again acquires no information. He assumes that she may have difficulty understanding and speaking English, especially since she just arrived from the Philippines. Clinician A notes that Client B cannot effectively communicate in English in his report. Based on the hospital report, the treatment team assumes that she cannot speak English and attempts to have interpreters present at significant appointments and meetings. Approximately two months later, Client B divulges to one of the interpreters that she can communicate in English but chooses not to since no one cared enough to take the time to assess her English skills.

(1) This critical incident represents a cultural misunderstanding.

☐ 5  ☐ 4  ☐ 3  ☐ 2  ☐ 1
Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

☐ Clinician’s lack of awareness of his/her own worldview
☐ Clinician’s reduced understanding of the consumer’s worldview
☐ Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)

(3) How could this critical incident be improved?
Critical Incident #6
Clinician A, a heterosexual clinician, is providing therapy at a university counseling center to Client B, a homosexual male. Client B reports experiencing multiple and severe episodes of depression for most of his adult life. Client B believes that his difficulties are related to feelings of isolation from family members who disagree with his career choice and sexual orientation. Client B reports that his partner is having trouble understanding his point of view because his partner’s family accepts him and the choices he has made. Client B’s partner goes with him to his session and waits in the waiting room for support. During the intake assessment, Client B states that he is also interested in couple’s counseling. With the client’s permission, Clinician A invites Client B’s partner into the session. In her effort to understand their relationship dynamics, Clinician A asks who is in the more dominant or male role, and who is in the more submissive or female role. The couple appears shocked and explains to Clinician A that these dynamics do not apply to their relationship. Clinician A is confused and feels embarrassed about the question she just asked. The clients do not appear to feel comfortable and start answering questions with one-word answers. They do not return to their next scheduled appointment.

(1) This critical incident represents a cultural misunderstanding.

Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree
□ 5                  □ 4         □ 3          □ 2           □ 1

(2) What percent of this critical incident would you attribute to each of these 3 domains?

Clinician’s lack of awareness of his/her own worldview
Clinician’s reduced understanding of the consumer’s worldview
Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)

(3) How could this critical incident be improved?

Critical Incident #7
Client B is a Latino consumer who was court-ordered to mental health treatment at a community mental health center. He has a history of abusing multiple substances and is currently diagnosed with schizophrenia, disorganized type. His symptoms include delusions, auditory hallucinations, grossly disorganized behavior and speech, and impaired social relationships. Client B is not interested in treatment, and is only attending the appointment because the judge mandated treatment. Client B does not know what to expect at a community mental health center. Prior to the initial interview, Clinician A, a Japanese American psychiatrist, reviews the forensic assessment, which indicates that
Client B received services from another community mental health center several years prior. Based on the previous assessment, Clinician A assumes that Client B is familiar with the treatment process, so he decides to briefly and quickly describe the services provided. Client B sits down, leans back on his chair and provides short one-word answers during his first appointment. Client B also does not make eye contact with Clinician A. Clinician A feels that Client B is being resistant and does not ask him if he has any questions. Client B walks out of the interview room without understanding his role in treatment.

(1) This critical incident represents a cultural misunderstanding.

[☐] 5 Strongly Agree
[☐] 4 Agree
[☐] 3 Neutral
[☐] 2 Disagree
[☐] 1 Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

_____ Clinician's lack of awareness of his/her own worldview
_____ Clinician’s reduced understanding of the consumer’s worldview
_____ Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)

(3) How could this critical incident be improved?

Critical Incident #8
Client B was raised in a family where the males were viewed as more dominant than the females in the household. Males are allowed to obtain an education and encouraged to work whereas women are expected to care for the family and the house. Client B has a long history of depressed mood, lack of concentration, suicidal thoughts, and significant weight gain; however, he refuses to seek mental health treatment because it may be an indication of weakness in the eyes of his parents. After going through a couple of severe episodes, a colleague encourages him to go to a community mental health center where all services are confidential. Client B recognizes the negative effects of his mood changes on his family and decides to take his co-worker’s advice. Hesitant about what to expect, Client B cautiously enters the interview room to be greeted by a female psychologist. He is taken aback and puts up his guard. Clinician A begins the interview as usual and asks him to describe the difficulties he has been experiencing. Client B states that his visit may be a mistake and stands to exit the room. Clinician A attempts to understand how she may have offended Client B by asking him to explain himself and his uncomfortable feelings. Client B becomes increasingly agitated and quickly leaves the center.
(1) This critical incident represents a cultural misunderstanding.

☐ 5  ☐ 4  ☐ 3  ☐ 2  ☐ 1
Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

☐ Clinician’s lack of awareness of his/her own worldview
☐ Clinician’s reduced understanding of the consumer’s worldview
☐ Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% *(The percentages should add up to 100%)*

(3) How could this critical incident be improved?

Critical Incident #9
Client B is a legally blind woman who has been experiencing severe bouts of depression including suicidal ideation for the majority of her adult life. She also suffers from type 2 diabetes and has had difficulty managing her condition, especially during her depressive episodes. Client B lost the majority of her eyesight approximately three years ago due to her diabetic condition. The severity of her blindness increased slowly, but she was able to cope with her disability until she could no longer work. Since then, her episodes have been increasing in severity and continue to negatively impact her interpersonal relationships and daily functioning. Client B requests behavioral health services from her primary care physician with hopes of finding someone who will be able to help her manage her comorbid physical and mental health conditions. Client B is warmly greeted by Clinician A, a social worker at the community health center, who escorts her into his office. Clinician A notices that she is walking with a cane and asks her if she needs some help. She responds, “No thanks, I am legally blind, that’s all.” During the consent process, he assumes she cannot read the consent forms and begins to read them to her. Client B takes offense but allows him to continue on. After the consent process is completed, Client B asks Clinician A, “How much do you know about people who are blind?” Clinician A pauses and does not know how to answer her question. Client B continues, “I am legally blind, not completely blind. I can still read.”

(1) This critical incident represents a cultural misunderstanding.

☐ 5  ☐ 4  ☐ 3  ☐ 2  ☐ 1
Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree
(2) What percent of this critical incident would you attribute to each of these 3 domains?

_____ Clinician’s lack of awareness of his/her own worldview
_____ Clinician’s reduced understanding of the consumer’s worldview
_____ Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)

(3) How could this critical incident be improved?

Critical Incident #10
Client B is a Filipino female who came to the community mental health center after discharge from a psychiatric hospital for a suicide attempt by drug overdose. Client B appears nervous, agitated, and uncomfortable during her initial meeting with Clinician A, a Caucasian psychologist. She also repeatedly asks Clinician A if she is crazy. As Client B continues to tell her history, she reveals that she has been attacked and raped on two different occasions by two Latino males while walking home from work. She reports that she is afraid to walk by herself, leave her house, and interact with males who remind her of her assailants. She also notes that she often experiences flashbacks, panic symptoms, loss of interest in activities, and hypervigilance. Her symptoms are so extreme and intrusive that she is unable to work. She reports that her inability to work interferes with her ability to care for her family, so she also experiences extreme feelings of guilt. Clinician A discusses other alternatives to working including the possibility of applying for social security benefits. Clinician A tells Client B that she needs to care for herself before she returns to work. Client B feels frustrated because she has a responsibility to her family, and the idea of putting her needs above the needs of her family does not feel right. Instead of telling Clinician A how she really feels, she smiles and nods, simply agreeing with Clinician A. Client B does not return to her next scheduled appointment, and Clinician A is not sure what happened during the previous session.

(1) This critical incident represents a cultural misunderstanding.

☐ 5 Strongly Agree
☐ 4 Agree
☐ 3 Neutral
☐ 2 Disagree
☐ 1 Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

_____ Clinician’s lack of awareness of his/her own worldview
_____ Clinician’s reduced understanding of the consumer’s worldview
Critical Incident #11

Client B is an Asian American student who presents to the university counseling center after being hospitalized for severe dehydration. She indicates to Clinician A, an African American psychiatrist, that she often has severe headaches, indigestion, decreased appetite and insomnia; and has been experiencing a significant decline in her academic performance. Client B believes that her lowered academic performance may be a result of a major medical illness, but several medical examinations failed to reveal a disorder. Client B reports that although she still thinks she is physically sick, the physician at the hospital suggested she see a mental health practitioner for an evaluation. Client B presents as both depressed and anxious during the interview. Clinician A attempts to get a detailed background history from Client B, but it proves to be difficult because Client B tends to respond to questions with short, polite statements and often does not offer personal information. Client B also avoids sharing her feelings and presents her problems as primarily physical and academic. Client B seems hesitant about the idea of mental health counseling and frequently asks for feedback about her performance. During a second interview, Client B admits that she chose medical school because her parents wanted her to, and not because she is interested in becoming a doctor. She also states that she has never been comfortable with expressing herself to her parents, as this is not the way her family typically communicates. Clinician A encourages Client B to express her feelings toward her parents, and Client B responds by becoming quiet and stating that she feels guilty. She decides that therapy is not the right choice for her. Clinician A does not understand the client's decision to terminate therapy.

(1) This critical incident represents a cultural misunderstanding.

☐ 5 Strongly Agree ☐ 4 Agree ☐ 3 Neutral ☐ 2 Disagree ☐ 1 Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

☐ Clinician’s lack of awareness of his/her own worldview
☐ Clinician’s reduced understanding of the consumer’s worldview
☐ Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)
(3) How could this critical incident be improved?

---

Critical Incident #12
Client B is a lesbian woman who is ambivalent about sharing her sexual orientation with other individuals because of previously encountered positive and negative experiences associated with coming out. She is diagnosed with schizoaffective disorder and recently lost her job and medical insurance coverage. Her previous mental health provider suggested that she apply for public assistance and subsequently try to obtain services from a community mental health center until she finds another job. After becoming eligible for public assistance, Client B decides to go to the nearest community mental health center for services. Clinician A greets her and asks her to complete forms about her background history. She also sits through a lengthy interview with Clinician A but walks out of the interview feeling frustrated because Clinician A did not ask her about her sexual orientation. Client B remembers that her previous social worker asked for this information at the beginning of her first session as a part of a standard set of interview questions and found that it made it easier to discuss personal matters with him. Client B feels that this information is essential to her treatment process because her episodes often significantly impact her romantic relationships. Client B is frustrated as she tries to contemplate ways to share this information with Clinician A.

(1) This critical incident represents a cultural misunderstanding.

[ ] 5 Strongly Agree
[ ] 4 Agree
[ ] 3 Neutral
[ ] 2 Disagree
[ ] 1 Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

_____ Clinician’s lack of awareness of his/her own worldview
_____ Clinician’s reduced understanding of the consumer’s worldview
_____ Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)

(3) How could this critical incident be improved?

---

Critical Incident #13
Client B is a multi-racial Filipino, Japanese, and Chinese woman with serious mental illness who has been working and living independently in her own apartment for approximately six months. She was diagnosed with schizoaffective disorder
approximately three years ago but with support from her treatment team, medication monitoring, and increased social support, she is meeting many of her personal goals. Client B comes to the community mental health center for her regular appointment with Clinician A, a Cuban psychiatrist. She reports that things have been going great, but she is experiencing some difficulties at work because her supervisor told her that others are taking advantage of her, and she wants her to stand up for herself. Specifically, they ask her to do their work, borrow money, and perform personal favors. Client B notes that her response to these co-workers is typically to be tardy or call in sick. Client B is confused by her situation because she feels very fortunate for her job and wants to appease her boss, but she also wants to be liked by her co-workers. Clinician A recommends assertiveness training and assigns her to a group conducted during business hours. Approximately one month later, Client B reports to Clinician A that she put in her letter of resignation. Clinician A does not realize that recommending a program that promotes skills, which could result in an uncomfortable work environment if she implements them, may have precipitated her decision to resign.

(1) This critical incident represents a cultural misunderstanding. 

- [ ] 5 Strongly Agree
- [ ] 4 Agree
- [ ] 3 Neutral
- [ ] 2 Disagree
- [ ] 1 Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

- Clinician’s lack of awareness of his/her own worldview
- Clinician’s reduced understanding of the consumer’s worldview
- Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)

(3) How could this critical incident be improved?


Critical Incident #14

Client B is a 68-year-old male with a long and traumatic history of childhood sexual abuse. He indicates experiencing severe symptoms such as recurrent and intrusive thoughts, persistent avoidance of stimuli that reminds him of the events, hypervigilance, and occasional outbursts of anger. Due to strong encouragement from a close friend, Client B goes to the nearest community mental health center for help. Client B meets Clinician A, a psychologist, who appears to be very similar to himself but is only 28 years old. Client B feels uncomfortable sharing personal experiences with someone who is the same age as his children and decides to test his credibility and expertise by asking a series of questions. At first, Clinician A answers each question as best as he can and tries
to reassure Client B that he has had extensive training in treating individuals with similar difficulties, and is going to try his best to help him in any way he can. After what feels like unrelenting attempts to discredit him, Clinician A becomes defensive, recalling previous incidents in which his expertise was questioned because of his age. Clinician A’s tone and affect change dramatically toward Client B. This confirms Client B’s preconceived notions about Clinician A. Client B states, “I told you that you are too young to understand where I am coming from” and storms out of the interview room.

(1) This critical incident represents a cultural misunderstanding.

[Multiple choice questions]

(2) What percent of this critical incident would you attribute to each of these 3 domains?

- Clinician’s lack of awareness of his/her own worldview
- Clinician’s reduced understanding of the consumer’s worldview
- Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)

(3) How could this critical incident be improved?

Critical Incident #15
Client B is currently a very active member in her church and finds that her faith helps her cope with her mental illness. She is diagnosed with borderline personality disorder and has a pervasive pattern of unstable and intense personal relationships, unstable self-image, impulsivity, self-mutilation, and excessive feelings of emptiness. Client B has been receiving services from Clinician A, a social worker at a community mental health center, for approximately two years. They have devised various ways of helping to improve Client B’s mental health status, but it seems as if actively participating in church related activities has been the best approach. Client B indicates to Clinician A that she would like him to discuss her progress with one of her priests because she would like both of them to understand how their approaches have impacted and improved her overall quality of life. Clinician A indicates that while it is a good idea, his large case load may prevent him from being flexible around scheduling a meeting and that her religious beliefs are different from his own. He states that although he recognizes a positive change in her, he does not feel comfortable with developing a collaborative alliance with her priest. Client B is disappointed by this response, and feels anger toward Clinician A.
(1) This critical incident represents a cultural misunderstanding.

☐ 5  ☐ 4  ☐ 3  ☐ 2  ☐ 1
Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

- Clinician’s lack of awareness of his/her own worldview
- Clinician’s reduced understanding of the consumer’s worldview
- Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100%  *(The percentages should add up to 100%)*

(3) How could this critical incident be improved?

Critical Incident #16
Client B has been experiencing severe mood changes over the past year. His most recent episode was characterized by elevated mood, inflated self-esteem, extreme distractibility, and racing thoughts, which lasted for approximately four days. He also has a history of experiencing both manic and depressive episodes. In addition, he has a long history of cocaine and crystal methamphetamine use. Client B presents to the community mental health center because his symptoms have affected both his ability to work and his relationship with his partner. His partner, Mr. X, does not understand how Client B’s moods can change so abruptly and would like to discuss effective ways to deal with these changes. Although Client B has not previously disclosed his sexual orientation to his social worker, he feels his partner’s involvement in his treatment may be helpful to his situation and their relationship. During their regular weekly meeting, Client B indicates his desire for his partner to sit in on the session. Clinician A says, “Okay, do you want me to get her? Is she in the waiting room?” Client B becomes uncomfortable as he recalls how difficult it was to come-out to the people he cares about. Client B hesitantly states, “Maybe this wasn’t such a good idea.” Clinician A insists on including his “girlfriend” because he feels it will be beneficial to Client B’s relationship. Client B becomes extremely upset and walks out of Clinician A’s office. Clinician A is confused as to what just happened.

(1) This critical incident represents a cultural misunderstanding.

☐ 5  ☐ 4  ☐ 3  ☐ 2  ☐ 1
Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree
(2) What percent of this critical incident would you attribute to each of these 3 domains?

____ Clinician’s lack of awareness of his/her own worldview
____ Clinician’s reduced understanding of the consumer’s worldview
____ Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% *(The percentages should add up to 100%)*

(3) How could this critical incident be improved?

______________________________

______________________________

Critical Incident #17
Client B is a young Japanese woman who is experiencing difficulties in both her marital relationship and her occupational functioning. She is seeking services from a community health center because a friend recommended a provider there and suggested that he may be helpful. Client B reports that she is no longer motivated to complete her work or fulfill her responsibilities and often feels like she does not have enough energy to do so. She reports that her therapy goal is to learn strategies and techniques to improve her motivation and concentration to complete work tasks. After Clinician A, a Caucasian psychologist, completes a lengthy interview, he recognizes common symptoms of Major Depressive Disorder that started recently after her third miscarriage. She reports symptoms of depressed mood, decreased motivation and concentration, significant weight loss, and anhedonia. When Clinician A asks how she has been reacting to the miscarriage, Client B reports that her mother and sister have helped her through the physical healing process, and she is feeling better. However, two weeks later she reports feeling the physical ramifications of the miscarriage, including feelings of fatigue, decreased motivation, and anhedonia. During this session, Client B indicates that her father took his own life in order to “save face” after losing his business. Clinician A suggests that her father might have also suffered symptoms from the Major Depressive Disorder that she is currently experiencing. He recommends intensive cognitive behavioral therapy as a means to address her irrational thoughts. Client B is surprised by this suggestion because it is common in her culture for people to commit suicide as a means of maintaining their families’ honor. She feels that Clinician A is not listening to her and does not return to her next scheduled appointment. Clinician A cannot explain what happened.

(1) This critical incident represents a cultural misunderstanding.

☐ 5 Strongly Agree
☐ 4 Agree
☐ 3 Neutral
☐ 2 Disagree
☐ 1 Strongly Disagree
(2) What percent of this critical incident would you attribute to each of these 3 domains?

- Clinician’s lack of awareness of his/her own worldview
- Clinician’s reduced understanding of the consumer’s worldview
- Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)

(3) How could this critical incident be improved?

Critical Incident #18
Client B is an 80-year-old survivor of World War II who experienced a lot of hardships and triumphs throughout his life. One of the most influential events to impact his life was the death of his brother after a bus exploded on O’ahu during the bombing of Pearl Harbor. He reports experiencing intense fear and helplessness as people around him died from the explosion. During this tragic incident, Client B was also injured but managed to escape relatively unscathed. His daughter encouraged him to seek help at a community health center because he is exhibiting memory impairment, disturbances in executive functioning, and significant impairments in his daily living skills. He also experiences some flashbacks, nightmares, and decreased concentration. Although quite resistant to the idea, Client B attends his scheduled appointment accompanied by his daughter. As both Client B and his daughter walk into the room, they look shocked as Clinician A is a 30-year-old social worker. Clinician A attempts to build rapport, but Client B becomes extremely uncomfortable and asks her how she thinks she is going to help him when he is almost three times her age. She states that she has had experience working with people his age and is sure that things will work out fine between them. Client B angrily asks, “So you think everyone has been through what I have, and you are equipped to help me deal with my problems?” Clinician A is surprised that her general statement offended Client B.

(1) This critical incident represents a cultural misunderstanding.

[ ] 5 Strongly Agree
[ ] 4 Agree
[ ] 3 Neutral
[ ] 2 Disagree
[ ] 1 Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

- Clinician’s lack of awareness of his/her own worldview
- Clinician’s reduced understanding of the consumer’s worldview

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Critical Incident #19
Client B is a female who is exhibiting a pattern of instability including frantic efforts to avoid real or imagined abandonment, unstable self-image, impulsive behaviors, chronic feelings of emptiness, and difficulty controlling anger. These symptoms have been occurring intermittently since her late teens and have gotten increasingly worse. She recognizes the need for psychiatric help but lives in a small, rural area and worries that her problems will not be confidential. She decides to commute to a community mental health center in another town in an attempt to avoid this problem. Client B examines her options and picks a site approximately two hours away from her town. Despite honest efforts to make her appointments, her limited means of transportation often interfere and she does not show up for appointments and calls to reschedule. Her male psychologist, Clinician A becomes concerned with her inconsistency and decides to address this problem at their next meeting. When Clinician A discusses his concerns and probes for reasons behind her missed appointments, Client B states that it is because of her limited means of transportation. Clinician A is not sure about the truthfulness of her response given her psychiatric history and continues to probe for a more “suitable” answer. Clinician A does not understand how someone who recognizes a need for help would let something like lack of transportation interfere with her ability to make her appointments. Client B becomes frustrated and storms out of the office.

(1) This critical incident represents a cultural misunderstanding.

☐ 5 Strongly Agree
☐ 4 Agree
☐ 3 Neutral
☐ 2 Disagree
☐ 1 Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

☐ Clinician’s lack of awareness of his/her own worldview
☐ Clinician’s reduced understanding of the consumer’s worldview
☐ Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)
Critical Incident #20
Client B is struggling with the death of her husband and decides to go to a community health center for help. Client B meets with Clinician A who is a psychologist. Client B tells him that she has been experiencing depressed mood, decreased concentration, fatigue, and feelings of worthlessness for approximately three weeks. She reports that her mood has been negatively affecting her relationships with her children and friends, and is also impacting her ability to care for herself and her responsibilities. After becoming more familiar with Clinician A, she discloses to him that she is a very spiritual woman who has the gift of communication with her ancestors and other spirits. She also divulges her ability to dream about future events and heal people’s mental and physical problems with prayer and natural herbs and plants. Clinician A appears shocked and begins to probe for the possibility of auditory and visual hallucinations. Client B is confused because she has shared something sacred with Clinician A, but he does not appear to understand her culture. During her next visit, Clinician A tells her that he has scheduled an appointment with the psychiatrist to see if medication for her voices and visions may be beneficial to her condition. Client B tells the psychiatrist that it is nothing to be concerned about and she does not need medication. However, the psychiatrist prescribes antipsychotic medications because he does not believe her story. She leaves the center feeling frustrated and betrayed.

(1) This critical incident represents a cultural misunderstanding.

☐ 5 Strongly Agree  ☐ 4 Agree  ☐ 3 Neutral  ☐ 2 Disagree  ☐ 1 Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

☐ Clinician’s lack of awareness of his/her own worldview
☐ Clinician’s reduced understanding of the consumer’s worldview
☐ Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)

(3) How could this critical incident be improved?

__________________________________________

__________________________________________

__________________________________________
Critical Incident #21
Client B is a Hawaiian female who has been struggling with Bipolar Disorder since young adulthood. She notes symptoms of decreased need for sleep, increased energy, distractibility, racing thoughts, increased spending, and decreased need to eat during manic episodes. When she is feeling depressed, she states that her symptoms include suicidal thoughts, decreased concentration, weight gain, and irritability. Client B has received treatment from a community mental health center on her island but feels uncomfortable most of the time and often misses her appointment. She indicates that her inconsistency is because she does not feel comfortable with the services provided. Client B is familiar with a community mental health center that integrates Hawaiian culture such as chanting, dancing hula, caring for the land, and planting and raising taro with mental health services, but it is located on another island. When she tries to discuss the possibility of creating a program like this with her Filipino psychiatric nurse, she is told that they do not have the necessary resources to provide such services. Client B asks Clinician A if she would be willing to share her suggestion with the rest of the treatment team, Clinician A replies that there is no scientific evidence to prove that such a program works and no one who has the background to devise or carry out such a program.

(1) This critical incident represents a cultural misunderstanding.

☐ 5 □ 4 □ 3 □ 2 □ 1
Strongly Agree Agree Neutral Disagree Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

_____ Clinician’s lack of awareness of his/her own worldview
_____ Clinician’s reduced understanding of the consumer’s worldview
_____ Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)

(3) How could this critical incident be improved?

Critical Incident #22
Client B is a 55-year-old non-traditional female student who is currently receiving services at a university counseling center. She has a long history of childhood sexual abuse and experiences flashbacks, recurring nightmares, insomnia, and avoidance of people, places, and situations that remind her of her past. These symptoms often interfere with her current level of functioning, and Client B has minimal sources of social support. She also has a history of alcohol dependence. Despite efforts to manage her illnesses, Client B was recently diagnosed with breast cancer and is undergoing chemotherapy. As
a result, Client B is having problems coming in for sessions and managing her mental health, physical health, and alcohol dependency by herself. She expresses these concerns to her 26-year-old counselor and asks for ways to improve the integration of all of her health services. Clinician A indicates she is unfamiliar with services or support groups available to older individuals experiencing multiple difficulties and tells Client B that she will look into it and phone her later. Clinician A is extremely busy and forgets to get the information or refer her to another provider with more expertise. She also forgets to address this issue at their next meeting. Client B feels frustrated and decides to seek help from someone else.

(1) This critical incident represents a cultural misunderstanding.

☐ 5 Strongly Agree
☐ 4 Agree
☐ 3 Neutral
☐ 2 Disagree
☐ 1 Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

_____ Clinician’s lack of awareness of his/her own worldview
_____ Clinician’s reduced understanding of the consumer’s worldview
_____ Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)

(3) How could this critical incident be improved?

Critical Incident #23

Client B is a Vietnamese male who recently immigrated with his family to the United States. He has been married for approximately 30 years and has two children. Client B told his primary care physician that he has been hearing voices, feeling like something or someone is following him, and thinking that someone is trying to kill him. He also reports a comorbid substance use disorder. Since the onset of these symptoms, he experienced a decline in personal hygiene, severely reduced physical health, and loss of his job as a factory worker. Client B and his family visit a community mental health center after his physician encourages them to do so. When the family enters the clinic, Clinician A, a Caucasian psychiatrist, tells them that he needs to conduct the session alone because the bilingual therapist called in sick. Unfortunately, neither Client B nor his wife’s speak English fluently. Clinician A resorts to the children’s English speaking skills to help them through the session. It appears as if the younger of the two is more fluent so Clinician A decides to rely on the younger son to act as a translator. Client B and his wife appear frightened and tense about what is being said in the interview room, and a heated discussion between both parents ensues. When Clinician A asks the child if
anything is wrong, the son politely indicates that everything is fine. Clinician A feels uncomfortable and asks to reschedule the appointment for a day when the bilingual therapist is available. Clinician A asks the youngest son to see if this is okay with Client B and his wife. The son says that his parents agree, but they do not return to the next scheduled appointment.

(1) This critical incident represents a cultural misunderstanding.

[ ] 5 Strongly Agree
[ ] 4 Agree
[ ] 3 Neutral
[ ] 2 Disagree
[ ] 1 Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

____ Clinician's lack of awareness of his/her own worldview
____ Clinician's reduced understanding of the consumer's worldview
____ Clinician's inability to develop/utilize appropriate intervention strategies and techniques

100% *(The percentages should add up to 100%)*

(3) How could this critical incident be improved?

________________________________________________________________________

________________________________________________________________________

Critical Incident #24
Clinician A is a very collaborative Caucasian psychologist who works at a university counseling center and encourages input from his clients in their therapy sessions. However, he recently began working with an Asian American male, Client B, who appears to be extremely resistant to this type of therapy. Client B’s primary diagnosis, Generalized Anxiety Disorder, involves unrealistic, distressing, and intrusive thoughts, excessive worrying about real-life problems, efforts to suppress these thoughts, and tendencies to engage in repetitive behaviors in order to prevent a dreaded event. Client B often expects Clinician A to give her solutions to her problems and does not feel that she is seeking therapy so that she can work through her problems herself. Client B often walks out of therapy feeling frustrated with the therapy style and the therapist. Clinician A attempts to explain the goals of the therapy further and states that this type of therapy is usually not as effective if Client B does not contribute and do her share. Frustrated with Clinician A’s style, Client B states, “I thought you were the expert, and you would be able to help me with my problems. Obviously, I was wrong.” Clinician A recognizes that he did not mean to offend her and was trying his best to explain his perspective. In his attempt to reconcile the situation, he continues to probe Client B for her feedback. She is angry and perceives him to be an incompetent provider. She responds tersely to his questions.
Critical Incident #25
Client B is a Chinese male who is working with Clinician A, a Chinese American psychiatrist, at a community mental health center. Client B reports that he moved to the United States to be closer to his children who immigrated to California nineteen years prior to his arrival. He had been living with his wife in China, but she recently passed away from a heart attack. Client B is seeking treatment at a community mental health center after his eldest daughter repeatedly asks him to do so. The daughter attends the intake session with her father. She reports that he appears to be “losing his mind.” In particular, she notes that her father is angry all the time and has unrealistic expectations of his children. Client B feels embarrassed and reports that he feels disrespected by his children. He also notes that they never come to him for guidance and often do not include him in their lives. His daughter reports that while his expectations might be appropriate in China, they are not appropriate in the United States. Clinician A believes there is an obvious generational difference. He automatically identifies with Client B’s daughter due to Clinician A’s own recent involvement in his father’s therapy. As a result, Clinician A encourages Client B to try to understand his daughter’s point of view. Quite upset and offended by the doctor’s comments, Client B no longer participates in the interview and allows his daughter to answer Clinician A’s questions. He does not return to his next scheduled appointment.

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(2) What percent of this critical incident would you attribute to each of these 3 domains?

____ Clinician’s lack of awareness of his/her own worldview
____ Clinician’s reduced understanding of the consumer’s worldview
____ Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% *(The percentages should add up to 100%)*

(3) How could this critical incident be improved?

Critical Incident #26
Clinician A is working with a female client with a history of delusional thoughts, visual hallucinations, and interpersonal and occupational difficulties at a community mental health center. The onset of her symptoms occurred after years of cocaine and methamphetamine dependence but has continued well beyond a period of abstinence. However, Clinician A, a psychiatric nurse, feels as if they are not actively addressing issues previously mentioned to a female provider. Clinician A believes that he is doing the best he can to help Client B but also senses a disconnect in their relationship as Client B appears to withhold certain information. During a session, Clinician A decides to ask Client B, “Is there anything that I have done to offend you?” Client B replies, “I don’t want to offend you, but I do not feel comfortable sharing certain things with you because you are a man.” Clinician A feels uncomfortable with Client B’s comment and does not know how to respond. He makes a statement about how he has had multiple interactions with women in his life, and he is confident that he is qualified to address any feminine issues that she may have. Client B responds politely to this comment and states, “Okay, I am sorry.” Clinician A feels good about the response but notices that Client B continues to withhold certain things from him.

(1) This critical incident represents a cultural misunderstanding.

□ 5 Strongly Agree □ 4 Agree □ 3 Neutral □ 2 Disagree □ 1 Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

____ Clinician’s lack of awareness of his/her own worldview
____ Clinician’s reduced understanding of the consumer’s worldview
____ Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% *(The percentages should add up to 100%)*
(3) How could this critical incident be improved?

______________________________

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Critical Incident #27
Clinician A is a social worker at a psychiatric hospital. Prior to their initial interview, Clinician A reviews case notes about Client B from a previous clinician. The notes indicate that Client B is experiencing depressed mood, increased sleep, appetite changes, decreased concentration, and suicidal ideation. The notes also state that Client B has been unable to hold a job over the past year and has minimal social support. After familiarizing himself with the limited information provided, he calls Client B into the interview room. As Client B walks to the door, Clinician A notices that he has long hair, wears make-up, is wearing a dress, and is otherwise feminine in appearance. Clinician A introduces himself to Client B who indicates that he prefers to be called Jane. Clinician A attempts to get a background history and accidentally calls Jane by Client B’s legal male name. Jane reminds him that she prefers to be called Jane. Clinician A apologizes but continues to get confused throughout the interview process. Clinician A feels uncomfortable as Jane is the first transgendered client he has worked with. Jane responds to his question with short one-word answers.

(1) This critical incident represents a cultural misunderstanding.

☐ 5 Strongly Agree
☐ 4 Agree
☐ 3 Neutral
☐ 2 Disagree
☐ 1 Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

_____ Clinician's lack of awareness of his/her own worldview
_____ Clinician's reduced understanding of the consumer's worldview
_____ Clinician's inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)

(3) How could this critical incident be improved?

______________________________

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Critical Incident #28
Clinician A is a Caucasian psychologist who recently completed group dynamics training and specialized training in co-occurring mental illness and substance abuse group therapy at a community mental health center. He decides to conduct a couple of groups
throughout the week. His groups are usually comprised of ten people of multiple ethnicities including Asian Americans, Pacific Islanders, African Americans, and Caucasians. They all have a severe and persistent mental illness as well as a comorbid substance abuse disorder. Clinician A attempts to facilitate a comfortable and open environment where individuals are encouraged to express their feelings about how drug use and mental health issues affect their lives. In addition, Clinician A tries to facilitate discussions that highlight misconceptions or differences among their personal experiences. Clinician A notices that while the Caucasian and African American participants tend to be fairly verbal in their groups, the Asian American and Pacific Islander individuals usually do not speak unless prompted. She also notices that even when some of the Asian American and Pacific Islander participants body language indicates disagreement, they do not willingly express their opinions. Clinician A is unsure about the most effective way to handle this situation and decides to force participation by implementing several role-play situations. Some of the Asian American and Pacific Islander participants stop attending group sessions but continue to meet regularly with their psychiatrists and case managers.

(1) This critical incident represents a cultural misunderstanding.

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Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

_____ Clinician’s lack of awareness of his/her own worldview
_____ Clinician’s reduced understanding of the consumer’s worldview
_____ Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)

(3) How could this critical incident be improved?

________________________________________________________________________
________________________________________________________________________

Critical Incident #29
Client B has been experiencing an exacerbation of his depressive symptoms because of his comorbid cancer condition. Since beginning chemotherapy treatment, he has experienced increased sadness, decreased appetite, sleep difficulties, decreased concentration, and suicidal ideation. Client B feels as if he is continuously struggling with situations regarding both his mental and physical health. After a recommendation from his primary care physician, Client B makes an appointment to see a psychologist, Clinician A, at a community mental health center. Client B reports that he is feeling extremely stressed because his primary care physician is recommending a blood
transfusion to replace extreme blood loss, but this medical procedure completely contradicts his religious beliefs. Clinician A probes to identify how it defies his religious belief, and he indicates that he is not allowed to receive other people's blood. Clinician A believes Client B is making an obviously life threatening mistake and tries to explain to Client B that surgery is his only option. Clinician A further states that if he does not concede to his doctor's recommendation then he may not survive for another year. Client B states, “I guess I will think about it.” Client B feels misunderstood and uncomfortable with the recommendations. Instead of confronting both of his providers, he decides not to return to his next scheduled appointment.

(1) This critical incident represents a cultural misunderstanding.

☐ 5 Strongly Agree
☐ 4 Agree
☐ 3 Neutral
☐ 2 Disagree
☐ 1 Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

_____ Clinician's lack of awareness of his/her own worldview
_____ Clinician's reduced understanding of the consumer's worldview
_____ Clinician's inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)

(3) How could this critical incident be improved?

Critical Incident #30
Client B is a Micronesian male who has been struggling with depression for two years with occasional periods of increased severity. He endorses depressed mood, social isolation, loss of energy or fatigue, decreased motivation, decreased concentration, and difficulty sleeping. Since the onset of his depression, he experienced difficulty holding jobs and interacting with his family and friends. Despite Client B's recognition of needing help, he does not want to go to a community mental health center because it may bring shame to his family. He tries to go to his family, friends, and church but does not feel like it is helping. After encouragement from another church member, Client B decides to schedule an appointment at a community mental health center. He hesitantly enters the doors and immediately feels uncomfortable. He looks for something familiar but does not find anything. There are no informational brochures available in Chuukese, and he does not see one Micronesian individual. Although he speaks English, he understands things better in Chuukese. Client B asks for a provider who speaks Chuukese and is told that there is no one available. He is encouraged to meet with an available provider to get more information. When he enters the interview room, he is greeted by
Clinician A, a Caucasian psychologist. He tries to comprehend what Clinician A is explaining but does not understand some of the words. Instead of asking questions, he decides that he does not feel that the services are appropriate for him and does not return.

(1) This critical incident represents a cultural misunderstanding.

[ ] 5 Strongly Agree
[ ] 4 Agree
[ ] 3 Neutral
[ ] 2 Disagree
[ ] 1 Strongly Disagree

(2) What percent of this critical incident would you attribute to each of these 3 domains?

[ ] Clinician’s lack of awareness of his/her own worldview

[ ] Clinician’s reduced understanding of the consumer’s worldview

[ ] Clinician’s inability to develop/utilize appropriate intervention strategies and techniques

100% (The percentages should add up to 100%)

(3) How could this critical incident be improved?

________________________________________________________________________

________________________________________________________________________
APPENDIX M

INFORMED CONSENT: MULTICULTURAL EXPERT VERSION

Item Development of a Provider Level Cultural Competency Instrument: Phase II
Andrea Nacapoy & John J. Steffen, Ph.D.
UH Department of Psychology/DOH Mental Health Services Research and Evaluation
2800 Woodlawn Drive, Suite 120
Honolulu, Hawai‘i 96822-1863
nacapoy@hawaii.edu
808-539-3961

Description of Project: This is the second phase of a research project we are conducting to help the Adult Mental Health Division (AMHD) of the Hawai‘i Department of Health develop a way of measuring and evaluating provider-level cultural competency using an assessment instrument that is based on the cultural assimilator format. We need to determine the content validity of the sample of critical incidents that were generated in Phase I. At least 10 to 15 cultural experts are expected to participate in this phase of the research project.

Invitation to Participate: You are being invited to take part in this research study because you were identified as a multicultural expert and we would like to solicit your expertise in evaluating and categorizing critical incidents that portray culturally diverse interactions.

Description of Procedures: You are currently linked to a secure web site where the Cultural Competency Critical Incident Evaluation Form is located. This evaluation form includes three questions for each of the critical incidents. Additional comments, suggestions, and questions will also be solicited after each incident is discussed in detail. You will also be asked to complete a demographic questionnaire, but the information obtained will not be connected in any way to the feedback you provide.

Risks and Inconveniences: No risks are expected for study participants. However, some participants may feel distress or embarrassment when sharing personal experiences. If you do feel uncomfortable, you are free to skip to the next question or end your participation at any time.

Benefits: What we learn from you may help others in the future by making services and programs more culturally appropriate.

Confidentiality: You will not be asked to write your name on the demographic. Any information obtained from the questionnaire will be kept strictly confidential and will not be linked to any data. You will not be identified in anything published as a result of this project.

Incentive: You will receive a $20.00 gift certificate to a bookstore for your participation.

Voluntary Participation: Your participation in this study is entirely voluntary. Refusal to participate in any part of the study will not affect you now or in the future. You can terminate your participation at any time without penalty.

Questions: Please feel free to ask any questions about anything that seems unclear to you. You can ask the principal investigator (Andrea Nacapoy, 539-3733) questions about this project at any time. You can also contact John J. Steffen, Ph.D., the supervisor of this project, at any time to ask questions about the research (808-539-3961). You may also contact the Committee on Human Studies, University of Hawai‘i, 2540 Maile Way, Honolulu, Hawai‘i, 96822 (808-956-5007) if you feel that you have been treated unfairly in any way relating to this study or have any questions regarding your rights as a participant in this study.

I certify that I have read and that I understand the foregoing, that I have been given satisfactory answers to my inquiries concerning project procedures and other matters and that I have been advised that I am free to
withdraw my consent and to discontinue participation in the project or activity at any time without prejudice.

I herewith give my consent to participate in this study with the understanding that such consent does not waive any of my legal rights, nor does it release the principal investigator or the institution or any employee or agent thereof from liability to negligence.

________________________________________  __________________________
Signature of Individual Participant                     Date
APPENDIX N

ITEMS RETAINED FOR THE PROVIDER-LEVEL CULTURAL COMPETENCY ASSESSMENT INSTRUMENT AFTER DATA ANALYZED FOR QUESTION 1

Critical Incident #1
Clinician A is a Filipino psychiatrist who moved to Hawai‘i when she was a child. She worked hard to adapt to American cultural beliefs as a means to try fit in with the other children in her school. Clinician A also stopped speaking Ilokano, participating in cultural activities, and eating Filipino food. She became very accustomed to the American way of life and identifies herself as “American.” She is now working at a university counseling center and encounters Client B, a Filipino female who was born in the Philippines and also moved to Hawai‘i when she was a child. However, in an attempt to maintain her Filipino culture, Client B devotes a lot of her time to the Filipino community and returns to the Philippines frequently. Client B presents with depressed mood, decreased motivation, and decreased concentration. Clinician A conducts an interview in which she assesses Client B’s background history and presenting problems in order to provide optimal treatment for her mental illness. After Clinician A completes the interview, she assumes that since they are the same age and ethnicity, and both moved to the United States around the same time, they have experienced a lot of the same things. Clinician A discusses how fortunate they both are to have moved to America, noting that she loves the opportunities offered in the States. Client B becomes agitated because she never indicated that she is happy to live in America and actually feels unhappy with her family’s choice to move. She is uncertain whether she wants to continue in treatment, but does not feel comfortable correcting Clinician A.

Critical Incident #2
Clinician A is a male community health center social worker who is from a family in which the males work and bring home money and the females usually care for the children and the household. Males also make the majority of family-related decisions. He is providing services to Client B who presents with depressed mood, significant weight loss, fatigue, psychomotor retardation, inappropriate guilt, and recurrent thoughts of death. Client B is also having marital difficulties and often does not want to get out of bed in the morning. Client B expresses frustration because although he works to provide for the family, his wife makes the majority of the family-related decisions. He indicates that he has no say in where his children go to school, how the money he earns is spent, or how to discipline their children. Although this is common in his culture, he recognizes that the males in other cultures are afforded many opportunities to contribute to major family-related decisions. Clinician A does not understand Client B’s family structure, hierarchies, values, and beliefs; and encourages Client B to stand up for himself, stating that, “the man of the house should have a say in these types of decisions.” Client B feels uncomfortable because he knows that this is not the case in his culture but sharing it with Clinician A may undermine his masculinity. Client B outwardly agrees with Clinician A and refrains from discussing the issue in future sessions although it is a major contributor to his high level of depression, stress, and low self-esteem.
Critical Incident #3
Clinician A, a heterosexual clinician, is providing therapy at a university counseling center to Client B, a homosexual male. Client B reports experiencing multiple and severe episodes of depression for most of his adult life. Client B believes that his difficulties are related to feelings of isolation from family members who disagree with his career choice and sexual orientation. Client B reports that his partner is having trouble understanding his point of view because his partner’s family accepts him and the choices he has made. Client B’s partner goes with him to his session and waits in the waiting room for support. During the intake assessment, Client B states that he is also interested in couple’s counseling. With the client’s permission, Clinician A invites Client B’s partner into the session. In her effort to understand their relationship dynamics, Clinician A asks who is in the more dominant or male role, and who is in the more submissive or female role. The couple appears shocked and explains to Clinician A that these dynamics do not apply to their relationship. Clinician A is confused and feels embarrassed about the question she just asked. The clients do not appear to feel comfortable and start answering questions with one-word answers. They do not return to their next scheduled appointment.

Critical Incident #4
Client B is a Filipino female who came to the community mental health center after discharge from a psychiatric hospital for a suicide attempt by drug overdose. Client B appears nervous, agitated, and uncomfortable during her initial meeting with Clinician A, a Caucasian psychologist. She also repeatedly asks Clinician A if she is crazy. As Client B continues to tell her history, she reveals that she has been attacked and raped on two different occasions by two Latino males while walking home from work. She reports that she is afraid to walk by herself, leave her house, and interact with males who remind her of her assailants. She also notes that she often experiences flashbacks, panic symptoms, loss of interest in activities, and hypervigilance. Her symptoms are so extreme and intrusive that she is unable to work. She reports that her inability to work interferes with her ability to care for her family, so she also experiences extreme feelings of guilt. Clinician A discusses other alternatives to working including the possibility of applying for social security benefits. Clinician A tells Client B that she needs to care for herself before she returns to work. Client B feels frustrated because she has a responsibility to her family, and the idea of putting her needs above the needs of her family does not feel right. Instead of telling Clinician A how she really feels, she smiles and nods, simply agreeing with Clinician A. Client B does not return to her next scheduled appointment, and Clinician A is not sure what happened during the previous session.

Critical Incident #5
Client B is an Asian American student who presents to the university counseling center after being hospitalized for severe dehydration. She indicates to Clinician A, an African American psychiatrist, that she often has severe headaches, indigestion, decreased appetite and insomnia; and has been experiencing a significant decline in her academic performance. Client B believes that her lowered academic performance may be a result of a major medical illness, but several medical examinations failed to reveal a disorder. Client B reports that although she still thinks she is physically sick, the physician at the hospital suggested she see a mental health practitioner for an evaluation. Client B
presents as both depressed and anxious during the interview. Clinician A attempts to get a
detailed background history from Client B, but it proves to be difficult because Client B
tends to respond to questions with short, polite statements and often does not offer
personal information. Client B also avoids sharing her feelings and presents her problems
as primarily physical and academic. Client B seems hesitant about the idea of mental
health counseling and frequently asks for feedback about her performance. During a
second interview, Client B admits that she chose medical school because her parents
wanted her to, and not because she is interested in becoming a doctor. She also states that
she has never been comfortable with expressing herself to her parents, as this is not the
way her family typically communicates. Clinician A encourages Client B to express her
feelings toward her parents, and Client B responds by becoming quiet and stating that she
feels guilty. She decides that therapy is not the right choice for her. Clinician A does not
understand the client’s decision to terminate therapy.

**Critical Incident #6**

Client B is a multi-ethnic Filipino, Japanese, and Chinese woman with serious mental
illness who has been working and living independently in her own apartment for
approximately six months. She was diagnosed with schizoaffective disorder
approximately three years ago but with support from her treatment team, medication
monitoring, and increased social support, she is meeting many of her personal goals.
Client B comes to the community mental health center for her regular appointment with
Clinician A, a Cuban psychiatrist. She reports that things have been going great, but she
is experiencing some difficulties at work because her supervisor told her that others are
taking advantage of her, and she wants her to stand up for herself. Specifically, they ask
her to do their work, borrow money, and perform personal favors. Client B notes that her
response to these co-workers is typically to be tardy or call in sick. Client B is confused
by her situation because she feels very fortunate for her job and wants to appease her
boss, but she also wants to be liked by her co-workers. Clinician A recommends
assertiveness training and assigns her to a group conducted during business hours.
Approximately one month later, Client B reports to Clinician A that she put in her letter
of resignation. Clinician A does not realize that recommending a program that promotes
skills, which could result in an uncomfortable work environment if she implements them,
may have precipitated her decision to resign.

**Critical Incident #7**

Client B has been experiencing severe mood changes over the past year. His most resent
episode was characterized by elevated mood, inflated self-esteem, extreme distractibility,
and racing thoughts, which lasted for approximately four days. He also has a history of
experiencing both manic and depressive episodes. In addition, he has a long history of
cocaine and crystal methamphetamine use. Client B presents to the community mental
health center because his symptoms have affected both his ability to work and his
relationship with his partner. His partner, Mr. X, does not understand how Client B’s
moods can change so abruptly and would like to discuss effective ways to deal with these
changes. Although Client B has not previously disclosed his sexual orientation to his
social worker, he feels his partner’s involvement in his treatment may be helpful to his
situation and their relationship. During their regular weekly meeting, Client B indicates
his desire for his partner to sit in on the session. Clinician A says, “Okay, do you want me to get her? Is she in the waiting room?” Client B becomes uncomfortable as he recalls how difficult it was to come-out to the people he cares about. Client B hesitantly states, “Maybe this wasn’t such a good idea.” Clinician A insists on including his “girlfriend” because he feels it will be beneficial to Client B’s relationship. Client B becomes extremely upset and walks out of Clinician A’s office. Clinician A is confused as to what just happened.

**Critical Incident #8**

Client B is a young Japanese woman who is experiencing difficulties in both her marital relationship and her occupational functioning. She is seeking services from a community health center because a friend recommended a provider there and suggested that he may be helpful. Client B reports that she is no longer motivated to complete her work or fulfill her responsibilities and often feels like she does not have enough energy to do so. She reports that her therapy goal is to learn strategies and techniques to improve her motivation and concentration to complete work tasks. After Clinician A, a Caucasian psychologist, completes a lengthy interview, he recognizes common symptoms of Major Depressive Disorder that started recently after her third miscarriage. She reports symptoms of depressed mood, decreased motivation and concentration, significant weight loss, and anhedonia. When Clinician A asks how she has been reacting to the miscarriage, Client B reports that her mother and sister have helped her through the physical healing process, and she is feeling better. However, two weeks later she reports feeling the physical ramifications of the miscarriage, including feelings of fatigue, decreased motivation, and anhedonia. During this session, Client B indicates that her father took his own life in order to “save face” after losing his business. Clinician A suggests that her father might have also suffered symptoms from the Major Depressive Disorder that she is currently experiencing. He recommends intensive cognitive behavioral therapy as a means to address her irrational thoughts. Client B is surprised by this suggestion because it is common in her culture for people to commit suicide as a means of maintaining their families’ honor. She feels that Clinician A is not listening to her and does not return to her next scheduled appointment. Clinician A cannot explain what happened.

**Critical Incident #9**

Client B is struggling with the death of her husband and decides to go to a community health center for help. Client B meets with Clinician A who is a psychologist. Client B tells him that she has been experiencing depressed mood, decreased concentration, fatigue, and feelings of worthlessness for approximately three weeks. She reports that her mood has been negatively affecting her relationships with her children and friends, and is also impacting her ability to care for herself and her responsibilities. After becoming more familiar with Clinician A, she discloses to him that she is a very spiritual woman who has the gift of communication with her ancestors and other spirits. She also divulges her ability to dream about future events and heal people’s mental and physical problems with prayer and natural herbs and plants. Clinician A appears shocked and begins to probe for the possibility of auditory and visual hallucinations. Client B is confused because she has shared something sacred with Clinician A, but he does not appear to
understand her culture. During her next visit, Clinician A tells her that he has scheduled an appointment with the psychiatrist to see if medication for her voices and visions may be beneficial to her condition. Client B tells the psychiatrist that it is nothing to be concerned about and she does not need medication. However, the psychiatrist prescribes antipsychotic medications because he does not believe her story. She leaves the center feeling frustrated and betrayed.

Critical Incident #10
Client B is a Hawaiian female who has been struggling with Bipolar Disorder since young adulthood. She notes symptoms of decreased need for sleep, increased energy, distractibility, racing thoughts, increased spending, and decreased need to eat during manic episodes. When she is feeling depressed, she states her symptoms include suicidal thoughts, decreased concentration, weight gain, and irritability. Client B has received treatment from a community mental health center on her island but feels uncomfortable most of the time and often misses her appointment. She indicates that her inconsistency is because she does not feel comfortable with the services provided. Client B is familiar with a community mental health center that integrates Hawaiian culture such as chanting, dancing hula, caring for the land, and planting and raising taro with mental health services, but it is located on another island. When she tries to discuss the possibility of creating a program like this with her Filipino psychiatric nurse, she is told that they do not have the necessary resources to provide such services. Client B asks Clinician A if she would be willing to share her suggestion with the rest of the treatment team, Clinician A replies that there is no scientific evidence to prove that such a program works and no one who has the background to devise or carry out such a program.

Critical Incident #11
Client B is a Vietnamese male who recently immigrated with his family to the United States. He has been married for approximately 30 years and has two children. Client B told his primary care physician that he has been hearing voices, feeling like something or someone is following him, and thinking that someone is trying to kill him. He also reports a comorbid substance use disorder. Since the onset of these symptoms, he experienced a decline in personal hygiene, severely reduced physical health, and loss of his job as a factory worker. Client B and his family visit a community mental health center after his physician encourages them to do so. When the family enters the clinic, Clinician A, a Caucasian psychiatrist, tells them that he needs to conduct the session alone because the bilingual therapist called in sick. Unfortunately, neither Client B nor his wife speak English fluently. Clinician A resorts to the children’s English speaking skills to help them through the session. It appears as if the younger of the two is more fluent so Clinician A decides to rely on the younger son to act as a translator. Client B and his wife appear frightened and tense about what is being said in the interview room, and a heated discussion between both parents ensues. When Clinician A asks the child if anything is wrong, the son politely indicates that everything is fine. Clinician A feels uncomfortable and asks to reschedule the appointment for a day when the bilingual therapist is available. Clinician A asks the youngest son to see if this is okay with Client B and his wife. The son says that his parents agree, but they do not return to the next scheduled appointment.
Critical Incident #12
Clinician A is a very collaborative Caucasian psychologist who works at a university counseling center and encourages input from his clients in their therapy sessions. However, he recently began working with an Asian American female, Client B, who appears to be extremely resistant to this type of therapy. Client B’s primary diagnosis, Generalized Anxiety Disorder, involves unrealistic, distressing, and intrusive thoughts, excessive worrying about real-life problems, efforts to suppress these thoughts, and tendencies to engage in repetitive behaviors in order to prevent a dreaded event. Client B often expects Clinician A to give her solutions to her problems and does not feel that she is seeking therapy so that she can work through her problems herself. Client B often walks out of therapy feeling frustrated with the therapy style and the therapist. Clinician A attempts to explain the goals of the therapy further and states that this type of therapy is usually not as effective if Client B does not contribute and do her share. Frustrated with Clinician A’s style, Client B states, “I thought you were the expert, and you would be able to help me with my problems. Obviously, I was wrong.” Clinician A recognizes that he did not mean to offend her and was trying his best to explain his perspective. In his attempt to reconcile the situation, he continues to probe Client B for her feedback. She is angry and perceives him to be an incompetent provider. She responds tersely to his questions.

Critical Incident #13
Client B is a Chinese male who is working with Clinician A, a Chinese American psychiatrist, at a community mental health center. Client B reports that he moved to the United States to be closer to his children who immigrated to California nineteen years prior to his arrival. He had been living with his wife in China, but she recently passed away from a heart attack. Client B is seeking treatment at a community mental health center after his eldest daughter repeatedly asks him to do so. The daughter attends the intake session with her father. She reports that he appears to be “losing his mind.” In particular, she notes that her father is angry all the time and has unrealistic expectations of his children. Client B feels embarrassed and reports that he feels disrespected by his children. He also notes that they never come to him for guidance and often do not include him in their lives. His daughter reports that while his expectations might be appropriate in China, they are not appropriate in the United States. Clinician A believes there is an obvious generational difference. He automatically identifies with Client B’s daughter due to Clinician A’s own recent involvement in his father’s therapy. As a result, Clinician A encourages Client B to try to understand his daughter’s point of view. Quite upset and offended by the doctor’s comments, Client B no longer participates in the interview and allows his daughter to answer Clinician A’s questions. He does not return to his next scheduled appointment.

Critical Incident #14
Clinician A is a social worker at a psychiatric hospital. Prior to their initial interview, Clinician A reviews case notes about Client B from a previous clinician. The notes indicate that Client B is experiencing depressed mood, increased sleep, appetite changes, decreased concentration, and suicidal ideation. The notes also state that Client B has been unable to hold a job over the past year and has minimal social support. After familiarizing
himself with the limited information provided, he calls Client B into the interview room. As Client B walks to the door, Clinician A notices that he has long hair, wears make-up, is wearing a dress, and is otherwise feminine in appearance. Clinician A introduces himself to Client B who indicates that he prefers to be called Jane. Clinician A attempts to get a background history and accidentally calls Jane by Client B’s legal male name. Jane reminds him that she prefers to be called Jane. Clinician A apologizes but continues to get confused throughout the interview process. Clinician A feels uncomfortable as Jane is the first transgendered client he has worked with. Jane responds to his question with short one-word answers.

**Critical Incident #15**
Client B has been experiencing an exacerbation of his depressive symptoms because of his comorbid cancer condition. Since beginning chemotherapy treatment, he has experienced increased sadness, decreased appetite, sleep difficulties, decreased concentration, and suicidal ideation. Client B feels as if he is continuously struggling with situations regarding both his mental and physical health. After a recommendation from his primary care physician, Client B makes an appointment to see a psychologist, Clinician A, at a community mental health center. Client B reports that he is feeling extremely stressed because his primary care physician is recommending a blood transfusion to replace extreme blood loss, but this medical procedure completely contradicts his religious beliefs. Clinician A probes to identify how it defies his religious belief, and he indicates that he is not allowed to receive other people’s blood. Clinician A believes Client B is making an obviously life threatening mistake and tries to explain to Client B that surgery is his only option. Clinician A further states that if he does not concede to his doctor’s recommendation then he may not survive for another year. Client B states, “I guess I will think about it.” Client B feels misunderstood and uncomfortable with the recommendations. Instead of confronting both of his providers, he decides not to return to his next scheduled appointment.

**Critical Incident #16**
Client B is a Micronesian male who has been struggling with depression for two years with occasional periods of increased severity. He endorses depressed mood, social isolation, loss of energy or fatigue, decreased motivation, decreased concentration, and difficulty sleeping. Since the onset of his depression, he experienced difficulty holding jobs and interacting with his family and friends. Despite Client B’s recognition of needing help, he does not want to go to a community mental health center because it may bring shame to his family. He tries to go to his family, friends, and church but does not feel like it is helping. After encouragement from another church member, Client B decides to schedule an appointment at a community mental health center. He hesitantly enters the doors and immediately feels uncomfortable. He looks for something familiar but does not find anything. There are no informational brochures available in Chuukese, and he does not see one Micronesian individual. Although he speaks English, he understands things better in Chuukese. Client B asks for a provider who speaks Chuukese and is told that there is no one available. He is encouraged to meet with an available provider to get more information. When he enters the interview room, he is greeted by Clinician A, a Caucasian psychologist. He tries to comprehend what Clinician A is.
explaining but does not understand some of the words. Instead of asking questions, he decides that he does not feel that the services are appropriate for him and does not return.
### APPENDIX 0

**VALID RESPONSES BY PARTICIPANT IDENTIFICATION NUMBERS FOR QUESTION 3: HOW COULD THIS CRITICAL INCIDENT BE IMPROVED?**

<table>
<thead>
<tr>
<th>Critical Incident</th>
<th>Comments and Suggestions (#: Participant IDs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>(30) Good- so far most of the scenarios involve counselors who are obviously biased. (35) No recommendations. (36) This is a really good one because it represents bias all the way. (37) Just edit the sentence that reads &quot;partner's family accepts him [the partner] because otherwise not clear who is accepted, the client or the partner.</td>
</tr>
<tr>
<td>4</td>
<td>(30) It's good. (35) No recommendations. (36) This example involves another Filipino female. Suicide attempt automatically assumes a psychiatric hospitalization. No need nervous, agitated, and uncomfortable, one adjective is fine. Her symptoms are so extreme and unable to work. No need say extreme in extreme feelings of guilt. The vignette is so long and has too many unnecessary things inside. Filipino doesn't really matter and depends on a specific clinical population (people who are raped).</td>
</tr>
<tr>
<td>8</td>
<td>(30) Good (35) No recommendations. (36) She is seeking services from a community mental health center because her friend recommends it. Simplify anhedonia. Comma reduction.</td>
</tr>
<tr>
<td>9</td>
<td>(30) Good (35) No recommendations. (36) Her mood affected her relationships with her children and friends. Don't need to say negative mood because. Sentence reduction and comma reduction. Change &quot;divulges&quot; to share. (40) Does not seem plausible that the client, given her beliefs and practices in alternative healing practices, would seek help at a community health center. If we had additional information such as her adult children who were college educated having strongly urged her to seek help at the community health center, and that she went primarily to appease them, that might make her behavior more believable.</td>
</tr>
<tr>
<td>11</td>
<td>(30) Good one (35) No recommendations. (36) Change sentence feeling like something or someone is following him, and thinking that someone is trying to kill him. Just say he feels like someone or something is following or trying to kill him. Comma reduction. The wife is tense about what is said in the interview, and a heated discussion arises.</td>
</tr>
<tr>
<td>12</td>
<td>(30) Good (35) No recommendations. (36) Take out very in the first sentence. No need say both very and collaborative. Encourages input from the client. Erase in the community session. Comma reduction. This actually happens.</td>
</tr>
</tbody>
</table>
| 13                | (35) No recommendations. (36) No need be specific about reason for wife's death. The fact that the clinician automatically with the client's daughter
and as a result encourages the client to understand his daughter's point of view. (37) Not clear what it means that client was "recently involved in his father's therapy." Oh, I see now that "he" refers to the clinician, not clear in first read...Just a general comment, it is confusing to read the incidents using letters (A & B) as names, I tend to get confused as to who is whom.

15
(30) Medical decisions are for MDs- The counselor should listen (35) No recommendations (36) No need use comorbid once you already spell it out. This is a really good one. No need use primary care physician twice. Comma reduction. (40) This is a difficult situation to evaluate in that it raises the issue of an ethical dilemma of whether the client is in danger of hurting himself. While the information provided does not indicate "imminent" danger ("he may not survive for another year"), this information comes from the clinician and it is not clear how valid is that information. I think it would be cleaner to not include any information that might raise this type of ethical dilemma as that clouds the issue of the clinician's intervention.

16
(35) I'm not sure that the above critical incident has anything to do with the cultural competency of the provider, but rather the clinic. Therefore, I had a difficult time allocating %s to the above question. (36) Comma reduction. Change the word, "endorses." As soon as you establish the point, move on to what you are tying to get at. This is a good one. Make it more fluid as trying to explain it to someone with a 2-year college education.

Overall Comments
(30) Is culture the same as demographics or language? Is difference culture? The definition of culture seems too broad.
(36) Using Clinician A and Client B is confusing. Don't need A and B. Simplify critical incidents by using simple words and reducing commas in a sentence. Make critical incidents more fluid.
(37) Also confused with Clinician A and Client B. Prefers names instead.
References


