Training Culturally Competent Psychologists: Where Are We and Where Do We Need to Go?

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The purpose of this mixed-methods study was to provide an updated overview of the cultural competency—training experiences of psychologists. The majority of the research on this topic was over 20 years old, and given the shifts that have occurred in the field and the advent of the American Psychological Association’s multicultural guidelines, a more contemporary understanding of the training experiences of psychologists was needed. In Study 1 (N = 9), qualitative interviews were conducted with psychologists, who shared information about their cultural competency—training experiences. Based on the results from Study 1, a survey was created for Study 2 and completed by 142 psychologists. The majority of participants reported that their cultural competency graduate training included a course in diversity (85%), supervised clinical experience with diverse populations (83%), and didactic training about cultural competency (82%); the majority of participants (76%) also reported that exploring personal biases had constituted part of their training. To a lesser degree, participants reported that their training included experiential activities (67%) and cultural immersion (38%). Findings from this study revealed that psychologists are highly satisfied with the training they received and that clinical supervision predicted satisfaction. Per the results, the ideal training should include a graduate school course in diversity, supervised clinical experience with diverse populations, additional didactic training, experiential activities, and possibly cultural immersion. Supervision was noted to play a key role in psychologists’ development as culturally competent practitioners.

Keywords: cultural competency, training for psychologists, training outcomes, multicultural education

Several models for training psychologists to be culturally competent practitioners have been proposed over the last (nearly) 50 years. These are largely rooted in Sue and colleagues’ (1982) seminal paper, which challenged the traditional and culturally encapsulated nature of psychology and highlighted the importance of knowledge, awareness, and skills as necessities for cultural competence. The current training mechanisms for psychology doctoral students (in the clinical and counseling domains) are based on guidelines set forth by the American Psychological Association (APA, 2017a). Per the APA’s (2015) Commission on Accreditation, accredited programs are expected to specify and implement a plan for integrating diversity into both didactic and experiential training that is based on “the multicultural conceptual and theoretical frameworks of worldview, identity, and acculturation, rooted in the diverse social, cultural, and political contexts of society, and integrated into the science and practice of psychology” (p. 92). Accredited programs are also expected to train students—interns–residents to “respect diversity and be competent

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Jonathan Singer, who holds a master of arts in clinical psychology, is a graduate research assistant at the University of Nevada, Reno. Jonathan Singer aims to assess preloss grief in cancer and dementia caregivers. Currently, he is researching preparedness in cancer and dementia caregivers in order to define preparedness in this population.

Rory T. Newlands, who is pursuing her PhD at the University of Nevada, Reno, is interested in understanding the interplay between gender, sexuality, and violence, in order to enhance prevention efforts and improve treatment outcomes for victimized populations. She is interested in increasing treatment access to underserved populations via tailoring treatments to take into account clients’ diverse culturally backgrounds. Additionally, her research interests include preventing negative mental health outcomes and burnout among first-line mental health care providers.

Jena B. Casas, who holds a master’s degree in psychology, is a graduate research assistant at the University of Nevada, Reno. She aims to answer research questions regarding psychological well-being and psychopathology of women and children postvictimization. A secondary research interest of hers is to examine the impact of culture in this same context. Currently, she is researching various aspects of cultural sensitivity and evidence-based interventions for Latina victims of interpersonal violence and sexual assault.

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in addressing diversity in all professional activities including re-
search, training, supervision/consultation, and service (p. 21).
Although the Commission on Accreditation (APA, 2015) has
indicated that doctoral programs must determine that doctoral
students have competency in individual and cultural diversity,
cconcrete mandates on how this training should be carried out or
what to include have been lacking.

A recent systematic review of the literature (Benuto, Casas, &
O’Donohue, 2018) found that the goals, curricular methods, and
outcomes of current cultural competency training varied widely
across studies. Training procedures across studies included lecture,
discussion, utilization of case scenarios, cultural immersion, role-
play, contact with diverse individuals, self-reflection of interac-
tions with clients, journaling, and service learning. The topics
covered across training included racism—discrimination, world-
views, cultural identity, general concepts about culture, biases, and
information about the clinical—client interaction as it relates to
cultural competency or diversity. It is interesting that cultural
competency training was noted to consistently increase knowledge
but inconsistently change attitudes, awareness, or skills.

In addition to training outcome studies, studies in which partic-
ipants were asked to retrospectively report on their training expe-
riences also exist, although the bulk of this research is 20 (or more)
years old. More contemporary research has indicated that social
justice content has a growing presence in multicultural courses
(Pieterse, Evans, Risner-Butner, Collins, & Mason, 2009), but
limitations regarding training in the area of lesbian, gay, bisexual,
transgender, queer (LGBTQ) issues (Anhalt, Morris, Scotti, &
Cohen, 2003) and skills-based training (Reynolds, 2011) persist.

Given the limited body of contemporary literature on training, the
shifts that have occurred in the field, the advent of the APA’s
multicultural guidelines (APA, 2002), and development of profes-
sion-wide competencies (APA, 2017b), a more contempo-
rary understanding of the training experiences of psychologists is
needed. The purpose of the current studies was to establish the
following:

1. What cultural competency—training experiences have
psychologists had?
2. How do psychologists use their cultural competency
training in their work with diverse clients?
3. How satisfied are psychologists with the training they
received in graduate school?
4. What do psychologists believe represents the ideal train-
ing that can help them move toward becoming culturally
competent practitioners?

Study 1

Method

Materials. The data collected and analyzed for this qualita-
tive study were part of the data-collection efforts for a larger
study. This study required the creation of an interview protocol.
The research questions and relevant literature were used to
create the initial draft of the interview protocol, which (along
with the research questions for feedback) was sent to three experts
in the field. Based on the feedback provided, revisions were made
to the interview protocol, and the interview protocol, ultimately
consisting of 10 open-ended questions, all of which were focused
on cultural competency and cultural sensitivity (see Benuto,
Singer, Casas, Gonzalez, & Ruok, 2018, for additional details),
was finalized; for the purpose of this article, data were analyzed
from four of the open-ended questions that were asked of partic-
ipants. These questions were (a) Please describe your training as it
relates to cultural competence, (b) How do you use your training
to work with diverse clients? (c) What additional training would
you find helpful or useful? and (d) How do you believe cultural
competency is achieved?

Procedure. After institutional review board approval was ob-
tained, participants were randomly recruited (via e-mail) from a
list of 30 psychologists who were professional contacts of the lead
researcher’s. Inclusion criteria for participation were that the par-
ticipant be a psychologist (clinical or counseling psychologist)
who worked with diverse populations (we did not set additional
inclusion criteria regarding to what extent the participant worked
with diverse clients). If an invitation was declined, then an invi-
tation was sent to another psychologist who was randomly selected
from the list. A total of 20 invitations were sent, and those
interested in participating (N = 9) provided their availability to
complete the semistructured interview via telephone. The inter-
views lasted between 32 and 69 min (M = 45, SD = 15).

Participants. Participants were primarily female (n = 6), of
an ethnic minority background (n = 5), and between the ages of 32
and 47 (M = 39.89, SD = 5.12). Participants were clinical (n = 7)
or counseling (n = 2) psychologists, had all attended an APA-
accredited program, and had graduated between 2 and 13 years
prior to the interview (M = 6.67, SD = 2.92). Participants were
employed in community clinics (n = 2), private practices (n = 4),
and academic medical centers or clinics (n = 3). Participants
reported spending between 32% and 100% of their weekly clinical
hours with cultural minority clients (i.e., Latinos, African Ameri-
cans, Pacific Islanders, Indians, and LGBTQ populations; M =
63.82%).

Data analysis. The audio-recorded interviews were tran-
scribed for coding purposes. The unit of analysis for this study was
training experiences, and thematic data analysis (using first- and
second-cycle coding; Saldana, 2015) was used to analyze the data.
Each line of the interview transcripts was reviewed, and a list of all
words, phrases, sentences, or paragraphs (Zhang & Wildemuth,
2012) that referenced training (or any derivative thereof) were
highlighted for additional analysis. Items on the list were examined
to determine how each was similar to and/or different from the
other items (Gibson & Brown, 2009) and then listed according to
commonality (Saldana, 2015). Similar items within the list were
then collapsed into emergent themes.

Results

Training experiences. Results from the thematic analysis re-
vealed that participants had a broad range of training experiences
that when evaluated thematically fell under 10 categories (no
subthemes were identified; see Table 1 for details).

Using training experiences in clinical work. Regarding how
participants use their training in their work with clients, partici-

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Table 1
Training Experiences

<table>
<thead>
<tr>
<th>Training experience</th>
<th>Study 1: Qualitative study (N = 9)</th>
<th>Study 2: Quantitative study (N = 142)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Graduate school course in diversity</td>
<td>9</td>
<td>100</td>
</tr>
<tr>
<td>Clinical supervision</td>
<td>5</td>
<td>55.56</td>
</tr>
<tr>
<td>Didactic training</td>
<td>9</td>
<td>100.00</td>
</tr>
<tr>
<td>Experiential activities</td>
<td>7</td>
<td>77.78</td>
</tr>
<tr>
<td>Exploring biases</td>
<td>5</td>
<td>55.56</td>
</tr>
<tr>
<td>Cultural immersion</td>
<td>3</td>
<td>33.33</td>
</tr>
<tr>
<td>Independent learning&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3</td>
<td>33.33</td>
</tr>
<tr>
<td>Consultation with professionals&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1</td>
<td>11.11</td>
</tr>
<tr>
<td>On the job training&lt;sup&gt;a&lt;/sup&gt;</td>
<td>2</td>
<td>22.22</td>
</tr>
<tr>
<td>Continuing education&lt;sup&gt;a&lt;/sup&gt;</td>
<td>2</td>
<td>22.22</td>
</tr>
</tbody>
</table>

<sup>a</sup> Postgraduate training experiences.

Participants reported that they maintained awareness of the implications of cultural factors in their work and awareness of their own limitations as clinicians. Participants also reported using their knowledge about specific cultural groups and also their knowledge base for the application of concrete—technical skills.

**Awareness.** Several participants (Participants 1, 4, and 7) indicated that they used their clinical training to ensure that they were aware of how cultural factors might impact symptom expression, diagnosis, and treatment. Other participants described how they used their training as a platform for recognizing what they didn’t know. For example, Participant 2 shared how his training helped him realize he didn’t have “all the answers.” He shared how he could ask questions in therapy with clients: “I’m not familiar with that [as an example]. What you just said about acculturation, what does that mean?” and he indicated that recognizing what he didn’t know helped him recognize when consultation was necessary.

**Knowledge.** All of the participants also shared how they used the information they learned in their training as a knowledge base about specific cultural groups. For example, Participant 5 stated:

I use my training to guide how I conceptualize a case. I meet with a client, and based on what I learn in the intake about them as an individual, I combine that with what I learned across my training experiences to formulate hypotheses about the issue the client is presenting with.

Participant 1 expanded on this notion of hypotheses as central to case formulation by sharing how, in the intake and assessment process, he develops hypotheses about how cultural factors might interplay with the presenting problem and then tests these hypotheses by doing more assessment. Finally, participants shared how they used their training as a mechanism for knowing how to apply concrete skills. For example, Participant 6 shared how she was trained to use genograms as part of the information-gathering process.

**Satisfaction with training and recommendations for improvement.** Some participants indicated that the training they received in graduate school was sufficient to prepare them for work with diverse clients (n = 3), whereas the majority of participants (n = 6) indicated that additional training was needed.

Specifically, participants reported a need for more “dialogue” and discussion about issues related to diversity (n = 1) and more concrete and technical training (n = 5). Participant 3 highlighted how her training in graduate school provided a good introduction. Participant 1 echoed this sentiment and indicated that

as an analogy, you can’t necessarily work on every single car that exists, so I wouldn’t be expected to develop mechanical competency across every single make and model of the car. They usually have a specialization. That doesn’t mean that they [mechanics] can’t work with a new car or new technology, but they’re going to focus their training based on what they’re going to work on. I think there’s a broad-based set of skills that are necessary and that are learned in graduate school—these are sufficient to begin the process. I think that the more expansive, more specific, training becomes relevant as you practice and identify an interest that might require you to develop competency that is more culturally specific.

This was reiterated by Participant 3, who indicated that more specialized training was necessary but that the type of training needed varies for each population and/or context and that as such, on-the-job training was ideal.

Regarding issues with training and recommendations for what would effectively prepare psychologists to work with diverse individuals, the majority of participants indicated that didactic training was important (n = 5), that training needed to be more concrete and technical (n = 5), and that the emphasis should be on individual differences as opposed to focused on categorical differences that are ascribed to different cultural groups (n = 3). For example, one participant shared how she believes there may be iatrogenic effects of learning categorically about ethnic groups because group membership does not necessarily indicate that the client ascribes to that group’s cultural values and beliefs. One participant captured the need for more skills-based training by sharing that he was left with the lingering question “So now what do I do with this?” Participant 6 elaborated further, stating that training needs to be more directive, and shared that this could be accomplished in the context of clinical supervision via the use of a one-way mirror or review of videotaped therapy sessions (with the inclusion of discussion of how cultural factors might be impacting the relationship, symptom expression, and so forth) via supervision.

Participants were asked what additional training they would find helpful or useful and to describe what training was necessary regarding cultural competency. Participants indicated that training should include experiential components (n = 3) and consultation with other experts in the field (n = 2). They also indicated that they needed training in how to get clients to engage (n = 1), that they needed one full year of working with a population to establish confidence—comfort in working with that population (n = 1), that continuing education was a necessary component of cultural competency training (n = 1), and that exposure to different cultural groups should constitute a part of training (n = 1). One participant indicated that training should be integrative, that is, integrated into all courses, and should begin at the very outset of doctoral work. Finally, one participant indicated that training should include reading about diversity beyond the discipline of psychology and should be more expansive and not just focused on ethnic differences, that is, privilege and microaggressions.
**How is cultural competence achieved?** As part of exploring the training needs of psychologists, participants were asked to share how they believed cultural competency was achieved (see Table 2). Participants clearly expressed the need for didactic training \((n = 6)\), but it was interesting that clinical experiences \((n = 7)\) were touted as more important than didactic training. It was also noted that cultural competency should always remain a work in progress, and the impossibility of having the knowledge base to be competent with all individuals from all cultures and subcultures was acknowledged. Thus, independent learning \((n = 4)\), consultation \((n = 3)\), and supervision \((n = 4)\) were also noted as important elements that contribute toward becoming culturally competent.

### Study 2

**Method**

After analyzing the qualitative data, we created a questionnaire to assess the generalizability of the results to a larger sample. Specifically, items were drafted based on the findings from the qualitative study. The initial draft of the questionnaire and the qualitative results were sent to two experts to obtain feedback and recommendations for improvement. Specifically, the experts were asked to provide input on the extent to which the items created mapped to the qualitative results. Their input was incorporated to create the final questionnaire.

**Measures.** The data analyzed in this study are part of the data-collection efforts for a larger study of which the goals were to identify how clinicians define cultural competency and sensitivity (Benuto, Singer, et al., 2018) and how clinicians engage in culturally competent clinical practice. Participant demographic information (i.e., ethnicity, sex, age, degree specialization, year doctoral degree was granted, and number of years licensed) was collected. Regarding training experiences, participants responded to six graduate school training activities and indicated whether they had had the training experience in graduate school (and specified whether they found it useful). If they indicated that they did not have the training experience in graduate school, they were asked to specify whether they wished they had had the experience or, conversely, whether they believed it would not have been useful. Participants were also asked how much training in cultural competency they had had since completing graduate school, indicated what training activities should constitute part of graduate school training in cultural competency, and rated how satisfied they were with the quantity and quality of training they received in graduate school using a 5-point Likert-type scale ranging from 1 (very dissatisfied) to 5 (very satisfied).

**Procedure.** The study recruitment period was open from March 2016 to January 2017. Participants were recruited via e-mail. Professional contacts of the lead researcher’s who were psychologists were invited via e-mail to participate in the study and were also asked to forward the invitation to any other professional contacts they had who met the inclusion criteria (i.e., being a psychologist and having experience working with cultural minorities); psychological associations and state boards were e-mailed and asked to forward the e-mail invitation to psychologists; and all internship sites listed in the Association of Psychology Post-doctoral Internship Centers (APPIC) were e-mailed and asked to forward the e-mail invitation to all past interns of the internship site’s.

**Participants.** After cases that had more than 5% missing data were omitted \((n = 133)\), the final sample consisted of 142 participants \((112\text{ female})\) ranging in age from 26 to 71 \((M = 40.53)\). The majority of the sample self-identified as non-Hispanic White \((79\%)\); 5% were African American, 5% were Asian–Pacific Islander, and 9% were Latina/o \((2\%\text{ self-identified as “Other”})\). Of the 142 participants, 50% reported having a PhD in clinical psychology, 37% had a PsyD (clinical psychology), and 11% reported having a PhD in counseling (an additional four participants did not endorse what type of psychologist they were but did indicate that they were a licensed practicing psychologist); 92% attended an APA-accredited program.

### Results

**Training experiences.** The majority of participants reported that as part of their graduate training they had had a graduate school course in diversity \((85\%)\), supervised clinical experience with diverse populations \((83\%)\), and didactic training about cultural competency \((82\%)\); the majority of participants \((76\%)\) also reported that exploring personal biases had constituted part of their training. To a lesser degree, participants reported that their training included experiential activities \((67\%)\) and cultural immersion \((38\%;\text{ see Tables 1 and 3 for a further breakdown of training experiences})\). Regarding postdoctoral training, 74% reported that they engaged in independent learning and received on-the-job training, 68% reported that the consulted with other professionals, and 61% reported that they obtained continuous education units.

**Satisfaction with training.** Participants were asked to rate how satisfied they were with the quantity and quality of training they received in graduate school using a 5-point Likert scale ranging from 1 (very dissatisfied) to 5 (very satisfied). The mean satisfaction rating across the sample was 4, which is equivalent to satisfied. Indeed, 115 \((81\%)\) participants stated they were satisfied or very satisfied with the quality of their training, and 113 \((80\%)\) stated that they were satisfied or very satisfied with the quantity of the training they received. Participants were also surveyed as to whether specific training experiences were helpful; the majority of participants (between 81% and 97%) reported that the training experiences they had had were helpful. Of those participants who endorsed that their training did not include the training experiences they were surveyed about, the majority (between 73% and 85%) of the sample indicated that they believed the training experience

### Table 2

<table>
<thead>
<tr>
<th>Learning experience</th>
<th>Study 1: Qualitative study ((N = 9))</th>
<th>Study 2: Quantitative study ((N = 142))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical experiences</td>
<td>7</td>
<td>77.78</td>
</tr>
<tr>
<td>Didactic</td>
<td>6</td>
<td>66.67</td>
</tr>
<tr>
<td>Independent learning</td>
<td>4</td>
<td>44.44</td>
</tr>
<tr>
<td>Clinical supervision</td>
<td>4</td>
<td>44.44</td>
</tr>
<tr>
<td>Consultation</td>
<td>3</td>
<td>33.33</td>
</tr>
</tbody>
</table>
would have been helpful (see Table 3 for a more detailed breakdown).

In addition to examining descriptive statistics regarding satisfaction, two linear regressions were computed to determine what training experiences (if any) predicted satisfaction with the quantity and quality of diversity training that participants had received in graduate school. A simple linear regression was calculated to predict satisfaction with quality of diversity training based on six predictors (diversity course, clinical experiences, didactic, independent learning, supervision, and consultation) using dummy coding. A significant regression equation was found, $F(6, 133) = 2.32, p < .05$, with an $R^2$ of .091. As can be seen in Table 4, supervision had a significant positive regression weight ($\beta = .242$), indicating that supervision was the only significant predictor of the quality of diversity training. When satisfaction with the quantity of diversity training received was the outcome variable, the inclusion of both supervision ($\beta = .202$) and exploration of personal biases ($\beta = .243$) had a significant positive regression weight, indicating that supervision and exploration of personal biases were the only two significant predictors of the satisfaction of quantity of diversity training (see Table 5). The whole regression equation was significant, $F(6, 133) = 2.58, p < .05$, with an $R^2$ of .091.

Achieving cultural competence and ideal training. Participants were provided with a list of training experiences and asked to check the experiences they thought were needed to achieve cultural competence; participants endorsed that cultural competency is achieved via clinical experiences, didactic training, supervision, independent learning, and consultation (see Table 2 for additional details). A total of 85% of the participants endorsed all five options as part of how competency is achieved, with clinical experiences being the most commonly endorsed. When asked “How important are each of the following training experiences are for achieving cultural competency?”—rated on a 3-point Likert-type scale ranging from 1 (Not at all) to 3 (A great deal)—the majority of participants selected A great deal for the training experiences listed (see Table 6 for a detailed breakdown).

### General Discussion

This study offers an updated overview of cultural competency—training experiences using psychologists as participants. The majority of the research on this topic was over 20 years old, and given the shifts that have occurred in the field, the advent of the APA’s multicultural guidelines (APA, 2002, 2017b), and the demarcation of profession-wide competencies (APA, 2017a), a more contemporary understanding of the training experiences and preferences of psychologists was needed. Findings from this study revealed that psychologists have a wide array of training experiences and are satisfied with the training they received.

### Training Experiences

The results from this study indicate that the process for training doctoral students to become culturally competent continues to evolve. Approximately 41% of programs in the late 1970s (Bernal & Padilla, 1982) included a diversity-related course, compared with 62% in 1990 (Bernal & Castro, 1994). Although we did not look at programs (instead we surveyed individual psychologists), it is noteworthy that 85% of our sample reported having taken a graduate school course in diversity. This converges with findings that indicate that the majority of training programs offer a diversity course to their students—Hills and Strozier (1992) found that 87% of programs offer a diversity course—and that the most commonly

### Table 3

<table>
<thead>
<tr>
<th>Training experience</th>
<th>Had this training experience</th>
<th>Experience was helpful</th>
<th>Experience was not helpful</th>
<th>Did not have this training experience</th>
<th>Experience would have been helpful</th>
<th>Experience would not have been helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversity course</td>
<td>120 (85)</td>
<td>99 (83)</td>
<td>21 (18)</td>
<td>22 (15)</td>
<td>18 (82)</td>
<td>4 (18)</td>
</tr>
<tr>
<td>Clinical supervision</td>
<td>118 (83)</td>
<td>114 (97)</td>
<td>4 (3)</td>
<td>24 (17)</td>
<td>19 (79)</td>
<td>5 (21)</td>
</tr>
<tr>
<td>Didactic training</td>
<td>116 (82)</td>
<td>94 (81)</td>
<td>22 (19)</td>
<td>26 (18)</td>
<td>22 (85)</td>
<td>4 (15)</td>
</tr>
<tr>
<td>Experiential activities</td>
<td>95 (67)</td>
<td>78 (82)</td>
<td>17 (18)</td>
<td>47 (33)</td>
<td>39 (83)</td>
<td>8 (17)</td>
</tr>
<tr>
<td>Exploring biases</td>
<td>107 (76)</td>
<td>95 (89)</td>
<td>12 (11)</td>
<td>34 (24)</td>
<td>28 (82)</td>
<td>6 (18)</td>
</tr>
<tr>
<td>Cultural immersion</td>
<td>53 (38)</td>
<td>49 (92)</td>
<td>4 (8)</td>
<td>88 (62)</td>
<td>66 (75)</td>
<td>22 (25)</td>
</tr>
</tbody>
</table>

Note. $N = 142$. Data represent $n$ values, with percentage in parentheses.

### Table 4

Regression Results for Satisfaction With Quality of Training

<table>
<thead>
<tr>
<th>Training experience</th>
<th>$b$</th>
<th>$SE$</th>
<th>$\beta$</th>
<th>$t$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversity course</td>
<td>-.401</td>
<td>.274</td>
<td>-.15</td>
<td>-1.465</td>
</tr>
<tr>
<td>Supervision</td>
<td>.622</td>
<td>.242</td>
<td>.242</td>
<td>2.570*</td>
</tr>
<tr>
<td>Didactic</td>
<td>.081</td>
<td>.26</td>
<td>.032</td>
<td>.31</td>
</tr>
<tr>
<td>Experiential activities</td>
<td>.125</td>
<td>.196</td>
<td>.061</td>
<td>.635</td>
</tr>
<tr>
<td>Exploration of biases</td>
<td>.299</td>
<td>.228</td>
<td>.132</td>
<td>1.311</td>
</tr>
<tr>
<td>Cultural immersion</td>
<td>-.034</td>
<td>.179</td>
<td>-.017</td>
<td>-.19</td>
</tr>
</tbody>
</table>

Note. $R^2 = .095$. $^*p < .05$.

### Table 5

Regression Results for Satisfaction With Quantity of Training

<table>
<thead>
<tr>
<th>Training experience</th>
<th>$b$</th>
<th>$SE$</th>
<th>$\beta$</th>
<th>$t$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversity course</td>
<td>-.278</td>
<td>.276</td>
<td>-.103</td>
<td>-1.008</td>
</tr>
<tr>
<td>Supervision</td>
<td>.524</td>
<td>.244</td>
<td>.202</td>
<td>2.150*</td>
</tr>
<tr>
<td>Didactic</td>
<td>-.005</td>
<td>.261</td>
<td>-.002</td>
<td>-.019</td>
</tr>
<tr>
<td>Experiential activities</td>
<td>-.089</td>
<td>.197</td>
<td>-.043</td>
<td>-.453</td>
</tr>
<tr>
<td>Exploration of biases</td>
<td>.555</td>
<td>.23</td>
<td>.243</td>
<td>2.413*</td>
</tr>
<tr>
<td>Cultural immersion</td>
<td>.068</td>
<td>.181</td>
<td>.034</td>
<td>.377</td>
</tr>
</tbody>
</table>

Note. $R^2 = .091$. $^*p < .05$. 
used curricular methods in clinical training are didactic in nature (Benuto, Casas, et al., 2018). Our sample was diverse regarding types of training programs attended (i.e., program type [PsyD vs. PhD], private vs. public school), yet we found fairly consistent training experiences across our participants (the majority of them endorsed having had the same experiences), suggesting that there may be less variability across training programs than was previously documented (Pieterse et al., 2009).

Satisfaction With Training

Overall, participants in this sample reported being satisfied with their training experiences. This was observed in the direct examination of the questions asked of participants regarding how satisfied they were with the quantity and quality of their training and also via the questions that asked about specific training experiences and whether they found them helpful; supervision was consistently found to predict satisfaction with training. Additionally, the item with the highest endorsement regarding what constitutes ideal training was exploration of personal biases—the majority of participants reported this constituted part of their training experience, indicating that the most preferred training experience was being had by trainees.

Our findings suggest that training has improved because earlier studies revealed that many clinicians were unsatisfied and felt ill-equipped to treat diverse client populations (Anhalt et al., 2003; Iwamasa, 1996; Mintz, Bartels, & Rideout, 1995), felt the training received was not sufficient (Iwamasa, 1996; Mintz et al., 1995), and assigned low efficacy ratings to their programs’ ethnic minority education (Toia, Herron, Primavera, & Javier, 1997).

Implications for Training

Although participants were highly satisfied with existing training paradigms, there remains room for improvement. The results from this study can be used to guide improved training efforts for psychologists.

Training and client outcomes. Although our participants reported high levels of satisfaction with the training they received, whether clinicians’-trainees’ satisfaction translates to better outcomes with diverse clients warrants further exploration. Although a positive relationship between multicultural trainings and self-reports of multicultural competency has been found (Castillo, Brossart, Reyes, Conoley, & Phoummarath, 2007; Malott, 2010; Manese, Wu, & Nepomuceno, 2001; Reynolds & Rivera, 2012; Vereen, Hill, & McNeal, 2008), additional research exploring the relationship between cultural competency—training satisfaction and skills development is greatly needed. Indeed, training satisfaction may indicate better performance and confidence for the clinician or, conversely, training satisfaction may be unrelated to skill set but may bolster self-perceptions skills (which may ultimately be harmful if the trainee does not seek supervision). Nonetheless, satisfaction with supervision is an indicator that supervision may have had a positive impact on the supervisee’s functioning and well-being (Livni, Crowe, & Gonzalvez, 2012) and thus represents an important element of the training process.

Supervision as a training mechanism. Because supervision was predictive of satisfaction with training, it may represent the best forum for teaching clinical trainees how to work with diverse clients. This fits with both the evident need for skills-based training and training that emphasizes and appreciates intersectionality and the idiographic nature of culture. In this study, supervision may have predicted satisfaction with training because supervision focused on cultural factors likely encompasses a number of training objectives, that is, reflection on biases, didactic training, working with diverse clients, and so forth.

Skills-based training. Several of the participants expressed a desire for more concrete and technical training. This coincides with a concern that multicultural education has focused more on acquiring knowledge about different groups than on acquiring and developing skills for working with diverse clients (Carter, 2001). Indeed, the majority of training outcome studies have utilized beliefs, attitudes, knowledge, and awareness as outcome variables, and even when skills are used as an outcome variable, they tend to be self-reported skills (Benuto, Casas, et al., 2018). Although the impartation of knowledge within doctoral training programs in undeniably important, the results from this study indicate that training in the arena of cultural competency also needs to include skills-based training.

In clinical and counseling psychology as a profession, there is ample emphasis on didactic and lecture-based courses. However, there is at a minimum an equal (and arguably a more substantial) focus on active learning via practicum and supervision. The most recent APPIC survey indicated that, on average, students who apply for internship possess 602 hr of doctoral intervention and
164 hr of doctoral assessment (APPIC, 2015). Students also complete a yearlong internship, and most states require postdoctoral hours before a psychologist can become licensed. Although it is evident that psychology as a profession values a combination of active and didactic learning, the cultural competency literature has indicated that passive models for training are used most of the time (Benuto, Casas, et al., 2018). Thus, the incorporation of skills-based cultural competency training is necessary, ideally within the context of both didactic training and practicum. It is also noteworthy that in this study we found that supervision predicted satisfaction with training (albeit the effect size was small), again highlighting the importance of training experiences beyond those that are purely didactic. Participants’ suggestions that training should be nested or occur in conjunction with actual clinical work (i.e., practicum and supervision) converge with the recommendations of researchers that cultural competency training be incorporated into all aspects of trainings, such as research, practicum, and coursework (Kaplan, 2001; Terrell-Powell, 1999). Fortunately, resources that are practical and applied in nature and that are designed to help clinicians with psychological service delivery (e.g., Benuto, 2013a, 2013b, 2017; Benuto & Leany, 2017) have become available and represent one mechanism that supervisors can use to help practicum trainees with skill development. Despite the availability of these resources, it is noteworthy that there remains a lack of research on training elements and service delivery.

Emphasis on the idiographic nature of clients. The other recommendation for improving cultural competency—training experiences regards didactic training. In the results from both Study 1 and Study 2 there was an apparent appreciation that intersectionality is hugely prevalent and that working with diverse populations is largely context-dependent. Indeed, participants’ appreciation that the saliency of certain cultural variables will be context-dependent and the role of intersectionality in an individual’s cultural identity was evident in our sample. This finding was not surprising, given that the extant literature has highlighted how various cultural factors (i.e., economic status, immigration status, ethnicity; Benuto & Bennett, 2015) can intersect and impact service delivery. This is also congruent with the concept of cultural humility, which takes into account the fluidity of culture (Fisher-Borne, Cain, & Martin, 2015) in a way that historical paradigms of cultural competency do not. Supervisors (and to a certain extent professors providing didactic training) may wish to emphasize intersectionality and how various cultural factors can interplay with diagnoses, assessment, and treatment strategies.

Conclusions, Limitations, and Future Directions

Although this study provides new and needed insight on the training experiences of psychologists, it is not without its limitations. Although qualitative and self-report research allows for the collection of rich data, it assumes participants are being honest about their training experiences, are not engaging in social desirability, and are able to accurately recall their experiences. Given the generally positive views of the participants’ in our sample, social desirability or a ceiling effect may have been present. Another possible limitation is self-selection bias, with those who had positive training experiences being more likely to participate in our study. Along these lines, there was a relatively low response rate, given how many venues for recruitment were solicited to share the participation request. Furthermore, the homogeneity of the demographic characteristics of the sample issues of generalizability arises. In a related vein, given our decision to limit the sample to clinical and counseling psychologists, it is unknown to what degree our results generalize to other helping professions. Finally the effect size was small in the multiple regressions we ran; only 10% of the variance in satisfaction with quality of diversity training scores was predicted by the variables examined. Future research is needed to determine more fully what truly predicts satisfaction. Additionally, future researchers should investigate the relationship between training and client outcomes, supervision should be considered a central element of training culturally competent practitioners, skill development should be emphasized in training contexts, and training should include an appreciation for the idiographic and intersectional nature of being human.

References

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