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Development of an Online Training Module for the Shifting Cultural Lenses Model

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DEVELOPMENT OF AN ONLINE TRAINING MODULE FOR THE SHIFTING

CULTURAL LENSES MODEL

by

Gabriela A. Nagy

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ABSTRACT
DEVELOPMENT OF AN ONLINE TRAINING MODULE FOR THE SHIFTING
CULTURAL LENSES MODEL

by

Gabriela A. Nagy

The University of Wisconsin-Milwaukee, 2014
Under the Supervision of Shawn Cahill, Ph.D.

There is a growing need for mental health professionals to provide evidence-based

practices in a culturally competent manner, in part, due to the current and projected

increases in racial and ethnic minority and immigrant populations in the United States

and barriers to mental health services for those populations. In light of many barriers to

access to mental health services for underserved populations, one crucial factor is cultural

incompetence of providers. This study sought to address the mental health imperative to

improve the culture competence of clinicians by creating a cultural competence training

for health professionals using a behavioral model and methodological framework that

would be effective, scalable, efficient, and cost and time-effective. The present study

aimed to 1) develop a cultural competence training module from an existing model, and

2) evaluate preliminary efficacy, feasibility and acceptability of the cultural competence

training module using a randomized controlled trial (RCT) that compared a standard

therapy training (Behavioral Activation) with that therapy training plus the cultural

competence training. The training took place bi-weekly over 18 weeks in 6 one-hour and

a half sessions. Training content was delivered online and through self-paced materials.

Study findings are presented as preliminary and exploratory. Results overall were

promising suggesting that the trainings provided significant increases in cultural

competence skills as evidenced by the cultural competence subscale of the Behavioral

Activation Skills Assessment (BASA) and the skills subscale of the Multicultural

Awareness, Knowledge and Skills Survey (MAKSS) for participants that underwent the

cultural competence training. However, results on the BASA evidenced a slightly

smaller, yet significant improvement in cultural competence for participants who did not

participate in the cultural competence training. Lastly, results on the other BASA scales

indicate that participants significantly improved in their BA competency at similar rates

as those found in previous pilot studies.

This master's thesis is dedicated to *mi familia* and *RJK*,

without whom none of this would have been possible.

Thank you for providing me with the inspiration and

motivation to reach this achievement.

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As it relates to psychotherapy, culture matters (Hoffman, 2013; López, Garro & Kopelowicz, 2012; U.S. Department of Health & Human Services, 2001). Over the past several decades, the helping professions have taken a special interest in multicultural issues as they relate to psychotherapy, testing, research, and teaching. As such, there has been a great deal of support behind the multicultural psychology movement. However, there is still work to be done with regards to increasing our cultural competence skills as mental health professionals. Online training of mental health professionals in cultural competence is one pathway to targeting this possible barrier to access. This project hopes to take preliminary steps to reduce mental health disparities through development and dissemination of a training package for mental health professionals to sensitively extend treatments to individuals from historically underserved populations and/or from distinct cultural backgrounds from their own.

Barriers to Mental Health Care Access for Racial and Ethnic Minorities in the United States

Differential utilization of mental health services. The ramifications of a complicated United States (U.S.) history, replete with racial inequalities, are such that there are documented disparities in mental health service utilization between racial and ethnic groups. Some research has shown that Caucasians are more likely to use outpatient mental health services compared to African Americans, when eligible for Medicaid (Snowden & Thomas, 2000); receive more mental health services in general than African Americans and Hispanics (Cook, McGuire & Miranda, 2007); and are less likely to be hospitalized than African Americans and Native Americans (Snowden & Cheung, 1990). Alvidrez (1999) reported that Caucasian women are much more likely than ethnic women

to have made a mental health visit in the year prior to the research being published. Moreover, African Americans have significantly higher odds of being diagnosed with schizophrenia than Caucasians in lower poverty areas and are at higher risk for involuntary psychiatric commitment than any other ethnic group (Chow, Jaffee & Snowden, 2003). African Americans and Latinos in low-poverty areas are more likely to be referred for commitment by a law enforcement official than any other ethnic groups (Chow, Jaffee & Snowden, 2003). In regards to counseling, minority students are more likely to underutilize counseling services (Brinson & Kottler, 1995).

Health disparities research has proposed several explanations for the phenomenon of low utilization of mental health care services and low retention, especially in racial and ethnic minorities, including lack of insurance coverage and unstable coverage (Commonwealth Fund, 2004); differential stigma such that members of minority groups bear higher stigma regarding mental illness (Snowden & Cheung, 1990; Gary, 2005); lack of access to mental health resources (Snowden & Cheung, 1990); and bias on the part of gatekeepers (Snowden & Cheung, 1990).

Of interest for this manuscript, are factors related to cultural (in) competence as those factors taken together could prove to be a barrier to mental health services for many. Some counseling literature has attributed mental health disparities in part to a lack of counselors who value and respect cultural differences and who are not sensitive to particular cultural differences (Brinson & Kottler, 1995). Moreover, Scheppers et al. (2006) proposed the following possible barriers to treatment: lack of cultural knowledge on the part of the provider, denying the salience of religion and spirituality in treatment, ignoring the existence of parallels in sets of beliefs and practices, ethnic mismatching,

discourteous care, stereotypical attitudes towards minorities, and authoritative communication styles of providers.

As racial and ethnic minority populations increase in the U.S., the differential utilization of mental health services might become more salient if current health disparity trends are not reversed. Given projected trends, mental health service providers will inevitably experience increases in diversity of the clients that seek services. Thus, it will become important for provision of mental health services to critically take into account the cultural contexts of each individual being served.

Treatment barriers for depression. In the U.S., the yearly prevalence rate is 15 million for major depressive disorder and 21 million for mood disorders (e.g., major depressive disorder, dysthymic disorder, and bipolar disorder; Kessler, Chiu, Demler & Walters, 2005). This represents the leading cause of disability for individuals ages 15 to 44 (WHO, 2004) and provides a $44 billion annual cost to society (Antonuccio, Thomas & Danton, 1997; Wang, Simon & Kessler, 2003; Greenberg, Kessler, Birnbaum, Leong, Lowe, Berglund, Corey-Lisle, 2003). In 2008, the World Health Organization identified depression as the third most burdensome disease in the world and projected that by 2030 it will become the most burdensome disease in the world, across all individuals and all countries (WHO, 2008). Worldwide, of all people affected by depression, fewer than half of those affected receive effective treatment (WHO, 2012). Some proposed barriers to access for depression treatment include lack of resources, lack of trained providers, and social stigma (WHO, 2012). Taken together, these data underscore the need for dissemination of efficacious treatments delivered by mental health professionals.

Furthermore, if depression treatments are to be disseminated on a large scale, they should incorporate some discussion of culture.

   Underrepresentation of racial and ethnic minorities in research. In addition to disparities in mental health services utilization, underrepresentation of racial and ethnic minorities in clinical research could be in it of itself a barrier to access. Historically, psychology research has not been sufficiently inclusive of underrepresented and diverse populations (Trimble, Stevenson & Worell, 2003). For example, many researchers have proposed that having a homogenous sample increases the internal validity of research findings, resulting in the exclusion of minorities from research samples (Sue, 1999). The concern, however, is that such homogeneous internally valid studies may not be particularly meaningful to minority populations, not represented in the original samples, to whom policy makers may want to disseminate the treatment (Sue, 1999). If this is the case, individuals belonging to racial and ethnic minority groups would be disadvantaged in the type of mental health services available to them that are effective.

Increasing Attention to Culture in Psychotherapy

   Diversification of the United States. The U.S. is quickly diversifying and becoming a society that is multiracial, multicultural, and multilingual (Sue & Sue, 1990). As per census data, the total U.S. population increased 9.7 percent from 2000 (281.4 million people) to 2010 (308.7 million people; Ennis, Rios-Vargas, & Albert, 2011). Furthermore, more than half of the total U.S. population growth was due to an increase in the Hispanic population between 2000 (35.3 million people) and 2010 (50.5 million people) – now comprising 16 percent of the total population and the largest racial and ethnic minority group (Ennis, Rios-Vargas, & Albert, 2011). The definition for Hispanic

or Latino used by the U.S. census "refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race" (Ennis, Rios-Vargas, & Albert, 2011). The terms Hispanic and Latino are used interchangeably. The Black population increased 15.4 percent from 2000 (36.4 million people) to 2010 (42 million people), making it the second largest racial and ethnic minority group at 13.6 percent of the total population (Rastogi, Johnson, Hoeffel, & Drewery, 2011). As defined by the 2010 U.S. Census, the terms Black or African American "refer to a person having origins in any of the Black racial groups of Africa" (Rastogi, Johnson, Hoeffel, & Drewery, 2011). The terms Black and African American are used interchangeably in this paper. Those identifying as Asian composed 5.6 percent of the total population in 2010 (17.3 million people) – a 46 percent increase from 2000 (11.9 million people) thus making it the not only the third largest racial and ethnic minority group, but also the fastest growing (Hoeffel, Rastogi, Kim, & Shahid, 2012). The 2010 U.S. Census defines Asian as "a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam" (Hoeffel, Rastogi, Kim, & Shahid, 2012). The fourth largest minority group, the Indian and Alaska Native population, had a 26.7 percent increase from 2000 (4.1 million people) to 2010 (5.2 million people), now comprising 1.7 percent of the total population (Norris, Vines, & Hoeffel, 2012). Lastly, in 2010 1.2 million people in the U.S. identified as Native Hawaiian and Other Pacific Islander (NHPI), either alone or in combination with one or more other races – and a 40 percent increase from 2000 (874,000 people; Hixson, Hepler, & Kim, 2012), making its growth three times faster than the total U.S. population. The

definition used by the 2010 U.S. Census cites that an American Indian or Alaska Native
"refers to a person having origins in any of the original peoples of North and South
America (including Central America) and who maintains tribal affiliation or community
attachment" (Norris, Vines, & Hoeffel, 2012).

With the current trends, it is projected that total U.S. population will increase to
438 million in 2050 and that 82 percent of that increase will be due to immigrants
arriving from 2005 to 2050, which is equal to 117 million people added to the population
made up of immigrants and their U.S.-born children or grandchildren (Passel & Cohn,
2008). The Hispanic population, the largest minority group in the U.S., is projected to
triple in size by 2050 making it 29 percent of the total population (Passel & Cohn, 2008).
Furthermore, the Caucasian population is projected to become a numerical minority
group representing 49 percent of the total population by 2050 (Passel & Cohn, 2008).

including culture to psychology to better serve our consumers. Moving
forward, mental health providers, researchers and policy makers will inevitably be faced
with trends that bring the issue of culture in psychology to the forefront. Hall (1997)
proposed that as the U.S. becomes a more diverse nation, the field of psychology ought to
adjust in training of mental health professionals, research and clinical work to keep up
with the demands or risk ethical, economic and professional problems (Hall, 1997).
These problems could include providing ineffective services, providing low quality
education, harming through research, and not acting as advocates (Fouad & Arredondo,
2007). Racial and ethnic diversity changes will impact the populations that mental health
professionals service, including students, client populations, research participants, and
organizational communities (Fouad & Arredondo, 2007). Thus, the importance of

recognizing culture has been stated strongly by many authors. Being culturally sensitive, relevant and competent has the potential to produce the best possible treatment outcomes and retention rates, as treatment would be tailored to the client. Tharp's (1991) Cultural Compatibility Hypothesis in psychotherapy research posits "treatment is more effective when compatible with client culture patterns" (p. 802). In a pragmatic sense, cultural competence is a crucial skill for mental health professionals to possess as doing so will allow providers to be in better touch with the needs of those served and the marketplace, provide valuable services and uphold the principles of equity and fairness (Fouad & Arredondo, 2007).

Definitions of culture and related terms. Though many recognize the importance of culture in psychology, and specifically in psychotherapy, there are no agreed-upon definitions for the constructs of culture and related terms. Definitions historically have equated race, ethnicity and national origin with culture. For example, Betancourt and López (1993) cited the example of surveys and research instruments wherein individuals have to circle one or a combination of categories including race, ethnicity and national origin (e.g., Asian, American Indian, Black, Latino, and White) and findings are extrapolated to explain differences between groups. Especially problematic is the fact that great heterogeneity can be found between individuals belonging to specified ethnic groups or individuals from a given national origin (López, Kopelowicz & Carñive, 2002) whereby members from the same ethnic group might have different cultural values and beliefs from each other or members from distinct ethnic groups might share similar cultural values and beliefs (Clark, 1987; Helms, 1997).

In 2002, the American Psychological Association (APA) approved the *Guidelines*

on Multicultural Education, Training, Research, Practice and Organization Change for Psychologists (APA, 2003) – a guiding document of competencies related to seriously incorporating multicultural factors in clinical practice. This guiding document included important definitions related to multiculturalism, backed by the APA. The APA (2003) defined *culture* as "belief systems and value orientations that influence customs, norms, practices, and social institutions, including psychological processes (language, caretaking practices, media, educational systems) and organizations (media, educational systems)" (p. 380).

Though this document represents a valuable contribution in the field of multicultural psychology, there are several considerations to keep in mind. López (2003) proposed "the focus on beliefs, norms, values and shared meaning situates culture within the individual" (p. 427) and do not sufficiently take into consideration the social world. Thus, López and Guarnaccia (2000) conceive of culture as related to both the individual (psychological) and the social world. In addition to not giving adequate attention to the social world, these types of definitions reduce culture to a static entity rather than one that changes in response to a changing social world (López & Guarnaccia, 2000). López and Guarnaccia (2000) explain that culture is "a dynamic and creative process, some aspects of which are shared by large groups of individuals resulting from particular life circumstances and histories." Moreover, López and Guarnaccia (2000) explain that value-based definitions of culture place individuals as receiving culture from society, yet do not take into account an individual's ability to negotiate their cultural world.

In addition, the definition of culture as that which includes group-specific social norms, beliefs and values which are held and transmitted across generations (Betancourt

& López, 1993), has been criticized because (a) it excludes some groups (e.g., LGBTQ) as it cannot meet all aspects of the definition (i.e., cannot transmit across generations), (b) it is too inclusive because it would include groups (e.g., Jewish Americans and Irish Catholics) that the movement is not aimed to include, (c) it calls into question whether some other groupings are warranted (e.g., gender, religious groups, military), (d) it includes nearly everyone, and (e) the groups traditionally used are problematic because they are too large and are used out of convenience (O'Donohue & Benuto, 2010). The definition does not consider the great heterogeneity within individuals that belong to any ethnocultural group (López, Kopelwicz & Carñive, 2002).

For the purposes of our paper, we adopt a socially-based definition of culture by Lakes, López and Garro (2006), which defines culture as that which is at stake (or what matters) in local, social worlds. Lakes, López and Garro's (2006) definition draws from Kleinman's work on cross-cultural psychiatry. Kleinman's definition of experience, which is grounded in a medical anthropological perspective that keeps in mind the social nature of experience, rather than something that resides solely within the individual (López, Kopelowicz & Carñive, 2002). Kleinman (1995) proposed an alternative contextual definition whereby culture is socially grounded, derived from experience (Kleinman, 1995) and signifies what matters in one's local, social and moral world (Lakes, López and Garro, 2006). A strength of understanding culture as a process is that it accounts for the heterogeneity that exists between individuals from particular ethnocultural groups and the similarities that reside among members from distinct ethnocultural groups (López, Kopelowicz & Carñive, 2002). López and colleagues have used this conceptualization of experience to define culture in their development of the

Shifting Cultural Lenses (SCL) model, discussed below, and propose that a clear conceptualization of culture will ensure that interventions are congruent with the local cultural context.

Central to the discussion of culture is mention of race and ethnicity. The temptation to closely link culture to race and ethnicity is understandable as there are marked disparities in mental health care based on race and ethnicity. The APA (2003) defined, *race* as the "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" (p. 380). Further, it defined *ethnicity* as "the acceptance of the group mores and practices of one's culture of origin and the concomitant sense of belonging" (APA, 2003, p. 380). However, it could be problematic to equate culture with race and ethnicity. López and Guarnaccia (2000) propose that while it could be important to know that someone belongs to a particular racial and ethnic group as it may provide guidelines for specific cultural issues in psychopathology, it may be problematic also as it does not necessarily imply that a member of said group adheres to all cultural values and practices of the group.

Another concept closely linked with culture is *multiculturalism*. According to the APA, multiculturalism encompasses various domains that make up the construct of culture including the "broad scope of dimensions of race, ethnicity, language, sexual orientation, gender, age, disability, class status, education, religious/spiritual orientation, and other cultural dimensions" (APA, 2003, p. 380). Stemming from this definition, it is understood that each of us is a multicultural being who has been raised in a distinct cultural context. As individuals, we are shaped by our experiences by belonging or

identifying with various identities that sometimes interact with each other (APA, 2000).
When critically considering culture, as it relates to psychotherapy, we must take into
account that individuals hold multiple identities beyond race and ethnicity that have the
potential to shape the social world, and in turn, culture.

Increasing the Inclusion of Culture in Psychotherapy

        Cultural adaptations. In response to the question that has remained for several
decades about the role of culture in psychotherapy, cultural adaptations emerged (Bernal
& Domenech Rodriguez, 2012). *Cultural adaptation* is defined as "the systematic
modification of an evidence-based treatment (EBT) or intervention protocol to consider
language, culture, and context in such a way that it is compatible with the client's cultural
patterns, meanings, and values" (Bernal, Jimenez-Chafey & Domenech Rodriguez, 2009,
p. 362). Cardemil, Moreno, and Sanchez (2011) explain that there is no agreed-upon way
to culturally adapt treatments. López, Kopelowicz and Carñive (2002) propose that two
approaches have been used to culturally adapt well-established treatments. The first is to
take existing interventions and use them with culturally diverse groups and evaluate how
well they function with the population (López, Kopelowicz & Carñive, 2002). The
second is to change the existing intervention to be more explicitly attuned to cultural
factors and evaluate efficacy and effectiveness (López, Kopelowicz & Carñive, 2002).
Bernal and colleagues (Bernal, Bonilla, & Bellido, 1995; Bernal & Sáez-Santiago, 2006)
several proposed cultural factors to keep in mind when culturally adapting treatments: (1)
the language of the intervention, (2) metaphors to be used in the delivery of the
intervention (3) cultural knowledge about client values, customs, and traditions, (4)
recognition and consideration of additionally contextual influences in the client's life, (5)

the client-therapist relationship, (6) conceptualization and communication of the theoretical approach to treatment, (7) agreement on goals of treatment, and (8) methods for reaching goals of treatment.

 Support for cultural adaptations. The field of cultural adaptation attempts to bring together the evidence-based movement and the multicultural movement in the hopes of providing psychotherapy that is based on both research and considers culture in a way that is thoughtful, systematic and documented (Bernal & Domenech Rodriguez, 2012). Culturally adapted treatments "take into account the cultural, linguistic, and socioeconomic context of diverse ethnocultural groups" (Bernal, Jimenez-Chafey & Domenech Rodriguez, 2009, p. 361). It has been proposed that service utilization, length of treatment, and client's satisfaction could be increased when [Hispanic] customs, values, and beliefs are incorporated into the selection, modification or development of psychosocial therapies (Sue, Zane & Young, 1994). Seeing the growing need for therapies suitable for individuals from minority groups, some argued that EBTs should be adapted for various cultural groups. The rationale for cultural adaption of EBTs is that many ethnocultural groups do not share the same language, cultural values or both of EBTs that were developed within a particular linguistic and cultural context (Bernal, Jimenez-Chafey & Domenech Rodriguez, 2009).

 Arguments for cultural adaptations include the singularity-specificity argument, the ecological validity argument, the evidentiary argument, the feasibility-practicality argument, the science argument, and ethical argument (Bernal, 2009). The singularity-specificity argument posits that treatments need to account for specific group culture (Bernal, 2009) and should be tailored to specific cultural contexts (Hall, 2001). Hall

(2001) noted that interdependence, spirituality, and discrimination are constructs that were found to differentiate minority populations from majority populations in the U.S. (Bernal, 2009) and could be points of treatment adaptation for ethnocultural groups (ECGs; Bernal, Jimenez-Chafey & Domenech Rodriguez, 2009).

The ecological validity argument talks to the need for increased congruence between the experience of the client's ethnocultural world and the properties of a particular psychotherapy which are assumed by the therapist (Bernal, Jimenez-Chafey & Domenech Rodriguez, 2009) and when methods are enacted to reach this end, these are instances of cultural sensitivity (Bernal et al., 1995). Further, the ecological validity argument comes into play when one considers that most psychotherapy research is conducted with White, educated, verbal and middleclass patients and thus findings may not generalize to other ethnocultural groups such as ethnic minority communities (Bernal & Scharrón-del Río, 2001; Bernal, Jimenez-Chafey & Domenech Rodriguez, 2009).

The evidentiary argument points to findings that suggest that there is little evidence that shows that EBTs are effective for minority populations (Bernal, 2009) and thus the field should be considering culture, race, and ethnicity (e.g., Bernal et al., 1995; Canino & Alegria, 2008; Hall, 2001; Miranda, Bernal, Lau, Kohn, Hwang, & LaFromboise, 2005; Trimble & Mohatt, 2002; Sue, 1998). Some of that evidence highlights the need for adaptation of EBTs in regards to service use, treatment preferences, and beliefs about health (Cauce et al., 2002). The feasibility-practicality argument proposes that cultural adaptations are needed because racial and ethnic minority populations are rising and will soon be the numerical majority, adaptations to EBTs improve engagement and retention, it is likely that these treatments would be more

sustainable if they were culturally congruent and community grounded, and EBTs as is may not be relevant for minority patients (Bernal, 2009).

The science argument highlights that cultural adaptations will enable tests of efficacy to the extent that they could evaluate how well EBTs generalize and allows for tests of moderators and mediators (Bernal, 2009). Lastly, the ethical argument simply posits that the field of psychotherapy has an ethical responsibility to offer the best treatment possible by considering the values, culture, and context of their patients (Trimble & Mohatt, 2002).

Concerns with cultural adaptations. Given that for so long psychotherapy did not pay enough attention to cultural factors and were employed in a "one-size-fits-all (cultures)" approach, the efforts of those who proposed and developed cultural adaptations should be not only acknowledged, but also honored. The cultural adaptations movement is an important development in seriously including culture in psychotherapy as it begins to take tangible steps to provide culturally-relevant treatments. Yet, despite the literature citing that cultural adaptations work (e.g., Benish, Quintana & Wampold, 2011; Smith, Domenech Rodriguez & Bernal, 2011; Griner & Smith, 2006; Huey & Polo, 2008) and a lack of data supporting the efficacy of "unadapted" EBTs for minority populations (e.g., Chambless, Sanderson, Shoham, Bennett Johnson, Pope, Crits-Cristoph et al., 1996; Hall, 2001), there are several considerations to have in mind while discussing the cultural adaptation model including: feasibility of adapting EBTs for specific groups, potential for segregation, considerations about the best use of resources, questions about the integrity of the treatments, a potential to further a one-size-fits-all approach to psychotherapy, and consider to what extent they are warranted.

Adapting established treatments to certain populations becomes problematic as race and ethnic categories, as conceptualized by the U.S. census, encompass so many subgroups who arguably do not share similarities beyond skin color or familial ancestry. For example, the terms Hispanic or Latino encompass all persons originating from Spanish-speaking countries in the Americas (from 19 census-recognized nations). Even more confusing is that a Latino, as per the census, could be of any race – White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander (Ennis, Rios-Vargas & Albert, 2011). Thus, adapting an evidence-based treatment for "Latino culture" becomes a very difficult, if not impossible task as the category encompasses so many subgroups. Furthermore, it is not feasible to make a culturally adapted treatment under which millions of people will fit as attempting to do so would involve stereotyping and discounting important individual differences within a culture. O'Donohue and Benuto (2010) propose that due to the vast number of possible groupings, adaptations could be an infinite and infeasible process. Furthermore, Stuart (2010) has explained culture is so multidimensional and complex that adaptations could potentially lead researchers and clinicians to be culturally insensitive. And thus the question arises: how much knowledge about specific cultures is required to be culturally sensitive (O'Donohue & Benuto, 2010) or at least to develop a valid adaptation?

Cultural adaptations have the potential to segregate. Sue (1998) has argued that due to the fact that many minority populations are not adequately served because treatments are not culturally sensitive, specific services targeting ethnic minority populations should be created. However, Kramer (1984) proposed that the practice of creating ethnic-specific services would perpetuate segregation as specific treatments

would be created for specific groups. A component of culturally adapting treatments that

has been proposed is ethnic matching between mental health professional and client.

There is some evidence to suggest that African American, American Indian, Asian

American, Mexican American, and Caucasian clients have lower premature termination

rates, a greater number of sessions, and better treatment outcomes when matched with

ethnically similar mental health professionals (e.g., Sue, Fujino, Hu, Takeuchi & Zane,

1991, Sue & Zane, 1987; Sue, Zane & Young, 1994). Yet, while ethnic matching could

be important, ethnic matching between mental health professional and client in all cases

is not feasible. Furthermore, this might segregate the mental health field further as the

implication of this argument is that Caucasians take care of Caucasians, Latinos take care

of Latinos and so on.

Additionally, there is a concern that cultural adaptations are not the best use of

federal resources. Making different versions of treatments for different groups is costly

because more federal money needs to be spent to test the efficacy and effectiveness of

these therapies on specific ethnic groups. Moreover, culturally adapting treatments is

time-ineffective. The process of making changes to established therapies, training mental

health professionals in the adapted therapy, and testing their effectiveness requires studies

to be conducted, which may take a long time. Additionally, it would be infeasible to

perform all of the necessary studies on ESTs on different groups to prove the treatments

are generalizable to these different groups (O'Donohue & Benuto, 2010).

Moreover, culturally adapting established treatments calls into question the

integrity of the newly adapted treatments. ESTs have to meet certain standards to become

established treatments. However, the cultural adaptation movement assumes that ESTs

lack or have problematic external validity (O'Donohue & Benuto, 2010). For this reason, some scientists propose that to justify culturally adapting treatments, we must first show that the established treatments do not work for minority populations. The concern with adapting treatments before extending them to minority populations is that it might alter the integrity of the treatment that has been established. Thus, cultural adaptations could potentially change the theoretical propositional model or the implied theory of change (Bernal, 2009). The question remains about the extent to which culturally adapting treatments could change the proposed core components and procedures such that they create a new treatment (Bernal, 2009).

A defining difference between cultural adaptations and cultural competence is that, cultural adaptations are specifically tied to treatments (e.g., Bernal, Bonilla, & Bellido, 1995), whereas cultural competence is tied to the practices of specific providers (APA, 2003; Sue & Sue, 2008; Bernal, Jimenez-Chafey & Domenech Rodriguez, 2009). Bernal, Jimenez-Chafey and Domenech Rodriguez (2009) posit clinicians know that treatments are best when personalized to the needs and context of the client. Bernal and colleagues (2009) argue that there are two driving forces where friction arises when culturally adapting treatments. First, there is a need to acquire empirical information regarding treatment development, efficacy and effectiveness through scientifically rigorous, ecologically valid treatment studies (Bernal, Bonilla & Bellido, 1995). Second, there is the need to reduce health disparities by delivering evidence-based treatments more broadly to ethnocultural groups (Bernal & Domenech Rodriguez, 2012). They argue that one way to elegantly balance these driving forces is through the use of cultural adaptation procedures while recognizing the dangers that this one-size-fits-all approach

could invoke cultural stereotypes (Bernal, Jimenez-Chafey & Domenech Rodriguez, 2009; López, Kopelowicz and Carñive, 2002). Proponents of cultural adaptations suggest that cultural adaptations can get around the one-size-fits-all approach by considering language, culture, and context such that they would be compatible with the cultural patterns, meanings and values of each client (Bernal, Jimenez-Chafey & Domenech Rodriguez, 2009). However, this seemingly is closer to a cultural competence approach than a cultural adaptation one.

Lastly, there is the concern that adaptations to established treatments are not warranted. For example, O'Donohue and Benuto (2010) argue that the literature citing that ESTs do not generalize to some cultural groups is equivocal. O'Donohue and Benuto (2010) argue that there is no evidence to show standard evidence based therapies are insensitive.

Cultural Competence

Addressing the challenges surrounding cultural adaptations. We argue that an improved solution to the balancing act between staying true to established treatments while still including the salience of culture is to train in-session cultural competence skills to mental health professionals. Cultural competence training has the potential to eliminate some challenges that cultural adaptations of treatments may face.

Some research on cultural adaptations have explained that cultural adaptations are needed primarily for the fact that EBTs have not sufficiently considered cultural factors (different from mainstream white culture). For example, Cardemil (2010) explains that most studies have samples of racial and ethnic minorities are underrepresentative and underpowered. La Roche and Lustig's (2010) guide for adapting treatments suggests

taking the time to consider and understand the match or lack thereof between the cultural characteristics and assumptions of the intervention and the cultural characteristics of the target population. While we agree with these two points, we believe that cultural competence training can achieve this end while diminishing some logistic problems brought about with adaptations, by focusing on tailoring the treatment to the individual rather than for an entire group.

To address the problems associated with the definition of culture that has been used in the field of cultural adaptations, some in the cultural competence field have shifted the focus away from content the clinician ought to know about clients' culture, and on to the process the clinician engages in to understand what portions of the clients' lived experiences are salient in the present moment (López, 1997; Lakes, López & Garro, 2006). Engaging in this process eliminates the potential of falling into traps of stereotyping about whole groups or requiring clinicians to know presumably important cultural facts. The process is dynamic and thus can be molded more easily to individual clients better than systematic adaptations of entire treatment packages can.

Training of cultural competence resolves the issue of potential segregation with adaptations of treatments because culturally competence does not entail a therapist holding membership in a specific racial or ethnic group. Rather, the goal is for mental health professionals to be sensitive enough to be able to competently treat individuals from any racial or ethnic group. If a mental health professional learns how to be culturally competent, it should not matter if they match the client on demographic variables. What would matter in the dyad is that the therapist attempts to understand and empathize with the client's lived experiences and perspective to be able to work from the

same starting point with the client. Thus, it would be most important for the client and therapist to have a shared understanding of what will be worked on in treatment more than belonging to a specific ethnic group.

To address the reality that resources for investigating the effectiveness of treatments with multiple racial and ethnic minority groups (e.g., Asian Americans, Latinos, Black) are limited, the field of cultural competence brings about an adequate alternative which is to invest time and resources in the training of individuals, not altering established treatments. Investing directly in training of cultural competence in mental health professionals means instilling a skill set, which could be used in a variety of instances. These skills are needed so that mental health professionals are able to provide psychotherapy that is sensitive to their clients in a wide range of situations regardless of theoretical orientation, setting (e.g., inpatient, outpatient, hospital, community clinic) or client characteristics.

Given that there is a concern that cultural adaptations could potentially change the integrity of established treatments, the cultural competence field is an alternative to adaptations, which might potentially interfere less with treatment mechanisms. Said another way, the crux of cultural competence is on training skills that the professional can adapt to any circumstance, regardless of treatment modality. Furthermore, concerns about external validity might not be as relevant if mental health professionals learn cultural competence skills as they would be able to extend established treatments in a sensitive and relevant way to any individual requiring services.

The cultural competence field addresses the challenge of potentially creating a one-size-fits-all approach of adapting entire treatment packages because it aims to train

mental health professionals to be sensitive to individuals rather than to entire groups. Because of a problematic definition of culture which was adopted by the cultural adaptations field, the way individuals are assigned to specific groupings might not be reflective of factors that effectively discriminate among individuals. Thus, cultural competence suggests that the mental health profession seeks to understand what is important to the individual based on specific lived experiences rather than assumptions based on demographic characteristics. In doing so, mental health professionals are able to tailor treatments specifically to individuals rather than attempting to fit clients under an umbrella and assuming certain alterations would work for a large group of individuals.

"Shifting cultural lenses" model of cultural competence. Several researchers have proposed various models of cultural competence (e.g., Beckett et al., 1997; Bennett, 1993; Campinha-Bacote, 1994; Carney & Kahn, 1984; Castro, 1998; Cross, 1988; Cross et al., 1989; Sue and Sue, 2008; Toporek & Reza, 2001). In the present study, we have adopted Dr. Steven López and colleagues' SCL model of cultural competence (López, 1997; Lakes, López & Garro, 2006; Ribas, López, Sheinbaum et al., n.d.). Historically, cultural competence has been conceptualized as a content model whereby it is viewed as an entity within the clinician that includes values, beliefs, awareness and perceived skills when working with minority groups (Sue & Sue, 2008) and focuses on what cultural aspects matter for different cultural groups (López, Kopelowicz and Carñive, 2002). Conversely, the SCL model is a process model (López, 1997; Lakes, López & Garro, 2006) under which cultural competence is built upon the definition of culture as what is at stake in local social worlds (Kleinman, 1995) and a collaborative relationship between the clinician and the client whereby both parties shift between each other's cultural lenses

in an attempt to co-construct shared narratives (Mattingly & Lawlor, 2001) and focuses

on understanding the role of culture (López, Kopelowicz and Carñive, 2002). The goal of

therapy under this paradigm is for the clinician to present his or her perspective and to

access and validate the client's perspective (Lakes, López & Garro, 2006).

The first component of the SCL model is its unique conceptualization of culture,

which is contextual (Ribas, López, Sheinbaum et al., n.d.). Culture as operationalized for

the model is composed of identifying "what's at stake" in people's local, social and moral

worlds. In other words, the focus is on identifying what is important or what matters (e.g.,

values and beliefs) in an individual's personal lived experiences. The model moves away

from a conceptualization of culture as composed of fixed or static values, beliefs and

practices of groups and takes into account the dynamic nature of culture.

Second, the model defines cultural competence as the process of shifting between

cultural lenses of clinician and client (Ribas, López, Sheinbaum et al., n.d.). Given that

culture is conceptualized as unique perspectives derived from lived experiences, both the

clinician and the client come to the therapy room with their own perspective of the world.

Thus, to be culturally competent entails understanding the client's perspective of the

problem(s) to be tackled in therapy while also explaining the clinician's view of the

problem, without any presumed hierarchy where the clinician holds the answers (Ribas,

López, Sheinbaum et al., n.d.). By engaging in this process, the clinician is able to

provide treatment that is sensitive to the client's culture and lived experiences.

The third defining feature of the model is discourse or narrative plots between

clinician and client to guide treatment direction (Ribas, López, Sheinbaum et al., n.d.).

When clinicians engage in a process with clients whereby each present their perspective

on certain issues, both individuals can then construct a shared narrative which integrates separate perspectives that potentially can inform clinical work.

In the SCL model, the behavioral indicators of culturally competence include the ability to (a) assess the clients' view, (b) present the clinician's view, and (c) negotiate both views to come to an agreed upon understanding (Ribas, López, Sheinbaum et al., n.d.). Assessing the client's view entails explicitly asking the client what he or she wishes to gain from therapy, inquiring about what the client views as the problem and its cause, validating the client's definition of their problem and developing therapy goals in line with the definition, and demonstrating understanding of the client's cultural framework without disagreement or challenge (López, 1997). Presenting the clinician's view is composed of introducing the therapist's framework as a personal view rather than presumed fact, from a position of mutual respect and collaboration, and maintaining openness to adapting one's therapy to the cultural beliefs of the client (López, 1997). Coming to shared narratives is achieved by integrating the client's view into treatment, working towards client buy-in and negotiating perspectives with the client.

Developing an Effective Cultural Competence Training Program

Even though roughly a decade has passed since the Guidelines on Multicultural Education, Training, Research, Practice and Organization Change for Psychologists (APA, 2003) outlined a set of competencies in delivering appropriate multicultural care, there is still a dearth of research examining training of in-session cultural competence behaviors for mental health providers and empirical studies examining outcomes for providers trained in cultural competence. Comprehensively affecting change in mental health disparities at the level of cultural competence training requires investigation into

best practices for training and dissemination.

The case for cultural competence training. Historically, mental health professionals have received training in cultural competence through coursework in graduate programs or by being producers or consumers of cultural competence literature. However, this is insufficient as changing demographic trends will make it so that the overwhelming majority of providers will see clients from diverse backgrounds in the coming years. Protocols that train cultural competence for mental health professionals at various roles of their careers (training, research, and practice) that are acceptable to both clinicians and clients are needed now to meet this mental health imperative. Furthermore, these trainings need to be effective (i.e., efficiently teach skills, cost-effective, time-effective), easy to teach, scalable, and acceptable to mental health professionals from different disciplines (e.g., clinical social workers, psychiatrists) and clients from diverse settings and cultures (Kanter, Puspitasari, Santos & Nagy, 2012).

Online trainings. Online training protocols provide some solutions to this issue. The benefits of providing trainings online are that instruction is more easily disseminable as many people have access to the Internet, but far less have the ability to fly to a specified location where face-to-face trainings would take place. Additionally, online trainings are more cost-effective than traditional face-to-face trainings as airfare and lodging costs are eliminated. Moreover, traditional psychotherapy trainings are generally formatted in a workshop style that takes place usually over several days (DeViva, 2006; Gleacher et al., 2011; Lewis & Simons, 2011; Rubel, Sobell, Miller, 2000) and have been shown to produce changes in trainees' knowledge, but not skills (Beidas & Kendall, 2010). The online trainings may take that same time commitment and separate it into

discrete training modules of shorter time periods, providing trainees the opportunity to practice and receive feedback on the skills that they learn in their practice and with their clients through the course of the training (Puspitasari, Kanter, Murphy, Crowe & Koerner, 2013). Practice and feedback have been shown to be key features of effective training protocols (Beidas, Koerner, Weingardt, & Kendall, 2011).

Why should cultural competence training be added to behavioral activation training? For this study, an online training was chosen as the format through which to deliver a cultural competence training module based on the SCL model. The cultural competence training was delivered to mental health professionals online by adding it to an existing online training of Behavioral Activation (BA) for depression (Puspitasari, et al., 2013). The online BA training was thought to be a good fit for use with the SCL model because it, like the SCL model, emphasizes active learning for trainees to learn specific skills (Puspitasari et al., 2013). Furthermore, BA has been proposed very suitable for large-scale dissemination (i.e., through online trainings) because of its simplicity and because it is easy to train (Hollon, 2000; Kanter, Busch, & Rusch, 2009; Sturmey, 2009). Additionally, the BA training program has a modular format built around core skills (Puspitasari, et al., 2013) and thus teaching cultural competence in this manner is easy as a culture module would be added to the existing training program, without much alteration of the existing package. Lastly, BA has been proposed to be a treatment that holds strength in being acceptable and adaptable to hard-to-reach populations and regions (Kanter et al., 2012) and thus the BA and the cultural competence portions of the training complement each other well.

How is this cultural competence training different from what naturally happens in the therapy room? López (1997) has discussed that "the principles of effective psychotherapy and culturally competent psychotherapy overlap." However, López (1997) makes the point that in working with clients from distinct cultural backgrounds (generally ethnocultural minority groups) from the clinicians, implicit and explicit models of human behavior may differ between the client and the clinician. In turn, this has the potential to interfere with effective provision of mental health care (López, 1997).

Cultural competence, as López and colleagues (López, 1997; Lakes, López, & Garro, 2006) discuss it, is heavily influenced by collective empiricism. This leads it to resemble components that have traditionally been identified as common factors. A major component of common factors literature has centered on strengthening the therapeutic relationship – something that is also critical as one is culturally sensitive. However, the SCL model extends this idea by placing explicit attention on contextual factors that might be related to culture whereas this might not be the focus of the common factors literature.

Preliminary studies and research team experience. Three pilot studies of the effectiveness of online trainings of BA have been conducted using similar methodology (Puspitasari et al., 2013). For these trainings, four primary BA component skills were identified and operationalized in terms of discrete microskills that can be trained and practiced to criterion, consistent with a manual developed by Kanter and colleagues (2009). The BA components taught, consistent with previous work on identifying BA core components (e.g., Kanter, Manos, Bowe, Baruch, & Rusch, 2010; Kanter & Puspitasari, in press), included (a) providing a rationale, (b) assessment of which

activities to schedule, (c) activity scheduling, and (d) strategies to use when activity scheduling does not succeed (strategies targeting avoidance). Each skill is trained in a training module. The trainings take place online, in small groups of 8 to 10 trainees, and each module is taught in a single 1.5 hour session. Sessions occur weekly or bi-monthly, allowing time for trainees to practice the skills between training sessions and receive feedback during the subsequent session. Training session time focuses on role-playing and practicing the skills, allowing for real-time feedback on performance to be supplied by the trainer.

These preliminary studies have occurred concurrently with the development of the Behavioral Activation Skills Assessment (BASA; see Appendix A for BASA microskills checklist) that evaluates the use of the skills attained in the training in a structured role play format (Kanter, Manos, Bowe et al., 2010; Kanter & Puspitasari, in press). The BASA incorporates role plays between a trainee and a hypothetically depressed "client" using a script that prompts the trainee to perform the specific skills taught in the training. Tapes of role play sessions were then coded by trained coders. To date, three preliminary studies found that mental health professionals who undergo the training significantly increase their competence with BA skills (Kanter & Puspitasari, in press; Puspitasari, Crowe, Nagy et al., 2012).

The Present Study

The current study developed a cultural competence training module consistent with the modular BA training format developed by Puspitasari and colleagues (2013) and evaluated its impact through a randomized controlled trial (RCT). The cultural competence training module included self-paced materials to prepare trainees for the

training session, an experiential expert-led 90-minute session consistent with the format of the BA modules, and a skills assessment (role play with a hypothetical client). These components sought to facilitate the sustainability of an evidence-based cultural competence training module. The research team collaborated with the primary developer of the SCL cultural competence training, Dr. Steven López, to develop the training materials. Participants were randomly assigned to one of two conditions: BA or BA plus cultural competence (BA + CC). Participants completed an 18-week online training (see Appendix B for a breakdown of the training schedule). Objective assessments of cultural competence skill acquisition were conducted at baseline, post and at a 1-month follow-up using a modified BASA role play assessment. Though the use of a hypothetical client (using a script), as opposed to real clients, may limit the generalizability and clinical relevance of our findings, the use of a hypothetical client is an easy and standardized method of evaluating the acquisition of skills.

Study Aims

The first aim of the study was to evaluate preliminary effectiveness of the cultural competence training. We hypothesized that (1) the BA + CC condition would evidence greater acquisition of cultural competence skills in comparison to the BA condition from pre to post-training and would maintain gains at a 1-month follow-up; and (2) the BA and BA + CC conditions would not differ in their level of acquisition of BA skills (as measured by the BASA). Thus, the cultural competence training would not be detrimental to the learning of core BA skills.

Secondly, we aimed to detect changes in participants' multicultural awareness, knowledge and skills. We hypothesized that (1) as measured by the Multicultural

Awareness, Knowledge and Skills Survey (MAKSS; D'Andrea, Daniels, & Heck, 1991),

participants in the BA + CC condition would experience significant changes in their skills

related to multiculturalism, but not their knowledge or awareness; and that (2)

participants in the BA condition would not experience significant changes in skills,

knowledge or awareness.

Third, we aimed to assess acceptability of training for participants. We

hypothesized that study participants would evidence acceptability of the trainings as

evaluated through weekly qualitative and quantitative feedback.

The last aim of the study was to examine feasibility of the training module and

procedure. We predicted that training of cultural competence skills would be feasible as

assessed via number of training sessions attended, assessments completed, and

completion of self-paced materials.

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Methods

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Participants

Recruitment. To recruit participants, the research team collaborated with a cyber

interface where experts and researchers of EBTs provide online trainings to therapists

(PracticeGround). PracticeGround is composed of an online learning community through

which instruction to practitioners is given, and an online progress tracking which allows

measurement of practitioner's implementation of and client's responses to techniques

trained. The study was announced via a posting on the website of PracticeGround

(http://www.practiceground.org) and through mass emails to members of the listserv of

the Association of Behavioral and Cognitive Therapies (ABCT) and PracticeGround.

Participants who were interested were sent a detailed description of the trainings and

were contacted by the study coordinator to obtain informed consent. After obtaining

consent, participants were randomized into either the BA + CC or BA condition.

Participant characteristics. The study recruited 10 human subject participants

(older than 18 years old) internationally. The BA + CC condition enrolled six participants

and the BA condition enrolled four. The number of study participants was somewhat

smaller than the sample sizes used in previous studies due to difficulties in recruitment

and drop-out. Inclusion criteria was that the participant be provided informed consent

(see Appendix C), be licensed to practice psychotherapy or supervised by a licensed

individual (e.g., social work, psychology, psychiatry), have no previous training in BA or

the SCL model, and provide treatment for depression at the time of the training. There

was no exclusion criteria for therapists beyond not meeting the inclusion criteria listed

above. The study enrolled therapists from varying levels of expertise and from different

disciplines to increase generalizability.

Study Procedure

Following consent and randomization, participants were emailed the self-paced

materials and instructed to complete them before the expert-led sessions. In the week

before the first session of the training, the project coordinator scheduled participants for a

pre role play assessment with a trained role play assessor. 24 hours before the role play,

the project coordinator emailed the role play instructions (see Appendix D) as well as a

reminder for the role play. The BA + CC condition met in weeks 1, 3, 5, 7, and 9 of the

training period, and the BA condition met in weeks 2, 4, 6, 8, and 10. If a participant

missed a session with their condition, they attended that equivalent session with the other

condition. Both conditions received a sixth session after the end of the study. The BA

condition received the cultural competence module while the BA + CC condition received a debrief session that allowed participants to receive consultation on the BA practice and ask any questions they might have had regarding the training. For each session of the online training, study participants logged into the PracticeGround Collaboration Room and called into a designated conference line. Each week following the training session or during the off-week, participants were sent links to fill out the online questionnaires. In the week following the 10-week online training, each study participant completed a post role play assessment. Each study participant also completed a 1 month follow-up role play assessment.

  Behavioral activation training. The BA protocol used for this study followed the online, modular training format developed by Puspitasari and colleagues through several preliminary studies (Puspitasari, Crowe, Nagy et al., 2011). Each session consisted of a live online training wherein participants met with the trainer in the PracticeGround Collaboration Room, an interface which allows participants to view PowerPoint slides presented by the trainer and includes instant messaging capabilities through which participants are able to respond to the training material and interact with the trainer and other study participants. Additionally, participants called into a conference call line for audio during each session. Moreover, participants received key BA readings to provide an introduction to the treatment package which participants were encouraged to read before the start of the training. The first session of both conditions lasted 2 hours and the other four lasted 90 minutes. For the BA condition, the first session consisted entirely of BA history – a component that was not formally assessed in the outcomes as to not give participants in this condition an advantage. The first session of the BA + CC condition

entailed a 30-minute introduction to BA delivered by Dr. Kanter followed by the 90-minute cultural competence content delivered by Dr. López. Dr. Kanter is the developer of the online, modularized training of BA, and Dr. López is the developer of the SCL model and complimentary training. The following four training sessions were equal between conditions and were solely focused on BA skills. Session two trained skills to deal with client avoidance in BA. Session three trained skills for good activity scheduling. Session four trained skills for assessment in BA. Session five trained skills in presenting the BA rationale. The BA condition received a sixth session wherein participants received the culture module after the study was completed. The BA + CC condition also received a sixth session that was formatted as a "follow-up/debrief/consultation" and meant to make both conditions equal in time.

Cultural competence training. After randomization, those study participants in the BA + CC condition received readings centered on cultural competence (in addition to the BA readings) as well as a self-paced video. This video provided an operational definition to culture, facts highlighting why culture in psychotherapy matters, the framework of cultural competence based on the SCL Model, and several principles of culture guiding case conceptualization. In session one, following Dr. Kanter's 30-minute introduction to BA and explanation for the importance of cultural competence in BA, Dr. López delivered the content of the cultural competence training. This 90-minute segment was adapted from Dr. López's existing daylong workshop-style cultural competence training which is normally delivered to mental health professionals. For the present study, the adapted cultural competence training included identifying what's at stake in people's local, sociocultural world to guide case conceptualization and the behavioral indicators of

cultural competence. The behavioral indicators as outlined in the SCL model are composed of accessing the client's views (C), providing the therapist's views (T), integrating the client's views (C1), working towards buy-in (C2), negotiation (C3), clinician's negative behaviors (D), and facilitating client's story (F). We hoped that the emphasis on what's at stake for the client was important for this training as it could have helped study participants identify activities to schedule that were consistent with the client's values and goals as well as guide case conceptualization. Besides these two didactic components, Dr. López also led three rapid-fire role plays in the session with the study participants wherein they utilized newly-learned cultural competence skills and obtained immediate feedback from Dr. López. Participants in the BA condition received the cultural competence module in a sixth session after the 1-month follow-up had been completed.

Assessment Protocol

      Role player training. Four female role play assessors underwent approximately 16 hours of face-to-face training on the role play assessments by the project coordinator through weekly meetings spanning a total of 15 weeks. In addition to face-to-face training, role play assessors were given readings centered on cultural competence written by the developers of the SCL model to read on their own to familiarize themselves with cultural competence skills as to be able to provide appropriate prompts for assessment of cultural competence in-session skills. Role play assessors were familiar with the BASA role play assessment and thus were not given any BA readings in an attempt to keep them as blind as possible to BA skills such that they would not lead study participants to certain answers and remain as neutral as possible. Role play assessors met with each

other to run through the role play manual (see Appendix E) and give each other feedback

for approximately 2 hours during the training period. The training content delivered to the

role play assessors was catalogued in a manual developed in part by the primary

developer of the BASA measure as well as the project coordinator (see Appendix E).

      BASA coder training. Two coders were trained by the primary developer of the

BASA measure to rate study participants on the items of the original BASA. BASA

coders were given a BA reading (Kanter, Bowe, Baruch & Busch, 2011) as part of their

training to do on their own to increase their knowledge of BA materials before actually

beginning to code. After coders completed the readings, they took a BA knowledge test

(see Appendix F) developed by the trainer in order to demonstrate their understanding of

BA. Additionally, coders were trained for two months through weekly face-to-face

meetings with the trainer wherein they discussed ideal responses for each item and

completed at least two practice codings of role play assessments for the sake of

establishing an ICC of above 0.80 (Puspitasari et al., in press). If BASA coders were not

able to reach at least 0.8 reliability, they completed more practice role play codings until

0.8 was reached. Each practice coding was rated individually, and then BASA coders

discussed and compared their individual scores to reach consensus (Puspitasari et al., in

press). During instances where coders were consistently disagreeing based on definitions

of certain codes, the project coordinator met with coders to discuss their understanding of

the codes as they applied to specific examples and re-coded based on their new

understanding of the codes. Before the coding phase of the present study, these BASA

coders were trained to code the additional cultural competence items, which have been

added to the BASA, by the project coordinator (see Appendix A).

BASA role play adherence. At week 12 of training, the role play assessors completed a practice role play assessment with an unaffiliated (to the present study) graduate student in the Department of Clinical Psychology at the University of Wisconsin-Milwaukee (UWM) to assess level of reliability of delivering prompts and adherence to the script. An adherence checklist (see Appendix G) was utilized to measure the extent to which role players were consistent to the role play script and delivered prompts. Role players had to deliver at least 90 percent of the prompts to be allowed to conduct role play assessments with study participants.

Inter-rater reliability. All BASA coders achieved acceptable inter-rater reliability (intraclass correlation coefficients; ICC) with the expert criterion coder on a sample of multiple BASA tapes before the start of coding and in the context of multiple coding projects (ICC ≥ .70). Inter-rater reliability (ICCs) for coders at pre, post and follow-up ranged from .71 to .96 across the subscales (overall BASA = .94, rationale = .96, assessment = .92, activity scheduling = .84, targeting avoidance = .96, cultural competence = .71). Table 1 presents ICCs for the BASA.

SCL coder training. Two independent coders previously trained on the SCL Coding System (see Appendix H) were utilized for the present study. The first coder had participated in the development of the coding system and had previously served in the capacity of SCL coder, under the supervision of the primary developer of the SCL model, for approximately 2 years prior to the present study. Training to serve in this capacity entailed doing readings on the SCL model, coding several therapy sessions (approximately 40) using the coding system, and helping to refine it to increase reliability. In order to serve in this capacity she reached an ICC of above 0.70 through

practice codings. The second coder received personalized training on the SCL Coding

System from the primary developer of the SCL model his research team during an

intensive 1-week training at the University of Southern California. This training involved

doing readings centered on cultural competence written by López and colleagues (Ribas,

López, Sheinbaum et al., n.d.; López, 1997; Lakes, López & Garro, 2006), attending a

workshop intended for mental health workers in southern California, a feedback session

for three therapists that participated in a study wherein participants were rated using the

SCL Coding System, and four practice codings using real therapy sessions. At the end of

the training, this SCL coder reached an ICC of above 0.70. It is important to note that the

second coder also served as the project coordinator and thus was not fully independent

about study aspects such as randomization. Both coders completed further training in the

SCL model and coding system to reach inter-rater reliability with one another. This

training was in the form of readings, operationalizing anchors on the system and practice

codings to establish an ICC of above 0.80.

Measures

 Demographic questionnaire. A demographic questionnaire (see Appendix I),

devised by the research team, was used to collect study participant characteristics such as

gender, age, race and ethnicity, level of education, and questions related to the treatments

they use and the clients that they treat.

 Behavioral activation skills assessment (BASA; Pusptasari, Kanter &

Crowe, 2012). The BASA (Pusptasari, Kanter & Crowe, 2012; see Appendix A) assesses

study participants' abilities to implement BA skills through a role play with a

hypothetical client who follows a script which simulates a realistic clinical case

conceptualization (Puspitasari et al., 2013). Each role play assessment was conducted over the phone through the use of a conference line and lasted approximately 1 hour to complete. The role play used for the present study was broken up in two 25-minute segments aimed at assessing core BA skills: (a) providing the rationale and assessment, and (b) activity scheduling and techniques targeting avoidance. Role play instructions (see Appendix D) were as follows. For the first segment, study participants were told:

> "For this role play, it is the beginning of session one. Your task is to start therapy, briefly gather key information about your client in a manner consistent with assessment in Behavioral Activation and provide a rationale for Behavioral Activation. Try to do this assessment and present the model for treatment in approximately 25 minutes."

In the second segment, they are instructed as follows:

> "It is session seven. You have started Behavioral Activation. So far, your client successfully went to the career center and received training on how to post her resume online and find possible job openings. Her assignments last week were to (1) post her resume online, (2) go for a 20-minute run, and (3) watch a movie with her husband. Your task is start the session, review her homework, and schedule one or two new activities. Try to spend 25 minutes total on these tasks."

Study participants' role plays are rated on 42 items ranging from 0 (performed incompetently) to 1 (performed competently) on 0.1 increments for each BA core skill (see Appendix A) by two independent coders. Items are coded from a transcription of the role play. In addition to the original BASA items, the research team has added several other items to the BASA to compare the use of skills before and after the cultural

competence training (refer to Appendix A), which were derived from literature developed by López and colleagues (López, 1997; Ribas, López, Sheinbaum et al., n.d.).

Internal consistency. We sought to evaluate the internal consistency of each BASA subscale and for the entire BASA measure. Cronbach's α was calculated. Results indicated that subscales showed from having unacceptable to excellent internal consistency for all scores (α = .77 for cultural competence, α = .96 for providing the rationale, α = .47 for assessment, α = .40 for activity scheduling, α = .92 for avoidance, and α = .79 for total measure). Scores for each scale are displayed on table 2.

Level of implementation and confidence utilizing BA skills questionnaire. Through the use of an online questionnaire (see Appendix J), the level of implementation of BA strategies with clients was assessed. Study participants were asked to report the use of BA techniques with their clients after each training session. Additionally, participants were asked to report their level of confidence when implementing specific BA strategies.

Shifting cultural lenses coding system (SCL coding system; Ribas, López, Sheinbaum et al., n.d.) The SCL Coding System (see Appendix H) was developed to identify the in-session behaviors of clinicians that reflect cultural competence (Ribas, López, Sheinbaum et al., n.d.) following a framework outlined by the SCL model (López, 1997; Lakes, López, & Garro, 2006). The present study applied the SCL Coding System to the BASA role play assessments that were conducted with a hypothetical client. For coding, coders listened to the audio recording and had a transcript of the of the BASA role play. The coding system breaks therapist-client interactions into 10-minute segments and two coders independently identify specific instances of behavioral indicators:

accessing the client's views (C), providing the therapist's views (T), integrating the client's views (C1), working towards buy-in (C2), negotiation (C3), clinician's negative behaviors (D), and facilitating client's story (F). For each 10-minute segment and overall, coders individually rate the therapist on each of the behavioral indicators on a 5-point scale as follows: none (0), a little (1), some (2), quite a bit (3), and a great deal (4; see Appendix H). After two coders identify specific instances of behavioral indicators, they discuss scores and attempt to reach consensus.

Multicultural awareness, knowledge and skills survey (MAKSS; D'Andrea, Daniels, & Heck, 1991). To assess study participants' self-reported awareness, knowledge, and skills of multicultural psychology, the MAKSS (D'Andrea, Daniels, & Heck, 1991; see Appendix K) was used, delivered online. The MAKSS is a 60-item survey meant for therapists working with clients or groups. The items on the survey are divided evenly into three 20-item subscales – awareness, knowledge and skills. Questions are on a 4-point Likert-type scale as follows: very limited or strongly disagree (1), limited or disagree (2), good or agree (3), and very good or strongly agree (4).

Latino values questionnaire. To examine to what extent participants could identify traditional values endorsed by Latino/a clients, the research team devised a brief questionnaire (see Appendix L) composed of eight items, three of which were traditional Latino values and five which were not. Scores on this questionnaire reflected what percentage of the values participants were able to correctly identify as either traditional Latino values or not.

Acceptability questionnaire. Following each training session, participants received an online questionnaire (see Appendix M) that sought to elicit feedback

regarding components covered in each training session (i.e., cultural competence, providing the rationale, assessment, activity scheduling, and skills targeting avoidance). Study participants were instructed to give two ratings, one for quality and one for usefulness, of each component on a 5-point scale as follows: poor (1), fair (2), good (3), very good (4), and excellent (5). Additionally, participants were instructed to provide information regarding whether they found specific training components helpful. Lastly, qualitative feedback was collected specific to content delivered in each session.

Feasibility questionnaire. In order to determine if the training was feasible, completion of study components was evaluated through the use of an online feasibility questionnaire (see Appendix N), devised with the research team. The feasibility questionnaire was distributed after study participants completed study tasks. The completion of self-paced materials (e.g., readings, video) was recorded as well as the time the participant spent completing this portion of the training. If participants did not complete all self-paced materials, they were asked to list reasons why. Additionally, the number of training sessions and role plays completed were recorded. If there were any missed sessions or assessments, participants were asked to provide a reason for missing the specific component.

Results

Participant Characteristics

A participant flow diagram of the process (e.g., enrollment, training, assessments) through the phases of the randomized trial for both the BA + CC and BA conditions is displayed in Figure 1. Participant demographic information is displayed on Table 3. Ten participants (eight females) were enrolled in the study. Six were randomized into the BA

+ CC condition, and four into the BA condition. All participants were licensed mental health practitioners or supervised by one, including: one graduate student, one licensed clinical social worker, two marriage and family therapists, one psychiatric nurse practitioner, and five psychologists. The mean age of participants was approximately 44 (SD = 13). Seven participants self-identified as White/Caucasian/European American, one as Native American, one as bi-cultural, and one as South American. Participants' reported work settings included outpatient mental health clinic, combine outpatient and individual private practice, community mental health clinic, group private practice, individual private practice, and academic medical setting and teaching. The majority of participants provided psychotherapy on a part-time basis. Additionally, the most common treatment modalities reported were individual psychotherapy, group psychotherapy, and psychotherapy to adults. With regards to populations most commonly treated, participants reported White/Caucasian/European American, Black/African American, and LGBT. The most common presenting problems treated included major depressive disorder/dysthymia, anxiety disorders, chronic physical illnesses, marital/relationship difficulties, adjustment disorders, and axis II personality disorders. The majority of participants reported no experience with BA, prior to the training. Most participants had some to moderate levels of training in cultural competence. And the vast majority reported a moderate level of comfort working with diverse clients.

BASA Outcomes

Table 4 presents mean subscale and total scores for trainees at each time point. Mixed between-within subject analyses of variance (ANOVA) tests were conducted on all subscales of the BASA and for the overall scale (without the exploratory cultural

competence items). Effect sizes (Cohen's *d*) for the change scores for all participants on

the BASA subscales and entire measure were calculated. To look at change for each

trainee, reliable change index (RCI) scores, as per Jacobson and Truax (1991), on the

BASA measure as well as the subscales were calculated for each participant. It is

important to note that Jacobson and Truax (1991) originally calculated the reliable

change index utilizing test-retest reliability. However, the BASA instrument does not

presently have test-retest reliability available, thus for the purposes of these analyses, we

estimated it to the best of our ability by utilizing inter-rater reliability. Additionally, given

the small sample size and low power in our study, we report on change scores at the

participant-level. Lastly, in order to characterize reliable change in the BA + CC and the

BA conditions, Fisher's Exact Tests were conducted to examine differences between

conditions on number of participants reaching reliable change from pre to follow-up on

the BASA overall scale and subscales. Pearson Chi-Square Tests were not able to be

conducted given the small sample size (i.e., the lowest expected frequency in each cell

could not be above five for each cell due to the low number of participants).

 Exploratory BASA cultural competence subscale. Results comparing pre, post

and follow-up scores on the BASA cultural competence subscale suggest a significant

main effect for time indicating that everyone improved over the course of the study from

pre to post and from pre to follow-up, Wilks' Lambda = .16, $F (2, 7) = 17.84$, $p = .002$,

multivariate partial eta squared = .84. This resulted in a large effect size, $d = 1.68$. There

was no main effect for condition, $F (1, 8) = 0.05$, $p = .83$. Post-hoc analyses revealed no

significant differences at pre, $t (8) = -.57$, $p = .59$, and a small effect size, $d = -.36$. At

post, there were no significant differences, $t (8) = .07$, $p = .95$, $d = .05$. There also were

no significant difference at follow-up, t (8) = 1.02, p = .34, but a moderate effect size, d = .63. Additionally, there was not a significant effect for the interaction between time and condition, Wilks' Lambda = .65, F (2, 7) = 1.85, p = .23, multivariate partial eta squared = .35. In the BA + CC condition, there was a large effect from pre to post, d = 1.01; and a large effect from pre to follow-up, d = 2.14. In the BA condition, there was a moderate effect from pre to post, d = .77; and a large effect from pre to follow-up, d =. 86. Figure 2 represents mean scores by condition for the exploratory BASA cultural competence scale.

Specific BA rationale subscale. Results indicate a significant effect for time suggesting that everyone improved over the course of the study, Wilks' Lambda = .08, F (2, 7) = 38.24, p < .005, multivariate partial eta squared = .92. Regardless of condition, the analysis of the change between pre and follow-up for all participants showed a large effect size, d = -1.86. There was no main effect for condition, F (1, 8) = 2.21, p = .18. Post-hoc analyses revealed no significant differences at pre, t (8) = -.77, p = .47, but a moderate effect size, d = -.51. At post, there was not a significant difference, t (8) = -1.48, p = .18, but there was a large effect, d = -1.03. At follow-up, there was a trend towards significance, t (8) = -2.08, p = .07, and a large effect, d = -1.46. Furthermore, there was not a significant effect for the interaction between time and condition, Wilks' Lambda = .65, F (2, 7) = 1.89, p = .22, multivariate partial eta squared = .35. In the BA + CC condition, there was a small effect from pre to post, d = .49; and a large effect from pre to follow-up, d = 1.52. In the BA condition, there was a large effect from pre to post, d = 2.07; and a large effect from pre to follow-up, d = 3.36. Figure 3 represents mean scores by condition for the BASA rationale scale.

Assessment subscale. Results comparing BASA assessment subscale scores at pre, post, and follow-up indicated that there was not a significant effect for time suggesting there were no changes in trainee's scores across time, Wilks' Lambda = .91, F (2, 7) = .37, p = .71, multivariate partial eta squared = .10. Furthermore, this yielded a small effect size, d = .32. There was no main effect for condition, F (1, 8) = 1.83, p = .21. Post-hoc analyses revealed no significant differences at pre, t (8) = -.09, p = .93, d = -.06. At post, there was not a significant difference, t (8) = -1.41, p = .20, d = -.87. Additionally, there were no significant differences at follow-up, t (8) = -.82, p = .44, and a moderate effect, d = -.57. In addition, there was not a significant effect for the interaction between time and condition, Wilks' Lambda = .92, F (2, 7) = .30, p = .75, multivariate partial eta squared = .08. In the BA + CC condition, there was a small effect from pre to post, d = .02; and a small effect from pre to follow-up, d = .11. In the BA condition, there was a moderate effect from pre to post, d = .76; and a small effect from pre to follow-up, d = .07. Figure 4 represents mean scores by condition for the BASA assessment scale.

Activity scheduling subscale. Results suggested that there were no changes between scores at pre, post and follow-up on the BASA activity scheduling scale, Wilks' Lambda = .99, F (2, 7) = .04, p = .96, multivariate partial eta squared = .01. Results indicated a small effect size for time, d = .22. There was no main effect for condition, F (1, 8) = .12, p = .74. Post-hoc analyses revealed no significant differences at pre, t (8) = -.23, p = .83, d = -.16. At post, there was not a significant difference, t (8) = -.68, p = .51, but there was a small effect size, d = -.48. Additionally, there were no significant differences at follow-up, t (8) = .69, p = .51, but there was a small effect, d = .43.

Moreover, there was not a significant effect for the interaction between time and condition, Wilks' Lambda = .89, F (2, 7) = .44, p = .66, multivariate partial eta squared = .11. In the BA + CC condition, there was a small effect from pre to post, d = -.01; and a small effect from pre to follow-up, d = .36. In the BA condition, there was a moderate effect from pre to post, d = .58; and a small effect from pre to follow-up, d = .19. Figure 5 represents mean scores by condition for the BASA activity scheduling scale.

Techniques targeting avoidance subscale. Results comparing pre, post and follow-up scores on the BASA techniques targeting avoidance scale evidenced a significant effect for time suggesting that everyone improved over the course of the study, Wilks' Lambda = .15, F (2, 7) = 19.36, p = .001, multivariate partial eta squared = .85. Results indicated a large effect size, d = 1.15. There was no main effect for condition, F (1, 8) = .44, p = .53. Post-hoc analyses revealed no significant differences at pre, t (8) = .37, p = .72 but there was a small effect, d = .25. At post, there was not a significant difference, t (8) = -1.20, p = .27, but there was a large effect size, d = -.86. Additionally, there were no significant differences at follow-up, t (8) = -.56, p = .59, but there was a small effect, d = -.37. In addition, there was not a significant effect for the interaction between time and condition, Wilks' Lambda = .69, F (2, 7) = 1.56, p = .28, multivariate partial eta squared = .31. In the BA + CC condition, there was a large effect from pre to post, d = 1.14; and a large effect from pre to follow-up, d = .81. In the BA condition, there was a large effect from pre to post, d = 5.43; and a large effect from pre to follow-up, d = 1.79. Figure 6 represents mean scores by condition for the BASA techniques targeting avoidance scale.

BASA overall scale. Given that the cultural competence compared overall BASA scores, not incorporating scores on the cultural competence scale. Results indicated a significant effect for time suggesting that everyone improved over the course of the study from pre to post, and pre to follow-up, Wilks' Lambda = .37, F (2, 7) = 5.90, p = .031, multivariate partial eta squared = .63. This resulted in a large effect size, d = 1.53. There was no main effect for condition, F (1, 8) = 1.79, p = .22. Post-hoc analyses revealed no significant differences at pre, t (8) = -.44, p = .68 but there was a small effect, d = -.29. At post, there was not a significant difference, t (8) = -1.72, p = .12, but there was a large effect size, d = -1.20. Additionally, there were no significant differences at follow-up, t (8) = -.85, p = .42, but there was a moderate effect, d = -.59. Additionally, there was not a significant effect for the interaction between time and condition, Wilks' Lambda = .60, F (2, 7) = 2.33, p = .17, multivariate partial eta squared = .40. Regarding the overall measure of BA competency, in the BA + CC condition, there was a moderate effect from pre to post, d = .69; and a large effect from pre to follow-up, d = 1.13. In the BA condition, there was a large effect from pre to post, d = 3.04; and a large effect from pre to follow-up, d = 2.76. Figure 7 represents mean scores by condition for the BASA scale, not including cultural competence scores.

Reliable change by participant. A graph of individual participant scores on the BASA total measure are represented on Figure 8. These scores do not include the exploratory cultural competence subscale. Figure 9 represents individual participant scores on the BASA cultural competence scale.

Results for participant 1's (BA + CC condition) BASA scores are displayed on table 5. Single-subject analysis of overall BASA scale scores did not include the cultural

competence subscale as it was exploratory and we sought to compare results to previous trials utilizing the BASA measure. Overall, participant 1 evidenced steady, slight improvements in the overall BASA scale through pre, post and follow-up. However, participant 1's improvements did not result in a clinically meaningful change from pre to follow-up for the overall BASA scale, RCI = 1.65. Participant 1 did reach clinically significant changes improvements from pre to follow-up on the rationale (RCI = 5.56), avoidance (RCI = 2.25), and on the cultural competence (RCI = 5.89) subscales. On these subscales, participant 1 also showed steady improvements from pre to post and post to follow-up. Yet, results were not in the expected direction for the assessment subscale (RCI = - 1.78), nor for the scheduling subscale (RCI = - 0.35). On these subscales, scores slightly improved at post, and then dipped at follow-up.

Results for participant 2's (BA + CC condition) BASA scores are displayed on table 6. Overall, participant 2 evidenced clinically significant improvements from pre to follow-up on the overall BASA scale, RCI = 14.02. Participant 2 evidenced steady improvements from pre to post, and post to follow-up on overall BA competency scores. Also, Participant 2 evidenced significant improvements from pre to follow-up on the rationale (RCI = 8.08), assessment (RCI = 3.12), scheduling (RCI = 3.80), avoidance (RCI = 15.11), and the cultural competence subscales (RCI = 2.36). On the rationale subscale, participant 2 showed great improvements from pre to post, and then plateaued from post to follow-up. On both the assessment and the cultural competence subscales, scores dipped at post and then improved at follow-up. Regarding scheduling, participant 2's scores greatly improved from pre to post, and then dipped somewhat at follow-up. Lastly, there was steady improvement on the avoidance subscale.

Results for participant 3's (BA + CC condition) BASA scores are displayed on table 7. Participant 3's overall BASA scale scores were not in the expected direction and thus showed a slight worsening of BA competence from pre to follow-up, RCI = -1.65. Scores for overall BA competency were equivalent at pre and post, and then slightly decreased at follow-up. Additionally, Participant 3 also evidenced clinically significant worsening of scores in the assessment (RCI = -5.57) and scheduling subscales (RCI = -2.65). On the assessment subscale, scores dipped at post and rose slightly at follow-up – yet, scores were still below pre-training functioning. On the scheduling subscale, scores steadily decreased. However, participant 3 did show clinically significant improvements from pre to follow-up on the rationale (RCI = 6.06) and avoidance (RCI = 5.14). Scores steadily improved from pre to post, and post to follow-up on the rationale subscale. But, avoidance subscale scores greatly improved from pre to post, but slightly decreased at follow-up – but were higher than the pre-training score. Lastly, participant 3 did show slight improvements on the cultural competence subscale, but improvements were not clinically significant, RCI = 1.87. On this subscale, there was a pattern similar to that of the avoidance subscale.

Participant 4's (BA + CC condition) BASA scores are displayed on table 8. Participant 4's overall BASA scale scores were not in the expected direction and showed almost equivalent scores between pre and follow-up, RCI = -0.41. On the overall measure, participant's scores dipped at the post assessment, and came back up to pre-training functioning at the follow-up assessment. A similar pattern was seen on the scheduling subscale (RCI = 0.27). Participant 4's scores on the assessment (RCI = -5.35) and the avoidance subscales did evidence clinically significant worsening of scores from

pre to follow-up. Scores on these two subscales steadily decreased with each assessment. But, participant 4 did evidence clinically significant improvement of scores in the rationale (RCI = 6.57) and cultural competence (RCI = 3.65) subscales from pre to follow-up. On the rationale subscale, participant 4's scores dipped at post but greatly improved at follow-up. On the cultural competence subscale, scores steadily increased from pre to post, and post to follow-up.

Participant 5's (BA + CC condition) BASA scores are displayed on table 9. On the overall BASA scale, participant 5 showed clinically significant improvement from pre to follow-up, RCI = 5.36. Overall, scores increased a great deal from pre to post, and plateaued at follow-up. Participant 5 also evidenced clinically significant improvements on the rationale (RCI = 2.27), assessment (RCI = 3.12), avoidance (RCI = 9.00), and the cultural competence (RCI = 2.00) subscales. On the rationale, assessment, and cultural competence subscales, scores greatly increased from pre to post, and then dipped at follow-up – but were still higher than pre-training scores. On the avoidance subscales, scores steadily increased. Scores on the scheduling subscale stayed approximately equivalent (RCI = -0.18) and were not in the expected direction as scores slightly dipped at post and slightly increased at follow-up; but both post and follow-up scores were lower than the pre-training score.

Participant 6's (BA + CC condition) BASA scores are displayed on table 10. Participant 6 showed clinically significant improvements from pre to follow-up on all scales, including overall BASA scale (RCI = 14.43), rationale (RCI = 7.07), assessment (RCI = 8.69), scheduling (RCI = 3.09), avoidance (RCI = 12.21), and cultural

competence (RCI = 2.71). Participant 6 showed a pattern of steadily increases from pre to post and from post to follow-up on all scales.

Results for participant 7's (BA condition) BASA scores are displayed on table 11. Overall, participant 7 evidenced a clinically significant improvement in the overall BASA scale from pre to follow-up, RCI = 5.60. Overall BASA scores increased a great deal from pre to post, and then plateaued from post to follow-up. Additionally, participant 7 showed clinically significant improvements on the rationale (RCI = 6.31), assessment (RCI = 3.56), and the avoidance (RCI = 8.68) subscales. For the rationale and assessment subscales, participant showed a similar pattern in scores – steady improvements from pre to post, and from post to follow-up. However, on the avoidance subscale there was a great improvement from pre to post, and then a dip from post to follow-up. On the scheduling subscale, participant 7 evidenced a trend not in the expected direction – same scores in pre and post, and a dip from post to follow-up. This change was not clinically significant, RCI = -0.62. On the cultural competence scale, participant 7 evidenced slight improvements from pre to follow-up, but it was not significant (RCI = 0.94). Additionally, on this subscale, there was a dip from pre to post, and then a slight increase from post to follow-up.

Results for participant 8's (BA condition) BASA scores are displayed on table 12. Overall, participant 8 evidenced clinically significant improvements from pre to follow-up on the overall BASA scale, RCI = 7.42. However, his overall BASA score increased a great deal from pre to post, and then dipped slightly from post to follow-up. Participant 8 also evidenced clinically significant improvements on the rationale (RCI = 5.30), avoidance (RCI = 17.04), and cultural competence (RCI = 2.59) subscales. On the

rationale subscale, scores followed a similar pattern to the overall BASA scores, greatly

increasing from pre to post, and then slightly dipping at follow-up. Yet, scores steadily

improved from pre to post to follow-up on both the avoidance and cultural competence

subscales. Though on the scheduling subscale, participant 8 did slightly improve from pre

to follow-up, the difference was not clinically significant (RCI = 0.53). Additionally, on

this scale scores again followed a pattern similar to overall BASA scores whereby

increasing a post and then dropping slightly at follow-up. Scores on the assessment

subscale were not in the expected direction where it increased at post, and then dropped

below the pre-training score at the follow-up assessment. This change was not clinically

significant (RCI = -1.34)

Results for participant 9's (BA condition) BASA scores are displayed on table 13.

Participant 9 evidenced a clinically significant improvement on overall BASA scores

from pre to follow-up, RCI = 9.49. On the entire BASA, participant 9's scores greatly

improved from pre to post, and then dipped slightly at follow-up. Additionally,

participant 9 showed clinically significant improvements from pre to follow-up on the

rationale (RCI = 11.61), assessment (RCI = 3.56), and the avoidance (RCI = 20.50)

subscales. For the rationale and avoidance subscales, scores steadily increase from pre to

post to follow-up. On the assessment subscale, the score greatly increased from pre to

post, and then plateaued at follow-up. Results on the cultural competence scale did

evidence steady improvements through time, but differences were not clinically

significant, RCI = 1.89. Lastly, scores on the scheduling subscale were not in the

expected direction and showed approximately equivalent scores between pre and post,

and then a big decrease at follow-up. This decline was clinically significant, RCI = -3.09.

Results for participant 10's (BA condition) BASA scores are displayed on table 14. Participant 10's overall BASA scores indicate a clinically significant improvement from pre to post (RCI = 6.19). Overall scale scores increased from pre to post, and stayed consistent at follow-up. Results also indicated clinically significant improvements from pre to follow-up on the rationale (RCI = 8.59) and the scheduling (RCI = 2.21) scale. Scores on these two subscales steadily increased from pre to post to follow-up. There were improvements on the assessment (RCI = 1.78) and the cultural competence (RCI = 0.47) subscales, but improvements were not clinically significant. On both of these scales, scores were greatly increased at post, but slightly dipped at follow-up but not below pre-training scores. Lastly, scores were not in the expected direction on the avoidance scale, nor were changes clinically significant from pre to follow-up (RCI = -1.29). On this subscale, scores increased greatly at post, but dipped below pre-training score at follow-up.

Reliable change by condition. Differences in proportions of clients who reached reliable change from pre to follow-up were examined using Fisher's Exact Test for the BASA overall scale and subscales. On the rationale subscale, Fisher's Exact Test was not calculated as all participants in both conditions reached reliable change. On the assessment subscale, results indicated no significant differences between the number of BA + CC (3 of 6, 50%) and BA (2 of 4, 50%) participants who reached reliable change, Fisher's Exact Test, p = 1.0. Results suggested that on the activity scheduling scale, there was not a significant difference between the number of BA + CC (2 of 6, 33%) and BA (1 of 4, 25%) participants who reached reliable change, Fisher's Exact Test, p = 1.0. Results on the techniques targeting avoidance scale indicated no significant differences

between the number of BA + CC (5 of 6, 83%) and BA (3 of 4, 75%) participants who reached reliable change, Fisher's Exact Test, p = 1.0. Lastly, on the cultural competence scale, there were no significant differences between the number of BA + CC (5 of 6, 83%) and BA (1 of 4, 25%) participants who reached reliable change, Fisher's Exact Test Regarding the BASA overall scale (without cultural competence), results indicated that there were no significant differences between the number of BA + CC (3 of 6, 50%) and BA (4 of 4, 100%) participants who reached reliable change, Fisher's Exact Test, p = .20., p = .19. Reliable change percentages by scale and condition for each scale are displayed on tables 15 through 21.

Level of Implementation and Confidence Utilizing BA Skills Questionnaire

  Implementation of BA skills. We sought to compare participant's utilization of BA skills across the weeks of the training through mixed between-within subject ANOVAs. Specifically, we sought to explore patterns of skill employment on each of the skills on which the modules centered (e.g., BA rationale, informal assessment, values assessment, activity monitoring, activity scheduling, avoidance) by deriving percentages of depressed clients which whom each skill was employed. For example, if a participant had 10 depressed clients in one week and reported delivering a BA specific rationale to three participants, their score would be 30 percent for that skill. Given that there was a large amount of missing data at random it became difficult to run ANOVAs as participants generally provided information regarding their implementation of BA skills sporadically. For example, participant 1 provided rationale implementation for week 1 and week 3. Thus, it became difficult to draw out a meaningful pattern of skill utilization. This was not an isolated example as by and large all participants had missing data.

Additionally, we decided not to run parametric analyses as there were not equal numbers of data points provided each week for any subscales. Furthermore, when there were equal numbers of data points between weeks, they were not necessarily from the same participants. Percentages of implementation for each scale by week are displayed on tables 22 through 27.

Perceived confidence utilizing BA skills. In addition to examining what percentages of clients with whom specific BA skills were utilized, we sought to examine the level of perceived confidence therapists felt employing those skills. Just as with the implementation data, there was a great deal of missing data seemingly at random. As such, it became difficult to run parametric tests in order to see trends across time. Specifically, there were not equal data points from week to week, and when there were they were not necessarily from the same participants. Confidence ratings for each scale by week are displayed on tables 28 through 33.

SCL Codes

We sought to objectively rate therapist-(hypothetical) client interactions through pre, post, and follow-up using the SCL Coding System. During the phase of re-calibration between the two coders, 8 sessions were coded. Both coders rated independently and discussed scores. Additionally, when discrepancies occurred, coders discussed their understanding of a particular anchor with regard to specific therapist utterances. During this phase (approximately 40 hours) coders were not able to reach ICC's above .80 on all scales, as listed on table 34. Specifically, the ICC values equaled .70 for C (learning the client's perspective), .44 for T (communicating the therapist's perspective), .45 for C1 (integration of client's views), .66 for C2 (working towards buy-in), .15 for C3

(negotiation of a shared narrative), and .69 for F (facilitating the client's story). An ICC

could not be calculated for the D (clinician's negative behaviors) scale as there was not

enough variability in the sample. Given this, we conclude that this is an unreliable

measure of in-session cultural competence. In this light, we decided to not report on data

obtained from this measure.

Latino Values Questionnaire

Scores (percentage of items correct) on the Latino Values Questionnaire are

presented on table 35. Scores were compared from pre to post. In the entire sample, there

were no significant differences by time, t (6) = .000, p = 1.00. Additionally, when looking

at differences by time and condition, results indicated that there were no significant

differences in the BA + CC condition, t (4) = .000, p = 1.00. Moreover, given that only

two participants took the questionnaire at both time points, the correlation could not be

computed because the standard error of the difference is 0.

Multicultural Awareness, Knowledge and Skills

Average scores on each subscale (i.e., awareness, knowledge, skills) are

represented on table 36. Scores were compared from pre to post for the entire sample.

Results revealed no significant difference on the awareness subscale, t (7) = 0.00, p =

1.00, and a small sample size, d = .08. The knowledge subscale also did not experience

any significant differences, t (7) = -1.11, p = .31, d = .08. Results also indicated that there

was no significant difference in scores on the skills subscale, t (7) = -0.08, p = .94, and a

small sample size. We also sought to explore scores across time (from pre and post) by

condition. Results from the BA + CC condition indicated that there were no significant

differences on the awareness subscale, t (4) = 0.34, p = .75, and it produced a small

effect, $d = .18$. On the knowledge subscale, results indicated no significant differences, t (4) $= -1.72$, $p = .16$, and a small effect, $d = .31$. But, there was a significant improvement on the skills subscale, t (4) $= -5.25$, $p = .006$, and a small effect, $d = .44$. Regarding scores for the BA condition, results revealed no significant differences on the awareness subscale, t (2) $= -0.28$, $p = .81$, and a small effect, $d = .19$. The knowledge subscale also did not experience any significant differences, t (2) $= 1.11$, $p = .38$, and it revealed a small effect, $d = -.25$. Lastly, the skills subscale also did not experience any significant changes across time, t (2) $= 1.73$, $p = .26$, but there was a large effect, $d = -.82$.

Acceptability of Training

Table 37 provides a detailed breakdown of individual item ratings of quality and usefulness of specific training components. Table 38 represents percentages of participants that reported specific training components as helpful.

Before training preparation. Depending on the condition, participants were asked to complete certain tasks before the first session. The BA + CC group was asked to complete readings on the SCL model as well as watch a self-paced introductory video on principles underlying the model. Five out of six participants completed this questionnaire and rated both the quality and usefulness of the before training preparation as 3.60 (SD = .55) out of 5. These scores indicate "fair" quality of the material and that they were "somewhat useful". Six out of six (100 percent) BA + CC trainees reported that the before training preparation was helpful to them.

The BA condition was instructed to read articles focused on BA's history and theory. Two out of 4 participants completed this questionnaire and rated the quality at 2.00 (SD = 1.41) indicated a "poor" quality. Participants rated the usefulness at 2.00 (SD

= 1.15), indicating the readings were "mostly, not useful". Regarding helpfulness of the

BA readings, two out of four (50 percent) indicated they found them helpful.

Cultural competence module. Six participants out of six from the BA + CC

condition completed the weekly satisfaction questionnaire regarding the first session

meeting where they received the cultural competence module. The average total quality

score was 4.17 (SD =.75), indicating "good" quality of the content of the meeting and

understanding of the process-based approach to cultural competence (e.g., in-session

cultural competence behaviors). Six out of the six participants also rated the usefulness of

the module at 4.17 (SD =.75), thus indicating the module was "mostly useful". Regarding

helpfulness of the module, six out of six participants reported that they did find it helpful.

The qualitative feedback (see table 39) that was provided suggested that the participants

felt they could incorporate various components of the training into their practice. For

example, participants highlighted the importance of acknowledging possible different

perspective ("CC implies integrating perspectives and requires understanding client's

values"), having a shared narrative (e.g., "To more explicitly state my formulation of the

problem and search for a shared narrative with the client"), and for having a definition of

culture that goes beyond racial or ethnic categories (e.g., "There is a difference between

ethnicity and culture"). Participants did not comment on any components of the module

that they did not find helpful. When asked about any recommendations for presenting

information differently, there were mixed comments regarding the in-session rapid fire

role plays. One participant found them helpful (e.g., "The role plays were helpful, but we

ran out of time before reaching the last one"), while another mentioned that there need to

be changes (e.g., "The role plays were sometimes difficult to follow… it might have been helpful to have the leaders jump in and help the role play stay closer to the ideal").

BA history module. Qualitative feedback (see table 40) suggested that participants found several parts of this module helpful in learning about BA regarding its effectiveness (e.g., "The cost-effectiveness of BA training"; "The likelihood that BA, even without additional techniques, may be effective"; "It was helpful to know the efficacy of BA in general and across cultures"), its history (e.g., "It is helpful to see the history"), and the importance of knowing the treatment (e.g., "How costly depression will be in coming decades"). When asked if there were any components that were not helpful, one participant noted that there was material presented that was not listed in the slides (e.g., "It was a little taxing to follow along with the slides not congruent with the lecture. I found myself really focused on trying to write everything down."). With regards to any recommendations for future studies, participants reported the information on the slides be easier to read (e.g., "Some of the graphs were pretty small, but it was fine for an intro"), or having more accountability for the readings (e.g., "Maybe asking people to email back that they have received the preparatory reading/slides").

Delivering a specific BA rationale module. Four participants out of six from the BA + CC condition completed the weekly satisfaction questionnaire regarding the rationale module where they learned how to deliver a specific BA rationale (see table 41). The average total quality score was 4.75 (SD =.50), indicating an almost "excellent" quality of the content of the meeting and understanding on how to introduce BA (e.g., "three circles model"). Six out of the six participants also rated the usefulness of the module at 5.00 (SD =.00), thus indicating the module was "extremely useful". Regarding

helpfulness of the module, four out of six participants reported that they did find it helpful.

From the BA condition, one participant out of four completed the weekly satisfaction questionnaire regarding the rationale module and rated it at 4.00, indicating an almost "good" quality of the content. That participant also rated the usefulness of the module at a 4.00, this indicating the module was "mostly useful". Lastly, that participant reported that this module was helpful.

Qualitative feedback suggested that people found specific components of the module helpful to the extent they would incorporate it into their practice, such as the "three circles model" (e.g., "Discussing the cycle of depression with patients"; "The circle model, which presents the 'why' of BA"), setting up the context for BA (e.g., "Providing rationale is the first step in BA. By setting the treatment context, it makes future interventions meaningful"), and dealing with avoidance at the rationale (e.g., "How to respond to avoidance when presenting the BA rationale; approaching the client's response, particularly the cognitive piece, with a BA-consistent/behavioral response"). Participants did not report that any components in the module were not helpful. However, there was a recommendation to increase the number of in-session rapid fire role plays (e.g., "The role plays are very helpful. The more the better").

Assessment module. Four participants out of six from the BA + CC condition completed the weekly satisfaction questionnaire regarding the assessment module where they learned various kinds of BA assessments (see table 42). The average total quality score was 4.50 (SD =.58), indicating a "very good" quality of the content of the meeting and understanding on how to introduce BA (e.g., informal interviewing, values

assessment, activity monitoring). Six out of the six participants also rated the usefulness

of the module at 5.00 (*SD* =.00), thus indicating the module was "extremely useful". Of

those completed the questionnaire regarding helpfulness of the module (four out of six

participants), 100 percent reported that they did find it helpful.

Out of the BA condition, three out of six participants rated the quality of the

module. The mean score was 4.33 (*SD* = .58), indicating "good quality". Three out of six

participants rated the usefulness of this module at 4.00 (*SD* = 1.00) indicating that it was

"somewhat useful". Out of those that completed the weekly questionnaire following this

module (three out of four), 100 percent rated it as being helpful.

Qualitative feedback of this module suggested participants took away several key

points concerning assessment of activities to schedule, including being concrete and

specific (e.g., "Being concrete, specific and focusing on behaviors"; "Looking at

contingencies and short term rewards"), using forms (e.g., "The forms will be helpful, I

think, in helping me to be better organized and to identify activities that will be more

reinforcing for the client."), and keeping in mind avoidance when scheduling activities

(e.g., "Ongoing work on avoidance was helpful"). Additionally, when asked about

specific components of the training that did not feel helpful, one participant listed the in-

session rapid fire role play (e.g., "I have realized that I am really quite intimidated by the

other regular group class participants… I have to admit that I dread the role plays we do

more than any other role plays I have done I other trainings"). Yet, most participants

replied that nothing came to mind. Lastly, there were a mixture of responses concerning

if information should be presented differently in future studies. Specifically, some

reported that they liked everything about this module (e.g., "Everything has been

exceptionally helpful and well taught."), one participant remarked that the content feels realistic (e.g., "I liked having people discuss their personal cases or their clients, it makes the content more real."), and one participant reported they would like more in-session practice through role plays (e.g., "Although it probably would take at least an hour, it might be helpful to role-play an intake of a new client and have us identify the targets for BA assessment and come up with a case conceptualization").

Activity scheduling module. Four out of six participants in the BA + CC condition took the weekly questionnaire following the activity scheduling module where participants learned how to assign activation assignments (see table 43). The average total score was 4.75 (*SD* = .50) indicating the module's quality was "very good". Four out of six participants also rated the usefulness at 4.75 (*SD* = .50), indicating the module was "very useful" to them. Lastly, regarding the helpfulness of the module, 100 percent of participants that completed this questionnaire (four out of six participants) rated it as being helpful to them.

From the BA condition, three out of four participants took the acceptability questionnaire and rated the quality on average at 4.00 (*SD* = 1.00), indicating it was of "good" quality. Regarding the usefulness, of the participants (three out of six) that took the questionnaire the mean usefulness rating was 4.00 (SD = 1.00) suggesting it was "somewhat useful". Three out of six participants rated the helpfulness of this module and 100 percent found it helpful.

The qualitative feedback that was provided concerning this module suggested that participants felt they could incorporate specific tips of activity scheduling, including scheduling activities concretely (e.g., "Being specific and concrete"), problem solving

obstacles (e.g., "Looking for obstacles and problem solving the obstacles"), considering

task difficulty (e.g., "The idea that an assignment needs to be *just right*"), and scheduling

the right number of activities (e.g., "Taking small steps for 3-5 activities per week").

Regarding if there were components of the training that participants did not find helpful,

four participants reported "no", and one participant remarked on confusion regarding the

trainee's homework of scheduling activities for him/herself (e.g., "It is not clear if the

activities should be done just one time per week or numerous times during the week").

When asked about any changes to make for future trainings, participants reported having

readings with more anticipation to this module (e.g., "One thing that could have been

helpful was to get that article as soon as we signed up for the class"), having more time

be devoted to avoidance related to mood (e.g., "I would have liked to spend more time

discussing ways to respond to [the] *I did the activity, but my mood didn't change and I*

don't think this is working [prompt]"), and more background in behaviorism (e.g., "As I

have not been trained as a behaviorist, I would benefit from more examples of how to

frame core issues in behavioral terms, but I think that will come with practice").

　　　　Avoidance module. Six out of six participants in the BA + CC condition rated the

quality of the avoidance module where participants learned techniques to target

avoidance of scheduled items (e.g., use of reminders to maximize activity completion,

use of skills training to maximize activity completion, use of contingency management to

maximize activity completion). Means are listed on table 44. The mean quality score was

4.50 (*SD* = .55), suggesting the module was of "good" quality. Five out of six participants

on average rated the usefulness at 4.80 (*SD* = .45), indicating it was "very useful". Out of

the six participants that took the questionnaire, 100 percent found the module to be

helpful to them.

In the BA condition, three out of four participants completed the weekly acceptability questionnaire following the avoidance module. The average quality score was 4.33 ($SD = .58$), thus indicating a "good" quality. Three out of four participants also rated the usefulness of the module at 4.33 ($SD = .58$), suggesting it was "somewhat useful". Regarding the helpfulness of the module, three out of four participants completed this questionnaire item. 100 percent of them found it helpful.

Participants' qualitative feedback on this training module indicated specific components related to avoidance were helpful to the extent participants would incorporate into their practice. Specifically, participants commented on rumination as avoidance (e.g., "Treating rumination as yet another type of avoidant strategy."), the TRAP/TRAC techniques (e.g., "Using the acronym of changing TRAP to TRAC."), the outside-in approach (e.g., "Act according to a plan, not your mood") and connecting values to activities (e.g., "Linking activities to values"). Some participants reported that there were no components of this module that were not helpful. However, some participants reported that they would have liked real-life examples of avoidance (e.g., "I thought it would be helpful to have "client" examples of avoidance. Especially when there are many excuses they can give"), more practice (e.g., "I think more practice would help), and that they had difficulties with the rapid-fire role plays (e.g., "I found the group exercise very challenging and intimidating"). Regarding changes to make for future trainings, the majority of participants reported that no changes needed to be made. However, some reported that the in-session rapid fire role plays should have more real-life examples (e.g., "Perhaps help us to provide "real plays" that offer better examples of

avoidance"), and equal time for each participant to practice the skills (e.g., "Some participants had much more time to interact during the real play than others").

Feasibility

We sought to examine to what extent it would be feasible to conduct this sort of modularized online training through a feasibility questionnaire which examined percentages completed of specific training components (see table 45). Six out of ten participants (five in the BA + CC condition, and one in the BA condition) completed the feasibility questionnaire. Results indicated that all participants completed the training sessions and the role play assessments. However, in the BA + CC condition, of those that took the questionnaire 80 percent (four out of five participants) completed that self-paced cultural competence video. This video was only given to the BA + CC condition during the study, but provided to participants in the BA condition after the study was over. With regards to the reading, in the BA condition 20 percent (one out of five participants) "skimmed the reading", 20 percent (one out of five participants) "did half of the reading", 40 percent (two out of five participants) did "almost all of the reading", and 20 percent (one out of five participants) "completed all of the reading". In the BA condition, the participant who completed the questionnaire reported she "completed all of the reading". The feasibility questionnaire asked participants to explain why they did not complete certain aspects of the training if they had indicated so. Responses indicated that participants would have either liked to have these self-paced materials with more anticipation, or that their schedules were so full that it would not allow to completed these components.

Power Analysis

Power analyses for the present study were not carried out because they were not warranted. The present study is exploratory in nature and thus only preliminary effectiveness was examined. It is beyond the scope of this research study to use power analyses to detect meaningful effect sizes. Preliminary outcome findings will inform power analyses in future evaluations of training efficacy.

Discussion

This manuscript presents preliminary findings on the implementation and evaluation of an online, modularized BA training package (Puspitasari et al., 2013) that included an exploratory cultural competence component through the use of a small RCT. The training package is based on a modular active learning model and targets five core skills (e.g., cultural competence, providing a BA-specific rationale, assessment, activity scheduling, and techniques for targeting avoidance). The cultural competence component was based on a longer workshop-style training based on the SCL model developed by López and colleagues (López, 1997; Lakes, López, & Garro, 2006).

The primary aim of the present study was to examine efficacy of specific training modules. Our first hypothesis was that the BA + CC condition would evidence greater acquisition of cultural competence skills in comparison to the BA condition from pre to post-training and would maintain gains at a 1-month follow-up. The results yielded are inclusive with regard to this hypothesis. Specifically, both conditions evidenced significant improvements from pre to follow-up on the BASA cultural competence subscale, however the BA + CC condition experienced a change with an effect size that was almost double than that of the BA condition. Moreover, only the BA condition

improved significantly from pre to post. In addition, regarding whether changes from pre to follow-up were clinically relevant, we calculated RCIs for all subscales of the participants. Results suggested that out of the 10 study participants, six (five from BA + CC condition, one from BA condition) had evidenced reliable changes on the cultural competence subscale. Single subject analysis on this subscale indicated that from pre to post seven out of 10 participants (four from BA + CC condition, three from BA condition) improved, and from pre to follow-up nine participants (five from BA + CC condition, four from BA condition). Analyses were conducted on this scale to determine if there were significant differences by condition on number of individuals who reached reliable change. Results indicated that there were no significant differences.

The finding that both conditions improved in their cultural competence in-session skills is interesting. It is unclear whether the training dose was strong enough to produce more robust changes given the low power. Another possibility is that the learning of behavioral skills helps cultural competence. Yet another explanation could be that the cultural competence module is just teaching good therapy skills not specific to cultural competence. It is also possible that participants improved over times due to a practice effect given that the hypothetical client utilized in the role play assessment was used at every time point. Our interpretations of this data are limited, as these preliminary conclusions have been made from the BASA instrument. A stronger measure of cultural competence would have been the SCL Coding System, yet poor reliability on the measure prevented us from studying this.

Our second hypothesis was that the BA and BA + CC conditions would not differ in their level of acquisition of BA skills as measured by the BASA, such that cultural

competence training would not be detrimental to the learning of core BA skills. To begin to answer this question, we examined to what extent scores significantly changed over time. Overall, there appears that there was significant learning taking place across the board except for the assessment and scheduling subscales – results of which are unexpected provided that these are key components of BA.

Regarding overall BA competency (without taking into account the cultural competence subscale), results indicated that the BA condition saw significant improvements from pre to post, and from pre to follow-up; yet the BA + CC condition did not experience significant changes across time. Those in the BA condition experienced a slightly larger increase in their competency across time. And even though both conditions yielded large effect sizes when comparing scores from pre to follow-up, the BA condition evidenced an effect size twice the size of that of the BA + CC condition. Additionally, seven out of 10 (three from BA + CC condition, four from BA condition) participants evidenced clinically significant improvements from pre to follow-up as revealed by significant RCIs. When exploring results at the single-subject level, from pre to follow-up eight out of 10 (four from BA + CC condition, four from BA condition) participants evidenced improvements. From pre to post, again eight out of 10 (four from BA + CC condition, four from BA condition) participants evidenced improvements. Analyses examining if there were any significant differences between conditions on the number of participants who reached reliable change from pre to follow-up indicated that there were no significant differences.

On the rationale subscale, both conditions experienced significant improvements from pre to follow-up, whereas only the BA condition experienced significant

improvements from pre to post. Both conditions yielded large effect sizes, yet the BA condition yielded an effect size three times larger than that of the BA + CC condition. All participants in both conditions evidenced clinically significant improvements, according to RCIs, from pre to follow-up. Additionally, when comparing pre to follow-up scores on a single-subject basis, all participants improved. However, when comparing scores from pre to post, seven out of 10 (three from BA + CC condition, four from BA condition) participants showed increases in their scores on this subscale. Results suggested no differences between conditions on the number of participants who reached reliable change from pre to follow-up.

Results from the assessment subscale suggest that only the BA condition evidenced significant improvements across time, namely from pre to post. There were no significant changes from pre to post nor from pre to follow-up for the BA + CC condition, and no improvements from pre to follow-up for the BA condition. Results (from pre to follow-up) indicated that the BA condition evidenced a medium effect size where the BA + CC condition evidenced a very small effect size. RCI scores on the assessment subscale indicate that seven out of 10 (five from BA + CC condition, two from BA condition) participants evidenced clinically significant improvements from pre to follow-up. Single-subject analyses on this subscale reveal that from pre to follow-up six out of 10 (three from BA + CC condition, three from BA condition) participants evidenced improvements, and from pre to post seven out of 10 (three from BA + CC condition, four from BA condition) participants saw improvements. Regarding the number of participants who reached reliable change from pre to follow-up, results indicated that there were no significant differences between conditions.

Regarding the activity scheduling subscale, neither condition experienced significant improvements from pre to follow-up, nor pre to post. Moreover, both conditions yielded small effect sizes from pre to follow-up. RCI analysis indicated that five out of 10 (three from BA + CC condition, two from BA condition) participants evidenced clinically significant improvements from pre to follow-up. Furthermore, single-subject analyses indicated that from pre to follow-up six out of 10 (three from BA + CC condition, three from BA condition) participants evidenced improvements, and from pre to post five out of 10 (two from BA + CC condition, three from BA condition) participants saw improvements. Results suggested there were no significant differences between conditions on the number of participants who reached reliable change from pre to follow-up.

In the techniques targeting avoidance subscale, results revealed that both conditions evidenced significant improvements from pre to post, but not from pre to follow-up. Even though both conditions yielded large effect sizes when scores were compared from pre to follow-up, the BA condition had an effect size that was twice as large as the BA + CC condition. RCIs revealed that nine out of 10 (six from BA + CC condition, three from BA condition) participants evidenced clinically significant improvements from pre to follow-up. Furthermore, single-subject analyses indicated that from pre to follow-up seven out of 10 (four from BA + CC condition, three from BA condition) participants evidenced improvements, and from pre to post all participants evidenced improvements. Analyses examining differences between conditions on number of participants who reached reliable change were not significant.

In answering the question about to what extent cultural competence would or would not hinder acquisition of BA skills, results indicated that overall participants in the BA condition consistently showed higher scores across time. Additionally, on four scales (i.e., overall BASA measure, rationale, assessment, techniques targeting avoidance) the BA condition yielded larger effect sizes than the BA + CC condition. Moreover, on those four scales, though both conditions started at approximately equal baselines, the BA condition consistently showed higher scores at post and at follow-up. These findings taken together raise a concern that teaching cultural competence may somehow make it harder to maximize learning the BA model. Thus, our second hypothesis was not supported by the data.

Even though these results suggest that the cultural competence training might have hindered some learning of BA, results are promising with respect to the impact of training despite a very small sample size, as indicated by blind objective ratings of skill with a hypothetically depressed client before the start of training and after completion of all training components, including therapist receipt of personalized feedback. Provided that due to a small sample size our ability to detect statistically significant changes was hampered, it is important to note that by and large study data yielded generally large effect sizes for numerous scales (e.g., overall BASA score, rationale, avoidance, and cultural competence).

The second aim of the present study was to detect changes in participants' multicultural awareness, knowledge and skills through the use of the MAKSS measure and Latino cultural knowledge through the Latino Values Questionnaire. We first hypothesized that the BA + CC condition would experience significant changes in their

skills related to multiculturalism, but not their knowledge or awareness. Our second

hypothesis was that participants in the BA condition would not experience significant

changes in skills, knowledge or awareness. As expected, the results did not evidence

significant changes from pre to post for participants on the awareness or knowledge

subscales. We believe this is due to the fact that the training focused on in-session

cultural competence skills. However, results supported our first hypothesis suggesting

that participants who received the cultural competence module (BA + CC condition) did

evidence significant increases in their perceived multicultural skills, whereas those who

did not receive the module had equivalent scores before and after the training. These data

are promising to the extent that they provide some preliminary evidence to suggest the

training could improve one's perceived cultural competence skills. It is particularly

important to note that we noticed significant improvements in skills in both conditions on

the BASA, yet only the BA + CC condition significantly improved on the MAKSS skills

scale. Given that objective ratings of cultural competence (through the BASA) indicated

improvements in both conditions, it may be not only important to have the skills, but also

to believe that you have the skills. It is possible that those that did not receive the cultural

competence module did not believe they improved in their cultural competence solely

due to the fact that they did not receive the training. If the cultural competence training

taps into general skills, then it begs the question why we do not see changes in

perceptions of one's cultural competence? A further interpretation of this finding is that

the MAKSS (self-report) measure is more sensitive to demand characteristics, and the

BASA cultural competence subscale (objective rating) is a more objective rating of

cultural competence. Thus, it is possible participants in the BA + CC condition reported that the skills changed because that is what they felt they should report.

Given that the hypothetically depressed client that was utilized for the role plays was Puerto Rican and her narrative explained that her depression was a result of a *brujeria* (spell) cast onto her, we hypothesized trainees might see an increase in their knowledge of Latino values through the course of the study. Stated another way, we hypothesized that perhaps interacting with a client from a particular culture might increase one's ability to detect common values for that group. This hypothesis was unsupported as evidenced by scores on the Latino Values Questionnaire, devised by the research team. Specifically, scores remained virtually equal from pre to post. We had also hypothesized that those that knew more content about a specific group might display more cultural competence. Given that we could not utilize the SCL Coding System, we were not able to fully test this hypothesis. There are several possible explanations for this finding. It is possible that interacting with a client from a distinct cultural background briefly might not affect one's knowledge of values of a particular racial and ethnic group; the interactions with the client might not have been long enough to reflect changes, but they might be visible with a long-term client, or the values utilized in the questionnaire might have been invalid provided that it was briefly developed without an empirical basis for choosing such items. Furthermore, it is possible there were no changes in the questionnaire as the training was focused on in-session cultural competence skills, not multicultural awareness of other racial and ethnic groups.

However, the Latino Values Questionnaire may be problematic for a variety of reasons. First, the cultural competence module focuses on process and not categorizing

individuals into categories based on race or ethnicity. In this regard it is expected that we did not see any shifts in this measure. Secondly, the research team quickly devised this measure, which was not empirically driven. It is possible the research team did not tap into the correct constructs. Third, we recognize that there are not agreed-upon Latino values as the term Latino represents individuals from the majority of the Americas. As such, we know that there is pronounced heterogeneity of backgrounds and cultures when referring to Latinos. A values questionnaire is problematic as it reinforces cultural stereotypes and it becomes difficult to identify the items that make it onto a brief questionnaire as values can vary from individual to individual.

The third aim of the study was to assess acceptability of training for participants. We hypothesized that study participants would evidence acceptability of the training components as evaluated through weekly qualitative and quantitative feedback. Results indicated that participants generally found both the quality and the usefulness of the training to be very good. Participants were satisfied generally with the active learning components of the training modules, yet ratings of acceptability tended to be lower for training components participants were to complete before receiving the training modules. Specifically, participants generally felt they did not have enough time to complete the readings before the first module, but the cultural competence video was slightly more helpful. These data suggest that perhaps a shorted interactive video would be the best strategy to prime trainees before a modularized training in the future. It is possible that if more information is given in this format before the start of the training, improvements across time might be more pronounced.

The last aim of the study was to examine feasibility of the training module and procedure. We predicted that training of cultural competence skills would be feasible as assessed via number of training sessions attended, assessments completed, and completion of self-paced materials. By and large, results indicated that this type of training modality is feasible given that participants completed the vast majority of training components. Provided that in general participants cited time as the main reason for why they did not complete certain self-paced training components (i.e., readings, cultural competence video), future trainings ought to allow more time for participants to receive and go through these materials. Additionally, it is important to note that throughout the study one of the challenges was having the trainees complete all of the self-reported questionnaires. In fact, only six out of 10 participants completed the feasibility questionnaire. Given that these questionnaires were given once a week for a period of 10 weeks, it is possible participants found this to be burdensome. It is also possible that emails containing the links to the emails might have not been attention-grabbing enough and thus they might have been missed sometimes by participants. Though the trainers occasionally reminded participants to complete the surveys, it is possible there might be higher rates of completion with more frequent reminders from the trainers at the training sessions. Another possibility is that participants might not have liked the online format of the questionnaires. It is difficult to know what participants thought about the number and quality of weekly questionnaire as they were not asked to provide feedback on this aspect of the study. It would be important to include this in future studies.

The findings from this study are reported as exploratory and preliminary given several significant limitations, primarily the small sample size in both conditions. Secondly, conclusions from this study are limited as the original objective coding of cultural competence was not possible to report on. Additionally, the study participants did not complete all online weekly questionnaires, which made it difficult to compare scores from time point to time point. It is possible the online delivery of these questionnaires and time demands might have cause low completion rates. Moreover, when participants missed sessions, they attended the other teams corresponding modules. Thus, there is a potential leak between conditions. Additionally, BASA coders were not entirely independent from one another to the extent that they were allowed to discuss disagreements. Potentially, coders could have influenced one another. It also is important to note that the BASA scores of the participants of the present study were lower throughout compared to previous studies assessing the effectiveness of this BA training package delivered in an online format (Puspitasari et al., 2013). Lastly, the present study had a great deal of missing data from the self-report questionnaires. It is difficult to make conclusions based on this data as the same sizes on most weekly questionnaire significantly varied from week to week. It is possible that those that completed the questionnaires were motivated in the training and perhaps their scores might have looked differently from participants who did not complete the studies. Future studies ought to consider putting in place more reminders for participants to complete these questionnaires or larger incentives (e.g., giving a discount on the training to participants who complete all training components).

Nonetheless, despite these limitations, this study represents the first attempt to demonstrate an effective strategy to train in-session cultural competence skills to a wide range of mental health professionals embedded in a training for an evidence-based treatment for depression. Future studies aimed at improving the overall impact of the training and component analyses are necessary to evaluate potential active components of the training that account for improvement in cultural competence. Future studies should consider retaining the modularized format and adding multiple modules related to the SCL model. For example, one session could be devoted to the principles underlying the model, the remaining modules would correspond to specific behavioral indicators. Additionally, future studies ought to consider utilizing various hypothetical client scripts (e.g., clients from different cultural backgrounds) and randomize participants to receive a different one at each time point in order to decrease any possible practice effects. Additionally, instruments measuring common factors should be included to understand to what extent cultural competence is related to general therapy skills. Lastly, reliability for the objective measure of cultural competence (the SCL Coding System) needs to be improved. While the BASA cultural competence subscale was influenced by the SCL model, we feel that the SCL coding system could be an improvement as it is a more extensive measure.

Table 1

BASA measure inter-rater reliability

Scale	ICC	95% Confidence Interval	
		Lower	Upper
Overall BA Skill (w/o CC)	.94	.92	.96
1. Specific BA Rationale	.96	.91	.98
2. Assessment	.92	.80	.96
3. Scheduling Activities	.84	.66	.92
4. Techniques Targeting Avoidance	.96	.91	.98
Cultural Competence	.71	.39	.86

Note. ICC = Intraclass Correlation Coefficient

Table 2

BASA measure internal consistency

Scale	Cronbach's α
Overall BA Skill (w/o CC)	.79
1. Specific BA Rationale	.96
2. Assessment	.47
3. Scheduling Activities	.40
4. Techniques Targeting Avoidance	.92
Cultural Competence	.77

Table 3

Participant characteristics

Participant characteristics	BA + CC ($n = 6$)	BA ($n = 4$)	Total ($N = 10$)
Female: *n* (%)	4 (66.7%)	4 (100%)	8 (80%)
Age: *M (SD)*	44 (15)	45 (12)	44 (13)
Self-identified race/ethnicity			
White	4 (66.7%)	3 (75%)	7 (70%)
Native American	0 (0%)	1 (25%)	1 (10%)
Bi-cultural	1 (16.7%)	0 (0%)	1 (10%)
South American	1 (16.7%)	0 (0%)	1 (10%)
Highest degree			
BA/BS (in training)	1 (16.7%)	0 (0%)	1 (10%)
MA/MS/MPH	3 (50%)	1 (25%)	4 (40%)
PhD/PsyD	2 (33.3%)	3 (75%)	5 (50%)
Professional license			
None	0 (0%)	1 (25%)	1 (10%)
Licensed clinical social worker	1 (16.7%)	0 (0%)	1 (10%)
Marriage and family therapist	2 (33.3%)	0 (0%)	1 (10%)
Psychiatric nurse practitioner	0 (0%)	1 (25%)	1 (10%)
Psychologist	3 (50%)	2 (50%)	5 (50%)
Years of clinical experience: *M (SD)*	13 (13)	8 (9)	12 (11)
Work setting			
Outpatient mental health clinic	1 (16.7%)	0 (0%)	1 (10%)
Combine outpatient & individual private practice	1 (16.7%)	0 (0%)	1 (10%)
Community mental health clinic	1 (16.7%)	1 (25%)	2 (20%)
Group private practice	0 (0%)	1 (25%)	1 (10%)
Individual private practice	3 (50%)	1 (25%)	4 (40%)
Academic medical setting and teaching	0 (0%)	1 (25%)	1 (10%)
Hours per week in psychotherapy			
6-10 hours	0 (0%)	1 (25%)	1 (10%)
11-20 hours	1 (16.7%)	2 (50%)	3 (30%)
21-30 hours	4 (66.7%)	0 (0%)	4 (40%)
31-40 hours	1 (16.7%)	0 (0%)	1 (10%)
40+ hours	0 (0%)	1 (25%)	1 (10%)
Treatment modalities regularly used			
Individual	6 (100%)	4 (100%)	10 (100%)

Couples	2 (33.3%)	1 (25%)	3 (30%)
Family	3 (50%)	1 (25%)	4 (40%)
Group	4 (66.7%)	3 (75%)	7 (70%)
Children (0-12)	1 (16.7%)	0 (0%)	1 (10%)
Adolescents (13-17)	1 (16.7%)	2 (50%)	3 (30%)
Adults (18-65)	6 (100%)	4 (100%)	10 (100%)
Older adults (65+)	1 (16.7%)	0 (0%)	1 (10%)
Populations regularly treated			
White/Caucasian/European Am.	5 (83.3%)	4 (100%)	9 (90%)
Asian-American/Pacific Islander	4 (66.7%)	0 (0%)	4 (40%)
Middle Eastern	2 (33.3%)	0 (0%)	2 (20%)
Black/African American	4 (66.7%)	1 (25%)	5 (50%)
Non-white Hispanic or Latino/a	3 (50%)	0 (0%)	3 (30%)
Native American	3 (50%)	1 (25%)	4 (40%)
LGBT	5 (83.3%)	3 (75%)	8 (80%)
Other: South American	1 (16.7%)	0 (0%)	1 (10%)
Therapy provided in other languages			
Spanish	1 (16.7%)	0 (0%)	1 (10%)
Portuguese	1 (16.7%)	0 (0%)	1 (10%)
Presenting problems regularly treated			
Major depressive disorder/dysthymia	6 (100%)	4 (100%)	10 (10%)
Bipolar disorder/spectrum	3 (50%)	2 (50%)	5 (50%)
Anxiety disorders	6 (100%)	4 (100%)	10 (10%)
Trichotillomania, skin picking	5 (83.3%)	0 (0%)	5 (50%)
Psychotic disorders	2 (33.3%)	0 (0%)	2 (2%)
Somatoform disorders	3 (50%)	1 (25%)	4 (40%)
Chronic physical illnesses	5 (83.3%)	1 (25%)	6 (60%)
Sleep disorders	4 (66.7%)	1 (25%)	5 (50%)
Eating disorders	4 (66.7%)	1 (25%)	5 (50%)
Pervasive dev. disorders/ LD/MR	1 (16.7%)	0 (0%)	1 (10%)
Substance use/dependence	3 (50%)	2 (50%)	5 (50%)
Marital, relationship difficulties	5 (83.3%)	1 (25%)	6 (60%)
Adjustment disorders	4 (66.7%)	2 (50%)	6 (60%)
Axis II personality disorders	5 (83.3%)	4 (100%)	9 (90%)
Experience level with BA			
None	4 (66.7%)	2 (50%)	6 (60%)
Some	1 (16.7%)	2 (50%)	3 (30%)
Moderate	1 (16.7%)	0 (0%)	1 (10%)

Training in cultural competence			
None	1 (16.7%)	0 (0%)	1 (10%)
Some	1 (16.7%)	2 (50%)	3 (30%)
Moderate	2 (33.3%)	2 (50%)	4 (40%)
Extensive	2 (33.3%)	0 (0%)	2 (20%)
Level of comfort working with diverse clients			
Some	2 (33.3%)	1 (25%)	3 (30%)
Moderate	4 (66.7%)	3 (75%)	7 (70%)

Table 4

BASA scores

Scale	BA + CC (n = 6)			BA (n = 4)			Total (N = 10)		
	Pre	Post	FU	Pre	Post	FU	Pre	Post	FU
BASA	.41 (.07)	.49 (.15)	.54 (.15)	.43 (.07)[a,b]	.63 (.07)[a]	.61 (.06)[b]	.42 (.07)[c,d]	.55 (.14)[c]	.57 (.12)[d]
1.Rat.	.37 (.16)[e]	.48 (.27)	.60 (.14)[e]	.44 (.12)[f,g]	.70 (.13)[f]	.76 (.06)[g]	.40 (.14)[h,i]	.57 (.24)[h]	.66 (.14)[i]
2.Ass.	.35 (.14)	.36 (.09)	.37 (.16)	.36 (.12)[j]	.46 (.13)[j]	.44 (.09)	.36 (.12)	.40 (.12)	.40 (.13)
3.Sched.	.65 (.25)	.65 (.27)	.73 (.15)	.68 (.10)	.75 (.12)	.65 (.19)	.66 (.20)	.69 (.22)	.70 (.16)
4.Avo.	.25 (.13)[k]	.48 (.24)[k]	.46 (.33)	.23 (.09)[l]	.63 (.06)[l]	.57 (.26)	.24 (.11)[m,n]	.54 (.20)[m]	.50 (.30)[n]
CC	.32 (.13)[o,p]	.47 (.15)[o]	.59 (.12)[p]	.37 (.13)[q]	.46 (.09)	.50 (.16)[q]	.34 (.12)[r,s]	.46 (.12)[r]	.55 (.13)[s]

Note. BASA = Behavioral Activation Skills Assessment (Puspitasari et al., 2012); Rat = BA specific rationale; Ass = informal assessment; Sched = activity scheduling; Avo = techniques targeting avoidance; CC = cultural competence. Means with the same superscript were significantly different (p < .05). Overall BASA scores do not take into account cultural competence items.

Table 5

BASA scores for participant 1 (BA + CC)

Scale	Pre	Post	FU	RCI from pre to FU
BASA	.36	.39	.40	1.65
1.Rationale	.34	.29	.53	5.56*
2.Assessment	.33	.40	.25	-1.78
3.Scheduling	.74	.76	.70	-0.35
4.Avoidance	.04	.10	.11	2.25*
Cult. Comp.	.26	.46	.76	5.89*

Note. * = reliable change index was statistically significant (i.e., RCI > 1.96, p < .05).

Table 6

BASA scores for participant 2 (BA + CC)

Scale	Pre	Post	FU	RCI from pre to FU
BASA	.36	.66	.70	14.02*
1.Rationale	.52	.84	.84	8.08*
2.Assessment	.37	.22	.51	3.12*
3.Scheduling	.16	.96	.59	3.80*
4.Avoidance	.40	.63	.87	15.11*
Cult. Comp.	.48	.43	.68	2.36*

Note. * = reliable change index was statistically significant (i.e., RCI > 1.96, p < .05).

Table 7

BASA scores for participant 3 (BA + CC)

Scale	Pre	Post	FU	RCI from pre to FU
BASA	.53	.53	.49	-1.65
1.Rationale	.38	.41	.62	6.06*
2.Assessment	.58	.29	.33	-5.57
3.Scheduling	.87	.62	.57	-2.65
4.Avoidance	.29	.81	.45	5.14*
Cult. Comp.	.38	.67	.54	1.87

Note. * = reliable change index was statistically significant (i.e., RCI > 1.96, p < .05).

Table 8

BASA scores for participant 4 (BA + CC)

Scale	Pre	Post	FU	RCI from pre to FU
BASA	.37	.24	.36	-0.41
1.Rationale	.18	.12	.44	6.57*
2.Assessment	.42	.34	.18	-5.35
3.Scheduling	.76	.16	.79	0.27
4.Avoidance	.14	.34	.02	-3.86
Cult. Comp.	.14	.27	.45	3.65*

Note. * = reliable change index was statistically significant (i.e., RCI > 1.96, p < .05).

Table 9

BASA scores for participant 5 (BA + CC)

Scale	Pre	Post	FU	RCI from pre to FU
BASA	.46	.60	.59	5.36*
1.Rationale	.58	.75	.67	2.27*
2.Assessment	.20	.48	.34	3.12*
3.Scheduling	.76	.71	.74	-0.18
4.Avoidance	.31	.46	.59	9.00*
Cult. Comp.	.43	.63	.60	2.00*

Note. * = reliable change index was statistically significant (i.e., RCI > 1.96, p < .05).

Table 10

BASA scores for participant 6 (BA + CC)

Scale	Pre	Post	FU	RCI from pre to FU
BASA	.35	.52	.70	14.43*
1.Rationale	.22	.45	.50	7.07*
2.Assessment	.22	.42	.61	8.69*
3.Scheduling	.62	.68	.97	3.09*
4.Avoidance	.34	.54	.72	12.21*
Cult. Comp.	.26	.34	.49	2.71*

Note. * = reliable change index was statistically significant (i.e., RCI > 1.96, p < .05).

Table 11

BASA scores for participant 7 (BA)

Scale	Pre	Post	FU	RCI from pre to FU
BASA	.40	.57	.56	5.60*
1.Rationale	.45	.64	.70	6.31*
2.Assessment	.26	.28	.42	3.56*
3.Scheduling	.72	.72	.65	-0.62
4.Avoidance	.19	.65	.46	8.68*
Cult. Comp.	.53	.50	.61	0.94

Note. * = reliable change index was statistically significant (i.e., RCI > 1.96, p < .05).

Table 12

BASA scores for participant 8 (BA)

Scale	Pre	Post	FU	RCI from pre to FU
BASA	.52	.73	.70	7.42*
1.Rationale	.61	.89	.82	5.30*
2.Assessment	.43	.52	.37	-1.34
3.Scheduling	.74	.90	.80	0.53
4.Avoidance	.29	.63	.82	17.04*
Cult. Comp.	.43	.51	.65	2.59*

Note. * = reliable change index was statistically significant (i.e., RCI > 1.96, p < .05).

Table 13

BASA scores for participant 9 (BA)

Scale	Pre	Post	FU	RCI from pre to FU
BASA	.36	.62	.59	9.49*
1.Rationale	.33	.61	.79	11.61*
2.Assessment	.27	.43	.43	3.56*
3.Scheduling	.74	.75	.39	-3.09
4.Avoidance	.12	.69	.75	20.50*
Cult. Comp.	.26	.32	.42	1.89

Note. * = reliable change index was statistically significant (i.e., RCI > 1.96, p < .05).

Table 14

BASA scores for participant 10 (BA)

Scale	Pre	Post	FU	RCI from pre to FU
BASA	.43	.60	.58	6.19*
1.Rationale	.38	.65	.72	8.59*
2.Assessment	.49	.60	.57	1.78
3.Scheduling	.53	.62	.78	2.21*
4.Avoidance	.30	.55	.26	-1.29
Cult. Comp.	.27	.51	.31	0.47

Note. * = reliable change index was statistically significant (i.e., RCI > 1.96, p < .05).

Table 15

Number of Participants who Reached Reliable Change Index by Scale and Condition

Scale	BA + CC (*n* = 6)	BA (*n* = 4)	Total (*N* = 10)
	Pre-FU	Pre-FU	Pre-FU
BASA	4	4	7
1.Rat.	6	4	9
2.Ass.	5	2	7
3.Sched.	3	2	5
4.Avo.	6	3	9
CC	5	2	7

Note. BASA = Behavioral Activation Skills Assessment (Puspitasari et al., 2012); Rat = BA specific rationale; Ass = informal assessment; Sched = activity scheduling; Avo = techniques targeting avoidance; CC = cultural competence. Means with the same superscript were significantly different (p < .05). Overall BASA scores do not take into account cultural competence items.

Table 16

Reliable Change Index from Pre to Follow-up by Condition: Cultural Competence Subscale

RCI	Condition		Total
	BA + CC Condition (n = 6)	BA Condition (n = 4)	
Did not reach reliable change	1 (17%)	3 (75%)	4 (40%)
Reached reliable change	5 (83%)	1 (25%)	6 (60%)
Total	6 (60%)	4 (40%)	10 (100%)

Table 17

Reliable Change Index from Pre to Follow-up by Condition: Rationale Subscale

RCI	BA + CC Condition (n = 6)	BA Condition (n = 4)	Total
Did not reach reliable change	0 (0%)	0 (0%)	0 (0%)
Reached reliable change	6 (100%)	4 (100%)	10 (100%)
Total	6 (100%)	4 (100%)	10 (100%)

Table 18

Reliable Change Index from Pre to Follow-up by Condition: Assessment Subscale

RCI	BA + CC Condition (n = 6)	BA Condition (n = 4)	Total
Did not reach reliable change	3 (50%)	2 (50%)	5 (50%)
Reached reliable change	3 (50%)	2 (50%)	5 (50%)
Total	6 (60%)	4 (40%)	10 (100%)

Table 19

Reliable Change Index from Pre to Follow-up by Condition: Scheduling Subscale

RCI	BA + CC Condition (n = 6)	BA Condition (n = 4)	Total
Did not reach reliable change	4 (67%)	3 (75%)	7 (70%)
Reached reliable change	2 (33%)	1 (25%)	3 (30%)
Total	6 (60%)	4 (40%)	10 (100%)

Table 20

Reliable Change Index from Pre to Follow-up by Condition: Avoidance Subscale

RCI	BA + CC Condition (n = 6)	BA Condition (n = 4)	Total
Did not reach reliable change	1 (17%)	1 (25%)	2 (20%)
Reached reliable change	5 (83%)	3 (75%)	8 (80%)
Total	6 (60%)	4 (40%)	10 (100%)

Table 21

Reliable Change Index from Pre to Follow-up by Condition: Overall BASA Scale

RCI	BA + CC Condition (n = 6)	BA Condition (n = 4)	Total
Did not reach reliable change	3 (50%)	0 (0%)	3 (30%)
Reached reliable change	3 (50%)	4 (100%)	7 (70%)
Total	6 (60%)	4 (40%)	10 (100%)

Table 22

Self-Reported Therapist Implementation of BA Skills with Depressed Clients in Weekly Sessions for BA Rationale

	Percentage of clients with whom BA skills were utilized in sessions									
ID	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10
#1	0	---	0	---	---	---	---	---	---	---
#2	0	---	---	50	---	---	---	0	0	---
#3	16	0	0	0	0		---	0	---	21
#4	0	---	0	---	33	0	---	---	---	---
#5	0	0	---	0	0	0	0	0	25	---
#6	31	0	11	---	---	10	7	7	17	---
#7	0	---	0	21	5	6	6	6	---	---
#8	0	0	0	---	0	0	0	67	---	---
#9	0	---	---	---	0	---	---	0	---	---
#10	---	18	0	0	0	0	0	0	---	---

Note. Participants 1 through 6 were in the BA + CC condition. Participants 7 through 10 were in the BA condition.

Table 23

Self-Reported Therapist Implementation of BA Skills with Depressed Clients in Weekly Sessions for BA Assessment: Informal

Interviewing

	Percentage of clients with whom BA skills were utilized in sessions									
ID	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10
#1	14	---	9	---	---	---	---	---	---	---
#2	---	100	---	50	---	0	---	0	0	---
#3	16	100	93	---	21	---	---	60	---	21
#4	40	---	33	---	33	33	---	---	---	---
#5	100	50	---	75	67	75	75	75	75	---
#6	54	100	100	---	---	100	67	71	78	---
#7	0	---	0	0	0	0	0	0	---	---
#8	80	100	75	---	67	100	100	33	---	---
#9	0	---	---	0	---	---	---	0	---	---
#10	---	0	40	60	50	0	33	67	---	---

Note. Participants 1 through 6 were in the BA + CC condition. Participants 7 through 10 were in the BA condition.

Table 24

Self-Reported Therapist Implementation of BA Skills with Depressed Clients in Weekly Sessions for BA Assessment: Values

Assessment

ID	Percentage of clients with whom BA skills were utilized in sessions									
	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10
#1	11	---	0	---	---	---	---	---	---	---
#2	---	0	---	25	---	33	---	67	50	---
#3	---	26	93	0	0	---	---	100	---	21
#4	40	---	27	---	33	33	---	---	---	---
#5	0	50	---	25	0	0	50	25	25	0
#6	54	20	26	---	---	20	73	21	28	---
#7	0	---	8	0	0	0	0	0	---	---
#8	60	80	75	---	67	100	100	67	---	---
#9	0	---	---	0	---	---	---	0	---	---
#10	---	6	20	40	50	33	33	67	---	---

Note. Participants 1 through 6 were in the BA + CC condition. Participants 7 through 10 were in the BA condition.

Table 25

Self-Reported Therapist Implementation of BA Skills with Depressed Clients in Weekly Sessions for BA Assessment: Activity

Monitoring

ID	Percentage of clients with whom BA skills were utilized in sessions									
	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10
#1	3	---	6	---	---	---	---	---	---	---
#2	---	0	---	0	---	33	---	67	100	---
#3	---	100	33	0.6	21	---	---	48	---	21
#4	40	---	33	---	33	33	---	---	---	---
#5	0	0	---	25	67	50	75	75	50	---
#6	31	40	21	---	---	30	13	21	22	---
#7	0	---	0	0	0	0	0	0	---	---
#8	40	60	75	---	0	0	100	67	---	---
#9	0	---	---	0	---	---	---	0	---	---
#10	---	0	0	20	25	33	33	33	---	---

Note. Participants 1 through 6 were in the BA + CC condition. Participants 7 through 10 were in the BA condition.

Table 26

Self-Reported Therapist Implementation of BA Skills with Depressed Clients in Weekly Sessions for BA Assessment: Activity

Scheduling

ID	Percentage of clients with whom BA skills were utilized in sessions									
	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10
#1	6	---	6	---	---	---	---	---	---	---
#2	---	0	---	50	---	33	---	67	100	---
#3	14	95	13	20	1	---	---	48	---	21
#4	10	---	33	---	0.8	33	10	---	33	---
#5	100	50	---	50	67	75	75	75	75	---
#6	23	40	21	---	---	60	33	29	43	---
#7	0	---	8	21	0	11	13	6	---	---
#8	40	80	75	---	67	100	100	100	---	---
#9	0	---	---	0	---	---	---	0	---	---
#10	---	0	20	40	50	33	33	33	---	---

Note. Participants 1 through 6 were in the BA + CC condition. Participants 7 through 10 were in the BA condition.

Table 27

Self-Reported Therapist Implementation of BA Skills with Depressed Clients in Weekly Sessions for BA Assessment: Avoidance

| | Percentage of clients with whom BA skills were utilized in sessions | | | | | | | | | |
ID	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10
#1	6	---	6	---	---	---	---	---	---	---
#2	---	0	---	0	---	0	---	33	0	---
#3	14	100	33	49	21	---	---	48	---	21
#4	40	---	33	---	33	0	---	---	---	---
#5	67	50	---	50	67	75	75	75	75	---
#6	38	50	52	---	---	70	53	71	56	---
#7	7	---	0	21	0	6	19	13	---	---
#8	40	60	63	---	67	60	67	67	---	---
#9	0	---	---	0	---	---	---	0	---	---
#10	---	0	20	40	25	33	33	33	---	---

Note. Participants 1 through 6 were in the BA + CC condition. Participants 7 through 10 were in the BA condition.

Table 28

Self-Reported Therapist Confidence Regarding Implementation of BA Skills with Depressed Clients in Weekly Sessions for BA Rationale

ID	Percentage of clients with whom BA skills were utilized in sessions									
	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10
#1	2	---	1	---	---	---	---	---	---	---
#2	---	1	---	6	---	5	1	1	1	---
#3	2	2	2	6	2	1	1	1	---	6
#4	1	---	1	---	4	4	---	---	---	---
#5	1	1	---	1	1	1	1	1	5	---
#6	6	1	5	---	---	5	5	5	6	---
#7	---	---	3	3	2	2	3	3	---	---
#8	1	1	1	---	1	1	1	5	---	---
#9	1	---	---	1	---	---	---	1	---	---
#10	---	1	1	1	1	1	1	1	---	---

Note. Participants 1 through 6 were in the BA + CC condition. Participants 7 through 10 were in the BA condition. Scores are as follows: 1 = did not try; 2 = completely lacking confidence; 3 = somewhat lacking confidence; 4 = neutral; 5 = somewhat confident; 6 = very confident.

Table 29

Self-Reported Therapist Confidence Regarding Implementation of BA Skills with Depressed Clients in Weekly Sessions for BA

Assessment: Informal Interviewing

ID	Percentage of clients with whom BA skills were utilized in sessions									
	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10
#1	5	---	3	---	---	---	---	---	---	---
#2	---	5	---	6	---	6	1	6	1	---
#3	3	5	5	6	5	5	4	5	---	5
#4	2	---	5	---	4	4	---	---	---	
#5	2	5	---	5	6	6	6	6	6	---
#6	6	6	6	---	---	5	5	5	6	---
#7	---	---	2	3	1	2	1	1	---	---
#8	4	5	5	---	5	5	5	5	---	---
#9	1	---	---	4	---	---	---	1	---	---
#10	---	1	3	3	5	1	5	5	---	---

Note. Participants 1 through 6 were in the BA + CC condition. Participants 7 through 10 were in the BA condition. Scores are as follows: 1 = did not try; 2 = completely lacking confidence; 3 = somewhat lacking confidence; 4 = neutral; 5 = somewhat confident; 6 = very confident.

Table 30

Self-Reported Therapist Confidence Regarding Implementation of BA Skills with Depressed Clients in Weekly Sessions for BA

Assessment: Values Assessment

ID	Percentage of clients with whom BA skills were utilized in sessions									
	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10
#1	4	---	2	---	---	---	---	---	---	---
#2	---	1	---	5	---	5	1	5	5	---
#3	4	5	5	5	5	5	5	3	---	5
#4	2	---	5	---	4	4	---	---	---	---
#5	1	5	---	5	1	1	5	5	5	1
#6	6	5	6	---	---	6	5	6	6	---
#7	---	---	2	3	1	2	1	1	---	---
#8	4	5	5	---	5	5	5	5	---	---
#9	1	---	---	1	---	---	---	1	---	---
#10	---	3	3	3	4	4	5	5	---	---

Note. Participants 1 through 6 were in the BA + CC condition. Participants 7 through 10 were in the BA condition. Scores are as follows: 1 = did not try; 2 = completely lacking confidence; 3 = somewhat lacking confidence; 4 = neutral; 5 = somewhat confident; 6 = very confident.

Table 31

Self-Reported Therapist Confidence Regarding Implementation of BA Skills with Depressed Clients in Weekly Sessions for BA

Assessment: Activity Monitoring

	Percentage of clients with whom BA skills were utilized in sessions									
ID	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10
#1	5	---	4	---	---	---	---	---	---	---
#2	---	1	---	5	---	5	1	6	6	---
#3	4	4	4	5	5	4	5	2	---	5
#4	2	---	1	---	4	4	---	---	---	---
#5	1	1	---	3	5	5	5	5	5	---
#6	5	5	6	---	---	6	5	5	5	---
#7	---	---	2	3	1	2	1	3	---	---
#8	4	5	5	---	1	5	5	5	---	---
#9	1	---	---	1	---	---	---	1	---	---
#10	---	1	1	3	4	5	5	5	---	---

Note. Participants 1 through 6 were in the BA + CC condition. Participants 7 through 10 were in the BA condition. Scores are as follows: 1 = did not try; 2 = completely lacking confidence; 3 = somewhat lacking confidence; 4 = neutral; 5 = somewhat confident; 6 = very confident.

Table 32

Self-Reported Therapist Confidence Regarding Implementation of BA Skills with Depressed Clients in Weekly Sessions for BA

Assessment: Activity Scheduling

ID	Percentage of clients with whom BA skills were utilized in sessions									
	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10
#1	5	---	4	---	---	---	---	---	---	---
#2	---	5	---	1	---	6	1	6	6	---
#3	5	5	5	1	3	4	3	3	---	5
#4	2	---	1	---	4	4	---	---	---	---
#5	5	5	---	5	5	6	6	6	6	---
#6	5	5	6	---	---	5	5	5	5	---
#7	---	---	3	3	1	4	5	1	---	---
#8	4	5	5	---	5	5	4	5	---	---
#9	1	---	---	1	---	---	---	1	---	---
#10	---	1	3	5	5	5	5	---	---	---

Note. Participants 1 through 6 were in the BA + CC condition. Participants 7 through 10 were in the BA condition. Scores are as follows: 1 = did not try; 2 = completely lacking confidence; 3 = somewhat lacking confidence; 4 = neutral; 5 = somewhat confident; 6 = very confident.

Table 33

Self-Reported Therapist Confidence Regarding Implementation of BA Skills with Depressed Clients in Weekly Sessions for BA

Assessment: Avoidance

	Percentage of clients with whom BA skills were utilized in sessions									
ID	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10
#1	2	---	2	---	---	---	---	---	---	---
#2	---	1	---	1	---	1	1	5	1	---
#3	4	2	2	1	4	4	4	2	---	5
#4	2		1	---	3	3	---	---	---	---
#5	3	4	---	5	5	5	5	5	5	---
#6	6	5	6	---	---	5	5	5	5	---
#7	3	---	2	3	1	2	3	3	---	---
#8	4	4	5	---	4	4	5	5	---	---
#9	1	---	---	1	---	---	---	1	---	---
#10	---	1	4	4	5	3	3	3	---	---

Note. Participants 1 through 6 were in the BA + CC condition. Participants 7 through 10 were in the BA condition. Scores are as follows: 1 = did not try; 2 = completely lacking confidence; 3 = somewhat lacking confidence; 4 = neutral; 5 = somewhat confident; 6 = very confident.

Table 34

SCL measure inter-rater reliability

		95% Confidence Interval	
Scale	ICC	Lower	Upper
C. Learning the client's perspective	.70	.08	.91
T. Communicating the therapist's perspective	.44	-.74	.82
C1.Integration of client's views	.45	-.70	.82
C2. Work towards buy-in	.66	-.07	.90
C3. Negotiation of a shared narrative	.15	-1.66	.73
D. Clinician's negative behaviors	--	--	--
F. Facilitating client's story	.69	.06	.90

Note. ICC = Intraclass Correlation Coefficient. No values are reported for scale "D" as there was not enough variability in the sample.

Table 35

Latino questionnaire scores by condition

	Mean percentage correct (SD)	
Condition	Pre	Post
BA + CC (*n* = 5)	82.60 (11.23)	82.60 (16.62)
BA (*n* = 2)	81.50 (9.19)	81.50 (9.19)
Total (*N* = 7)	82.29 (9.93)	82.29 (14.09)

Note. There were no significant differences between time points either by condition or in the whole sample by time.

Table 36

MAKSS scores by condition

Scale	BA + CC		BA		Total	
	Pre (*n* = 6)	Post (*n* = 5)	Pre (*n* = 4)	Post (*n* = 3)	Pre (*N* = 10)	Post (*N* = 8)
Awareness	2.92 (.04)	2.91 (.07)	2.81 (.18)	2.85 (.23)	2.88 (.12)	2.89 (.14)
Knowledge	2.54 (.37)	2.67 (.47)	2.60 (.41)	2.48 (.55)	2.57 (.14)	2.60 (.47)
Skills	2.75 (.51)[a]	3.00 (.63)[a]	2.60 (.40)	2.13 (.70)	2.69 (.45)	2.68 (.75)

Note. Means with the same superscript were significantly different (p < .05). There was a significant difference in pre to post scores in the BA + CC condition. There were no other significant differences between time points either by condition or in the whole sample.

Table 37

Acceptability for training components – quality and usefulness ratings

Training component	BA + CC		BA		Total	
	Quality	Usefulness	Quality	Usefulness	Quality	Usefulness
Cultural competence module	4.17 (.75)[f]	4.17 (.75)[f]	---	---	4.17 (.75)[f]	4.17 (.75)[f]
History of BA module	---	---	3.75 (.96)[d]	3.75 (.96)[d]	3.75 (.96)[d]	3.75 (.96)[d]
Rationale module	4.75 (.50)[d]	5.00 (.00)[d]	4.00[a]	4.00[a]	4.60 (.55)[e]	4.80 (.45)[e]
Assessment module	4.50 (.58)[d]	4.50 (.58)[d]	4.33 (.58)[c]	4.00 (1.00)[c]	4.43 (.54)[g]	4.29 (.76)[g]
Activity scheduling module	4.75 (.50)[d]	4.75 (.50)[d]	4.00 (1.00)[c]	4.00 (1.00)[c]	4.43 (.79)[g]	4.43 (.79)[g]
Avoidance module	4.50 (.55)[f]	4.80 (.45)[e]	4.33 (.58)[c]	4.33 (.58)[c]	4.44 (.53)[h]	4.63 (.52)[h]
Before training preparation (e.g., readings, cultural competence video)	3.60 (.55)[e]	3.60 (.55)[e]	2.00 (1.41)[b]	2.00 (1.15)[d]	3.14 (1.07)[g]	2.89 (1.67)[f]

Note. [a] $n = 1$; [b] $n = 2$; [c] $n = 3$; [d] $n = 4$; [e] $n = 5$; [f] $n = 6$; [g] $n = 7$; [h] $n = 8$. For the rationale module, no standard deviation is available as only one person in this condition completed the questionnaire.

Table 38

Acceptability for training components – percentage of trainees that found specific components helpful

| | Percentage of trainees | | | | | |
| | BA + CC | | BA | | Total | |
Training component	Yes	No	Yes	No	Yes	No
Cultural competence module	100% [f]	0%	---	---	100% [f]	0%
History of BA module	---	---	100% [d]	0%	100% [d]	0%
Rationale module	100% [d]	0%	100% [a]	0%	100% [e]	0%
Assessment module	100% [d]	0%	100% [c]	0%	100% [g]	0%
Activity scheduling module	100% [d]	0%	100% [c]	0%	100% [g]	0%
Avoidance module	100% [f]	0%	100% [c]	0%	100% [i]	0%
Before training preparation	100% [f]	0%	50% [b]	50% [b]	80% [h]	20% [b]
Cultural competence readings	40% [b]	60% [c]	---	---	40% [b]	60% [c]
Cultural competence video	100% [f]	0%	---	---	100% [f]	0%
BA history readings	---	---	50% [b]	50% [b]	50% [b]	50% [b]

Note. [a] $n = 1$; [b] $n = 2$; [c] $n = 3$; [d] $n = 4$; [e] $n = 5$; [f] $n = 6$; [g] $n = 7$; [h] $n = 8$; [i] $n = 9$

Table 39

Acceptability of training sessions qualitative feedback – cultural competence module

Question	Trainee responses
Was there anything that was not clear or needs further attention?	*No* *No. The video is very clear and didactic.* *There are too many tasks to complete in a short amount of time. It would be better to have people complete the role play one week, the video one week, and then do the training.*
A section of the first class focused on the history of BA. What are you likely to remember and incorporate into your practice?	*Assessing what brings meaning to the person's life and what are the values of the person. Create activities that focus on those values.* *BA is as effective as CT, but simpler and easier to learn and apply. I am already incorporating activity monitoring and activity scheduling.* *The basic structure of BA and how to provide psychoeducation regarding BA to clients, clearly and simply.*
A section of the class focused on cultural competence. What are you likely to remember and incorporate into your practice?	*To more explicitly state my formulation of the problem and search for a shared narrative with the client.* *There is a difference between ethnicity and culture.* *CC implies integrating perspectives and requires understanding client's values.* *Using the client's language when restating the problem/issue that brought them in to practice* *Integrating my and the client's perspectives when discussing treatment.* *Responding to ambivalence/direct requests asking me to "tell me what to do"* *Look at the individual and not the "group" they may seem to ascribe.*
Was anything about the section of the class on	*No, the model was already familiar to me from the cross-cultural work I have done* *No[3 participants had same response]*

cultural competence that
was not helpful?

Anything you would
recommend be changed or
presented differently?

- *The role plays were helpful, but we ran out of time before reaching the last one*
- *No.*
- *The role plays were sometimes difficult to follow since, as each trainee took on a few sentences, the train of thought was taken in various directions. It might have been helpful to have the leaders jump in and help the role play stay closer to the ideal i.e.,, the main slide) or have the leaders comment when the trainee made a statement in reference to one of the main points on the summary slide (i.e., the trainee asks a question or makes a statement, the trainer highlights which component the trainee was attempting to use).*

Table 40

Acceptability of training sessions qualitative feedback – history of BA module

Question	Trainee responses
A section of the first class focused on the history of BA. What are you likely to remember and incorporate into your practice?	• *How costly depression will be in coming decades* • *The cost-effectiveness of BA training* • *The likelihood that BA, even without additional techniques, may be effective* • *It was helpful to know the efficacy of BA in general and across cultures.* • *It is helpful to see the history. I had read this 2 months ago in the BA book. This was a good overview. I think it will be helpful when clients refer to past therapies, that I can understand how Beck's work, Lewisohn's work etc. all fit together, and the logic of where to start. Why not start with the BA (chpt 9 in the Beck book from 1980), since it is the simplest, cost- effective and if it doesn't work, then move onto something else. They don't contradict each other. Also, the Sarah Silverman slide and the analogy of SSRIs with insulin pops up all the time in therapy.*
Was anything about the section of the class on the history of BA that was not helpful?	• *Nothing stood out for me.* • *It was a little taxing to follow along with the slides not congruent with the lecture. I found myself really focused on trying to write everything down.* • *No*
Anything you would recommend be changed or presented differently?	• *Some of the graphs were pretty small, but it was fine for an intro.* • *Maybe asking people to email back that they have received the preparatory reading/slides.* • *No.*

Table 41

Acceptability of training sessions qualitative feedback – BA rationale

Question	Trainee responses
The focus this class was on presenting the BA rationale. What are you likely to remember and incorporate into your practice?	• *How to respond to avoidance when presenting the BA rationale; approaching the client's response, particularly the cognitive piece, with a BA-consistent/behavioral response* • *writing on the white board the idea of the short term avoidance and how it effects the long term* • *The circle model, which presents the "why" of BA.* • *Discussing the cycle of depression with patients.* *Strategies to handle typical client challenges to the rationale for BA* • *Providing rationale is the first step in BA. By setting the treatment context, it makes future interventions meaningful.*
Was anything about the section of the class on presenting the BA rationale that was not helpful?	• *No [4 people had this same response]*
Anything you would recommend be changed or presented differently?	• *The role plays are very helpful. The more the better.* • *No.*

Table 42

Acceptability of training sessions qualitative feedback – assessment module

Question	Trainee responses
This section of the class reviewed assessment in BA. What are you likely to remember and incorporate into your practice?	• *Being concrete, specific and focusing on behaviors. Also ongoing work on avoidance was helpful.* • *Use of values to guide selection of assessment activities; handy tips and prompts for how to conduct a good assessment* • *Getting clear about assessment and case formulation* • *If stuck on one of the routine disruptions move on to another* • *Looking at contingencies and short term rewards* • *The forms will be helpful, I think, in helping me to be better organized and to identify activities that will be more reinforcing for the client.* • *To have a case conceptualization that includes a variety of activities, touching on as many of the 6 assessment domains as possible.* • *Asking specific questions about what the patient's life was like before depression, what is important to them (values assessment)* • *I have already incorporated continuous assessment, mainly using ABC and values forms. I also would like to use hierarchy activities form more frequently.*
Was anything about the section of the class on assessment in BA that was not helpful?	• *This is just my own experience, but I have realized that I am really quite intimidated by the other regular group class participants. Jonathan has an easy manner about him that is helpful and there was person joining the group just for this week that seemed much more easy going and validating of how hard it is to respond to avoidance, but in general, I find myself ill at ease with the other participants in our training group and I just draw a blank when it comes time for my participation in the roll play I am getting a lot out of the training (the lesson portion and Jonathan's role plays in particular) and putting it into practice with my own clients, however, I have to admit that I dread the role plays we do more than any other role plays I have done I other trainings. Maybe it is being on the phone with people that I don't know that I perceive as more advanced than myself. I actually find*

it most useful to hear Jonathan respond and model how he would play the BA therapist role with one of us role plying a client. I find it somewhat useful to her the other participants' responses, but with this I also have that anticipatory dread of my turn coming up and the inevitable comparison of how that are responding to how I will respond. Wish I could say concretely what would be helpful to change to make this more useful to me, but I can't. All I can say is that I love learning, I love attending trainings and that I dread the role plays in this class, for whatever reason.

- *No [4 participants had same response]*

Anything you would recommend be changed or presented differently?

- *As I mentioned above, I get the most out of the power point lesson and Jonathan roll playing how a BA therapist would respond.*
- *Everything has been exceptionally helpful and well taught. Thank you!*
- *Although it probably would take at least an hour, it might be helpful to role-play an intake of a new client and have us identify the targets for BA assessment and come up with a case conceptualization.*
- *No*
- *No, I liked having people discuss their personal cases or their clients, it makes the content more real.*

Table 43

Acceptability of training sessions qualitative feedback – activity scheduling module

Question	Trainee responses

This class focused on 5 tips for activity scheduling. What are you likely to remember and incorporate into your practice?	• *With whom, what, where, when... obstacles*
	• *Spend time in depth scheduling at least one activity; this in itself is an excellent intervention*
	• *being specific and concrete*
	   looking for obstacles and problem solving the obstacles
	   taking small steps for 3-5 activities per week
	• *Be specific and detailed in setting up parameters of activity.*
	• *The idea that an assignment needs to be "just right" (i.e.,, not too hard, but challenging)*
	   Identifying obstacles
	• *The act of concretely scheduling one activity, with attention to WWWW and potential obstacles. It is relatively easy to incorporate into typical sessions, and I was surprised by the impact of this simple intervention.*
	• *Be specific, identify potential obstacles, get patient's buy in/collaborate on activity selection, schedule 3-5 and focus on 1*

Was there anything about activity scheduling that was not helpful?	• *No [4 participants had same response]* • *It is not clear if the activities should be done just one time per week or numerous times during the week*
Anything you would recommend be changed or presented differently?	• *No [2 participants had same response]* • *I don't feel like the roll plays are going very well for me. I get the sense that other participants are somehow "getting this" a lot more easily than I am and I am not sure why. I really feel like I need more info and practice and training in the whole avoidance piece. I am not sure if others are just really fast learners or they have prior experience in this or are just more skilled clinicians. I know*

one participant, mentioned she felt the need to order your book to feel more comfortable with learning the dealing with avoidance skills. I will probably do that at some point as well, but probably won't have time to get though it now. I am going to try to make time to read as much of the long article that was sent out just before the class started. One thing that could have been helpful was to get that article as soon as we signed up for the class. It would have put me more at ease to feel a little more prepared.

- *I would have liked to spend more time discussing ways to respond to "I did the activity, but my mood didn't change and I don't think this is working." We spent some time discussing this at the end - perhaps include a slide with additional tips on this?*
- *Not really. As I have not been trained as a behaviorist, I would benefit from more examples of how to frame core issues in behavioral terms, but I think that will come with practice.*

Table 44

Acceptability of training sessions qualitative feedback – techniques targeting avoidance module

Question	Trainee responses
This class focused on techniques targeting avoidance. What are you likely to remember and incorporate into your practice?	• *Targeting the idea of "avoid avoidance"* • *Linking activities to values. eliciting help from others.* • *How to respond to rumination* • *Focus on inside out, long term goals and values.* • *"Act according to a plan, not your mood"* • *Treat rumination as avoidance and activate* • *Treating rumination as yet another type of avoidant strategy.* • *Using the acronym of changing TRAP to TRAC.* • *The process of gaining commitment to an activity and specifically scheduling it in order to target the avoidance* • *Daily activities and activations assignments may evoke aversive internal events, which may elicit avoidance strategies. Activation efforts may be hampered due these avoidance strategies.*
Was anything about the section of the class on strategies targeting avoidance that was not helpful?	• *I thought it would be helpful to have "client" examples of avoidance. Especially when there are many excuses they can give.* • *I found the group exercise very challenging and intimidating.* • *I think more practice would help.* • *Seemed like more technical difficulties this time, which can feel disruptive. But nothing about the material.* • *No, I think the instructions were presented in a clear and simple way.* • *No[4 people had this response]*

Anything you would recommend be changed or presented differently?	• *I am uncertain the role of therapist in this aspect.*
	• *Not sure.*
	• *No - it was great. The only thing I can think of is to consider including more examples of language you can use to respond to avoidance.*
	• *Perhaps help us to provide "real plays" that offer better examples of avoidance*
	• *Yes, some participants had much more time to interact during the real play than others.*
	• *No[3 people had this same response]*

Table 45

Feasibility questionnaire - completion of specific training materials

| Training component	BA + CC (*n* = 5)		BA (*n* = 1)		Total (*N* = 6)	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Role play assessments	5	100%	1	100%	6	100%
Training sessions	5	100%	1	100%	6	100%
Cultural competence video	4	80%	---	---	5	83.3%
Reading						
Skimmed the reading	1	20%	---	---	1	16.70%
Half of the reading	1	20%	---	---	1	16.70%
Almost all of the reading	2	40%	---	---	2	33.30%
All of the reading	1	20%	1	100%	2	33.30%
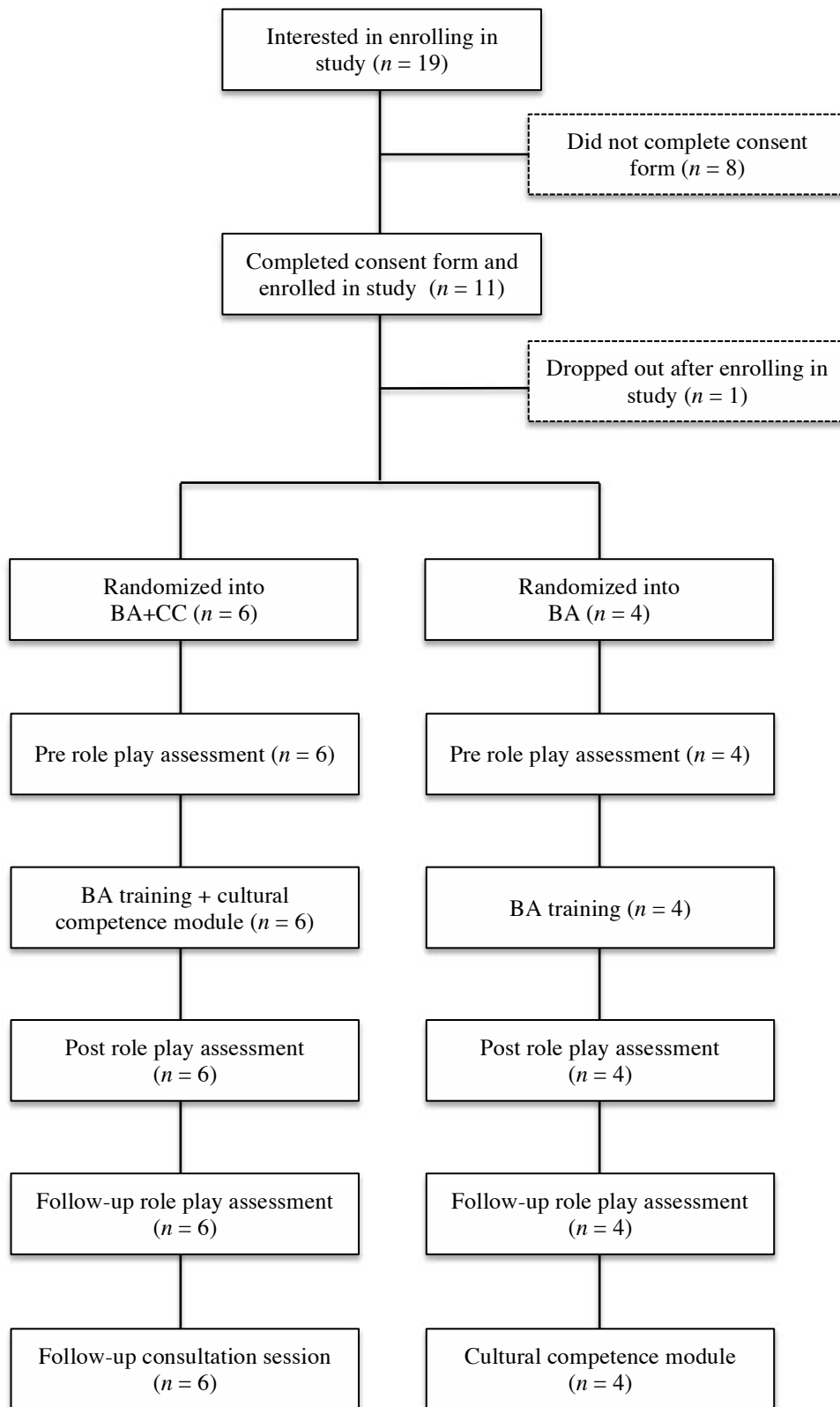
Figure 1. Participant Flow Chart
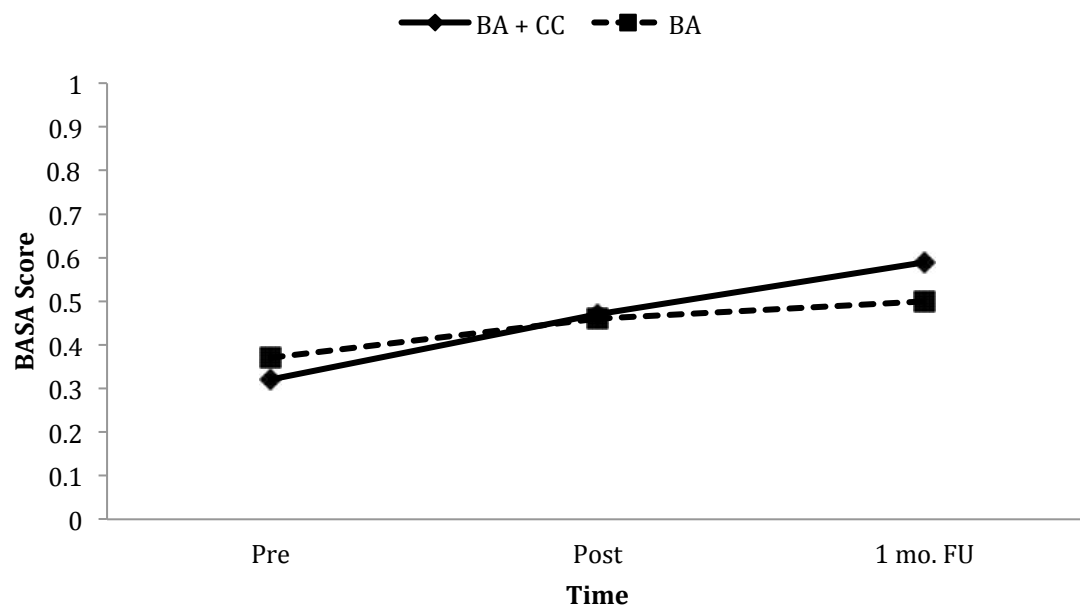
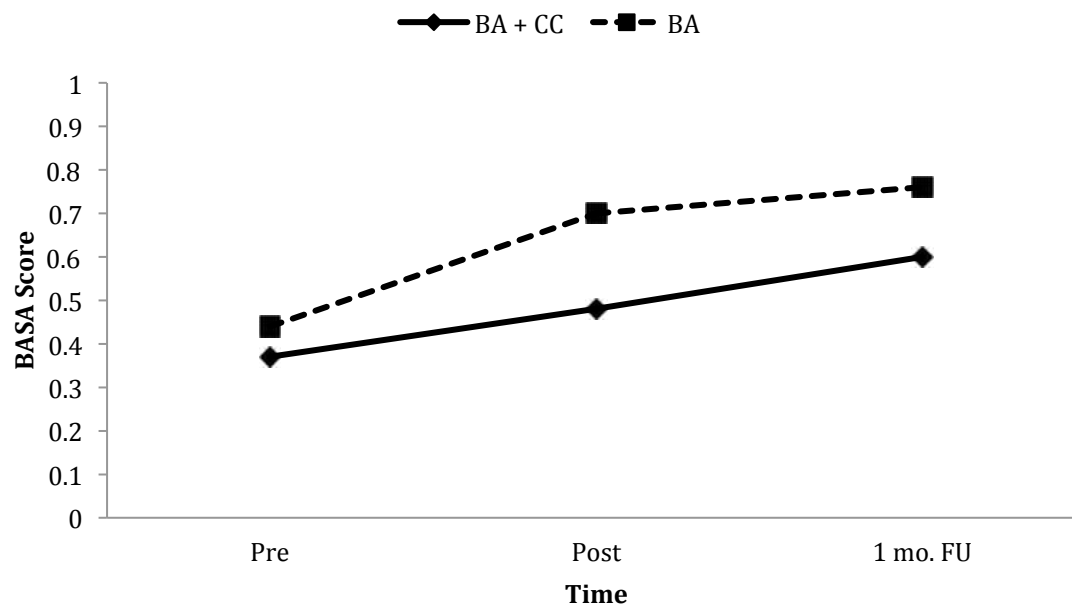*Figure 2*. Mean scores on the exploratory BASA cultural competence subscale by condition.
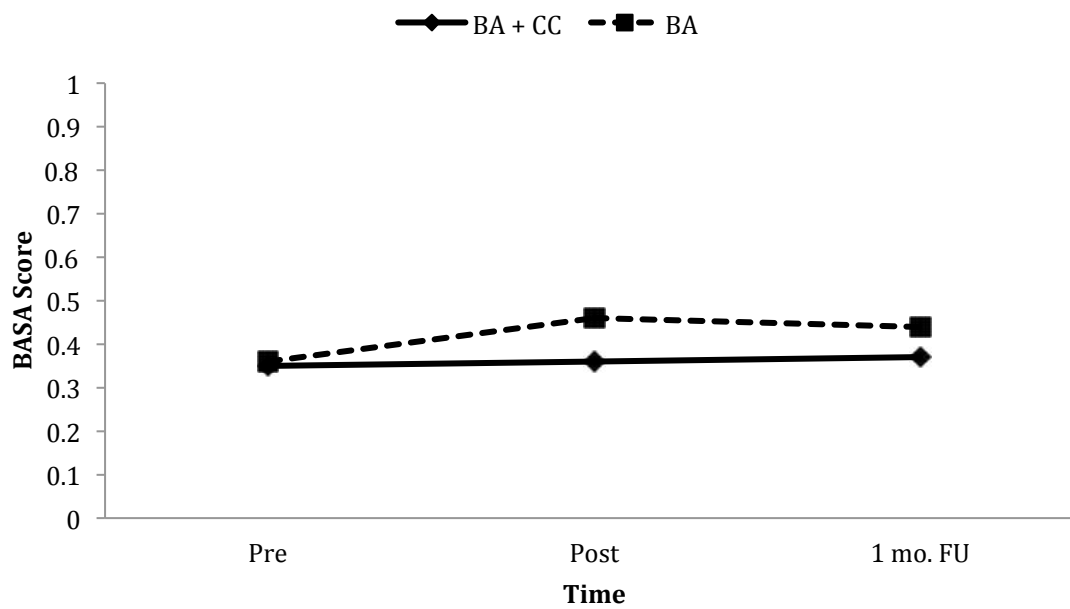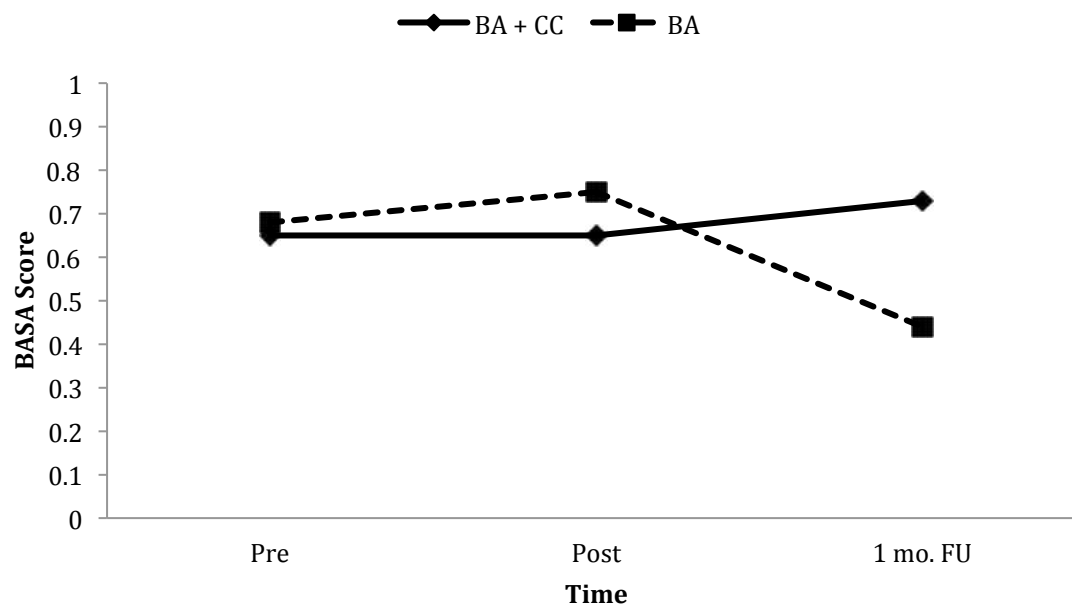
Figure 3. Mean scores on the BASA specific BA rationale subscale by condition.
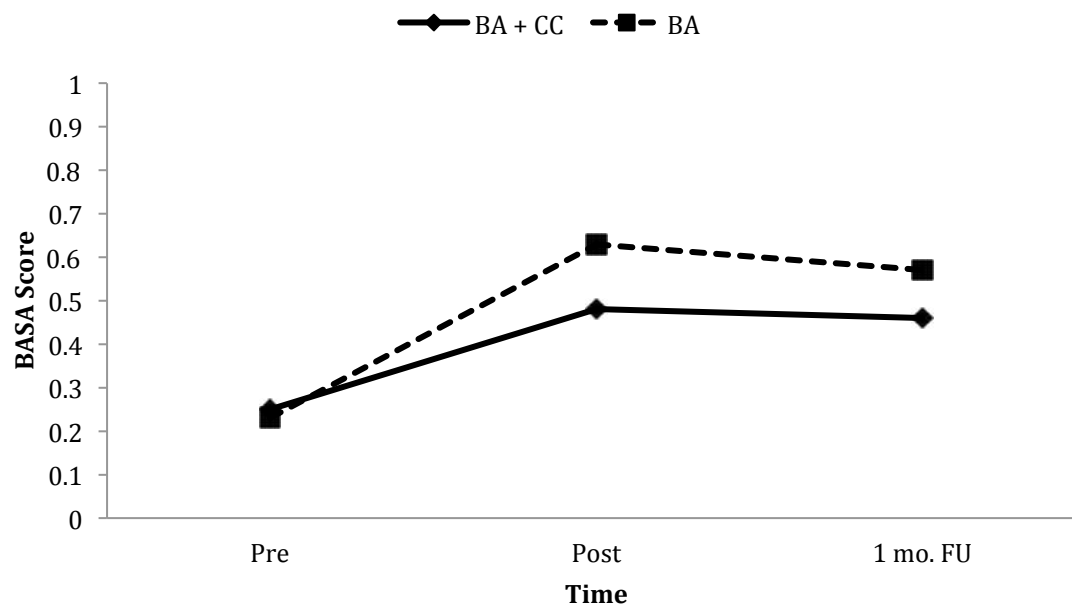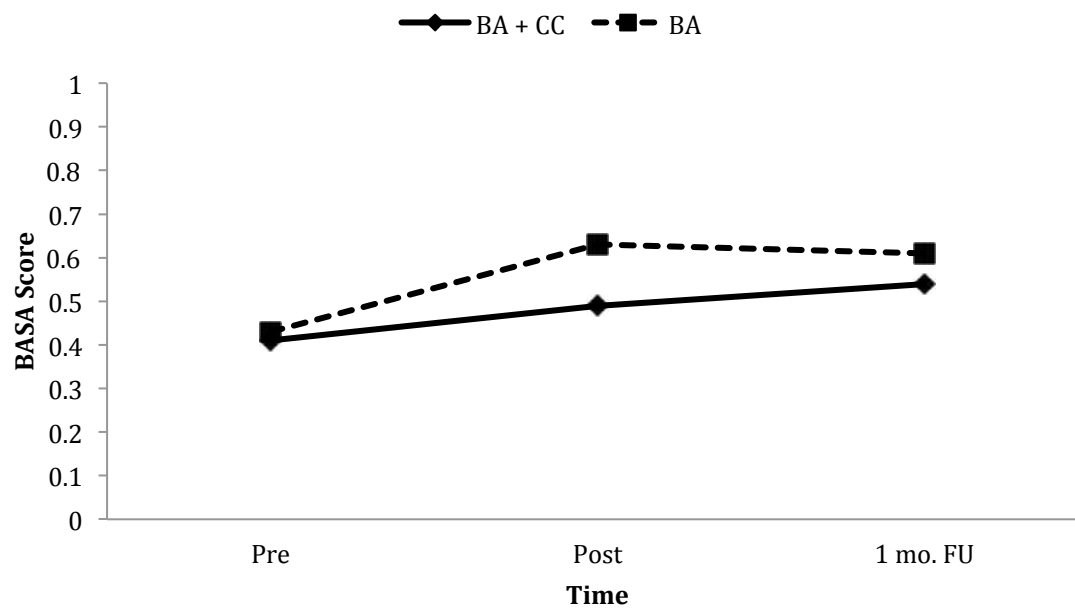
Figure 4. Mean scores on the BASA assessment subscale by condition.

Figure 5. Mean scores on the BASA activity scheduling subscale by condition.

Figure 6. Mean scores on the BASA techniques targeting avoidance subscale by condition.

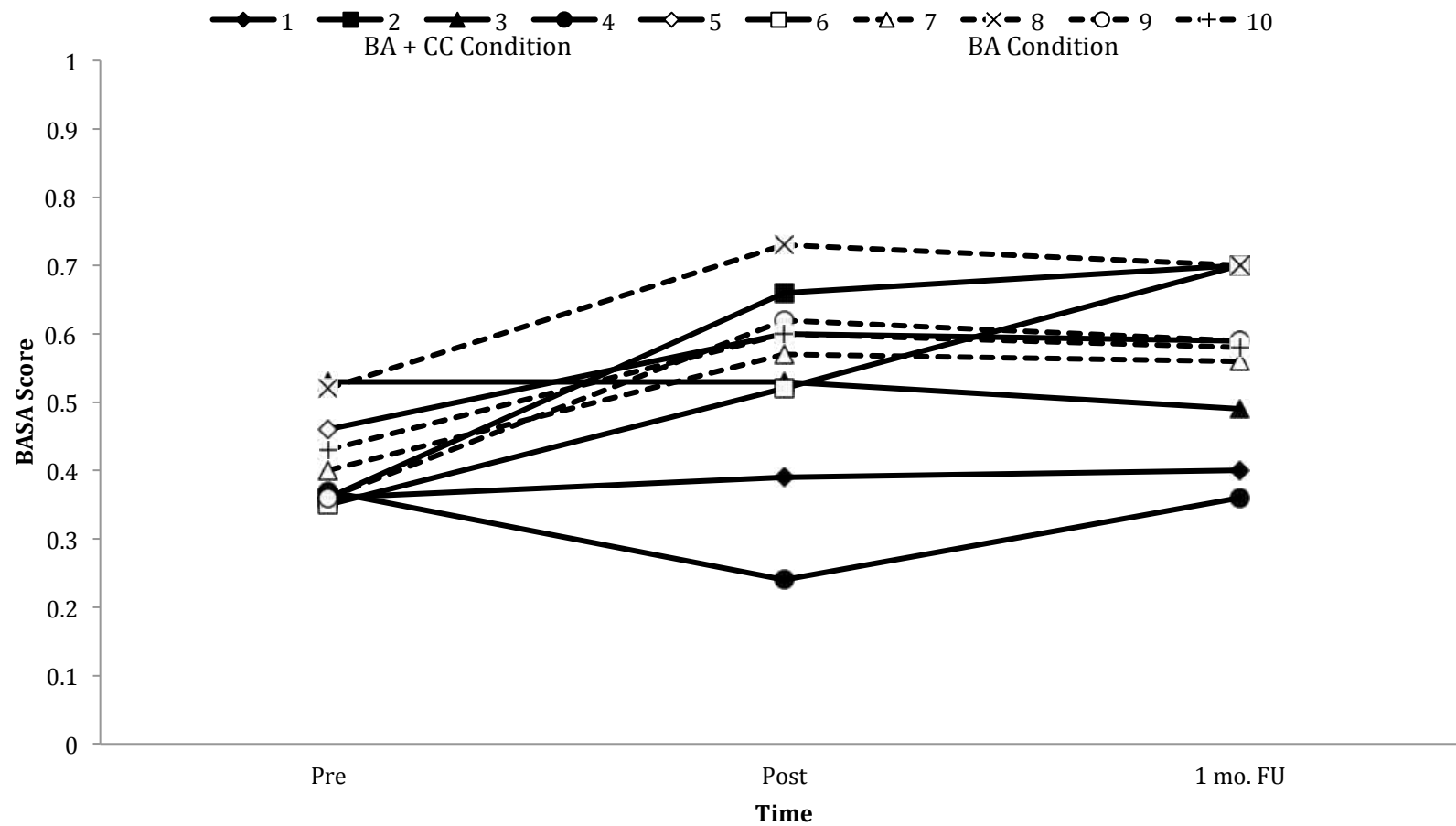*Figure 7.* Mean scores on entire BASA measure by condition.

Figure 8. Participant individual scores on the overall BASA (without cultural competence subscale).
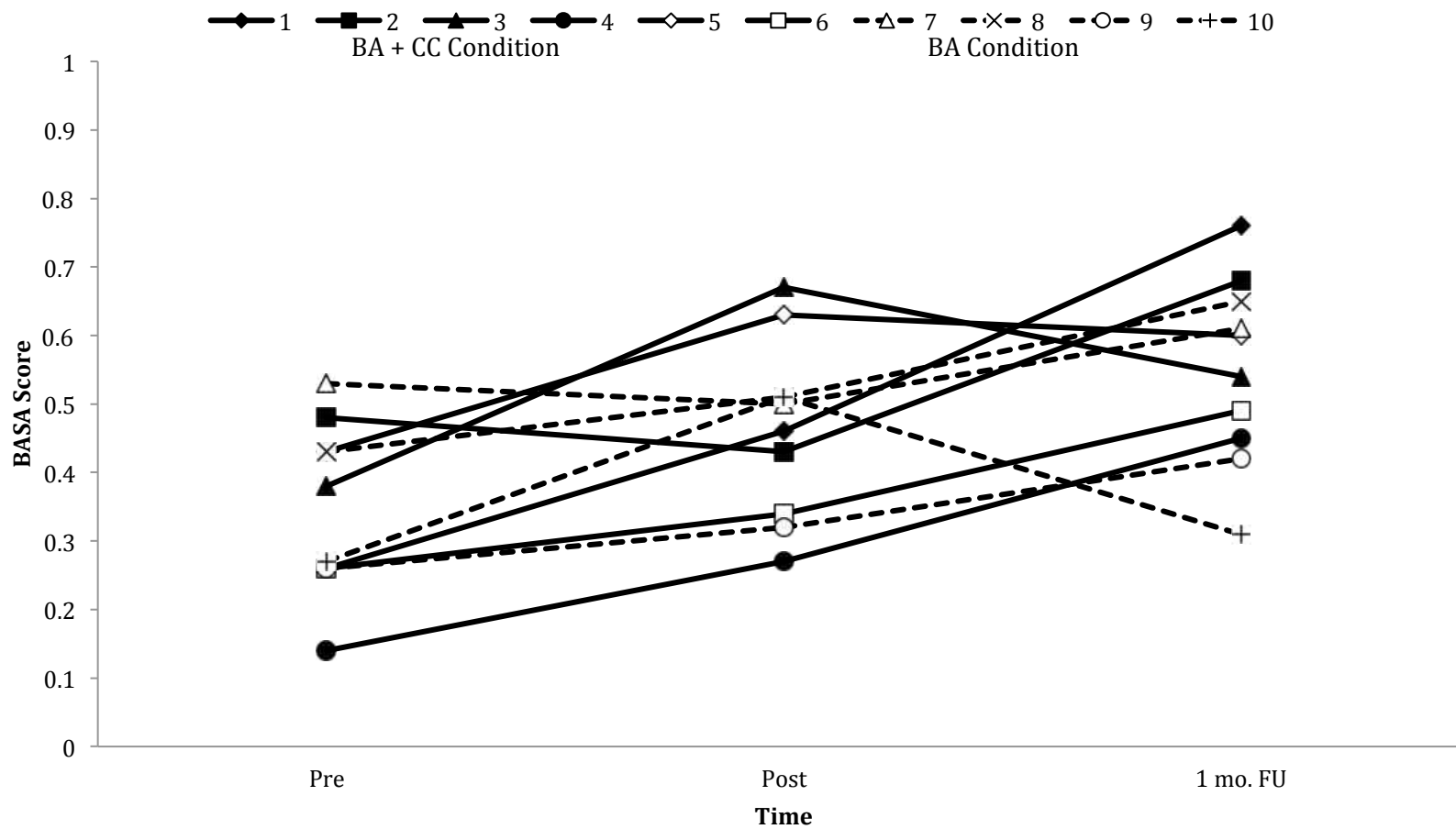
Figure 9. Participant individual scores on the BASA cultural competence subscale.

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Appendix A
BASA Microskills Checklist

Black = Original BASA items	
Red = *NEW* Cultural Competence BASA items	

Cultural Competence		
1	Therapist explicitly asks client what s/he wishes to gain from therapy.	
2	Therapist inquires as to what client views as the problem, its cause, and what the client has tried to do to help to understand level of impairment (helper model, problem definition, level of impairment)	
3	Therapist demonstrates understanding of client's cultural framework without disagreement or challenge	
4	Therapist introduces the BA framework as his/her personal view, not presumed fact, from a position of mutual respect and collaboration	
5	Therapist explicitly asks client if this view fits with their understanding of their problem, and asks for feedback and clarifies confusions	
6	Therapist asks the client to try the BA model from a position of mutual respect and collaboration	
Providing the Rationale (Shared Narrative: Integration)		
1	Identifies and discusses negative life experiences using client's narrative	
2	Identifies and discusses emotional responses (feelings) using client's narrative	
3	Identifies and discusses behavioral responses (action elements, secondary coping, avoidance) using client's narrative	
4	Validates emotional and behavioral responses as natural, normal, common (matter of fact)	
5	Discusses how responses lead to more negative life experiences (spiral or cycle of depression)	
6	Explains the goal of BA: activation as alternative to natural responses ("breaking the cycle")	
7	Uses the client's language instead of jargon	
8	Seeks feedback and verifies understanding of the rationale	
9	"Just do it: Discusses that therapist will coach, guide with strategies to help activation	
10	"Inside out": Offers rationale for outside-in approach in BA	
11	"Broken brain": Explains how activation can change the brain	
12	"How can BA help?: Therapist can integrate, work on buy-in or negotiate	
Assessing behavior to guide activity scheduling		
1	Assesses behaviors that the client used to do but stopped doing and/or would like to start doing	
2	Assesses avoidance behaviors (including subtle) of which the client is doing more	
3	Discusses the relation between activities/life contexts and mood	
4	Assesses, discusses and comments on client's long-term goals (values, aspirations) in behaviorally concrete fashion (response to "I'm not a good mother" prompt)	
5	Assesses, discusses and comments on client's core issues in behaviorally	

	concrete fashion	
6	Assesses, discusses, and comments on routine disruptions in behaviorally concrete fashion	
Activity Scheduling		
1	Collaboratively works with client to identify activities to work on	
2	Considers task difficulty and breaks assignments into smaller parts	
3	Schedules at least one activity concretely (e.g.,, what, where, when, with whom?)	
4	Identifies obstacles to at least one activity	
5	Identifies solutions to at least one obstacle	
Targeting Avoidance		
1	Helps client distinguish triggers, responses and avoidance patterns (3 circles)	
2	Validates responses and avoidance patterns as understandable and natural	
3	Identifies and discusses the short term benefits but long term problems associated with avoidance	
4	Discusses acting even when don't feel like acting ("acting according to plan not mood" or "outside-in" or something similar)	
5	Connects activity with client's goals and values	
6	Schedules activity concretely taking avoidance into consideration ("alternate coping," "*trac*," considers task difficulty and breaks activity down)	
7	"Rumination": Treats rumination as avoidance and discusses alternate coping ("RCA," attention to experience, refocus on task, active problem solving)	
Additional strategies to try if activity scheduling does not succeed at first		
1	Use public commitment	
2	Use stimulus control/reminder strategies	
3	Use skills training strategies	
4	Consider options for more regular check-ins	
5	Consider the use of arbitrary self-reinforcement	
6	Consider the use of contracts with others	

Appendix B
Breakdown of Schedule

Participants were randomly assigned to Group 1 or Group 2.

Meeting times for Group 1:
1. Tuesday March 5, 2013 (2 hours)
2. Tuesday March 19, 2013 (1.5 hours)
3. Tuesday April 2, 2013 (1.5 hours)
4. Tuesday April 16, 2013 (1.5 hours)
5. Tuesday April 30, 2013 (1.5 hours)
6. Tuesday July 2, 2013 (1.5 hours)
*All group meetings started at 12:00 Pacific/1:00 Mountain/2:00 Central/3:00 Eastern.

Meeting times for Group 2:
1. Tuesday March 12, 2013 (2 hours)
2. Tuesday March 26, 2013 (1.5 hours)
3. Tuesday April 9, 2013 (1.5 hours)
4. Tuesday April 23, 2013 (1.5 hours)
5. Tuesday May 7, 2013 (1.5 hours)
6. Tuesday July 9, 2013 (1.5 hours)
*All group meetings started at 12:00 Pacific/1:00 Mountain/2:00 Central/3:00 Eastern.

Appendix C
Informed Consent Form

UNIVERSITY OF WISCONSIN – MILWAUKEE
CONSENT TO PARTICIPATE IN RESEARCH

**THIS CONSENT FORM HAS BEEN APPROVED BY THE IRB FOR A ONE
YEAR PERIOD**

1. General Information

Study title: Training Cultural Competence within an Online, Modular Behavioral
Activation and for Depression Training

Person in Charge of Study (Principal Investigator): Dr. Jonathan W. Kanter,
Associate Professor of Psychology, University of Wisconsin-Milwaukee

2. Study Description

You are being asked to participate in a research study. Your participation is completely
voluntary. You do not have to participate if you do not want to.

Study description: The purpose of this study is to compare an online training program in
Behavioral Activation (BA) to a BA training plus Cultural Competence (BA + CC)
training provided to mental health professionals providing psychotherapy for culturally
diverse clients with depressive symptoms. Study participants will be randomized to
receive either BA or BA + CC training. As part of this study, you will receive an
interactive training seminar, and will be asked to use these new techniques as you judge
clinically appropriate. The duration of the study is 18 weeks. The purpose of the study is
to assess the impact of the training program on whether therapists use the techniques, the
acceptability of the techniques, and your skill in performing the techniques. If you agree
to participate, you will be asked to enter data about BA and/or CC techniques used, if
any, and their acceptability via online questionnaires. You will also complete role-play
assessments before, immediately after the training, and 1 month after the training. These
duties and time requirements are more fully explained in the nexts section of this
document. If you have any additional questions after reading through this form, you may
call 414-229-3834 to speak with Dr. Kanter.

3. Study Procedures

What will I be asked to do if I participate in the study? If you agree to participate, the
total duration of the study is 18 weeks, including role-play assessments and training
sessions. The training will consist of a **6** sessions of online training, the first session
lasting approximately 2 hours and the remaining sessions each lasting approximately an
hour and a half. During the week before the start of the workshop, the week after the

completion of the workshop (5 weeks) and 1 month following the training, you will schedule a role-play assessment with the Project Coordinator, Gabriela Nagy - a clinical psychology graduate student. This assessment involves an interaction with a hypothetical client role-played by Research Assistants (RAs) according to a script to test your ability to implement techniques learned in the training. Each role-play assessment will take approximately 1 hour to complete. The role-play assessments will be audiotaped for scoring purposes. Each week during the study, you will enter information on techniques used and their acceptability via online questionnaires. The total time required of therapists for data entry each week is 15-20 minutes.

4. Risks and Minimizing Risks

What risks will I face by participating in this study? There are few foreseeable immediate risks related to participation in this study. Participation in the training seminar may result in fatigue and the implementation of new strategies may be stressful at first. There are, however, no physical, social, or legal risks related to participating in this research study. Additionally, half of the study participants will not receive cultural competence training.

You have the right to withdraw from the study for any reason at any time and without penalty. If you withdraw from the study, it will not affect your ability to participate in future studies with UWM or PracticeGround. You may also contact the Principal Investigator, Dr. Jonathan Kanter, at any time if you have any concerns or are feeling discomfort due to study participation.

5. Benefits

Will I receive any benefit from my participation in this study? You will benefit from training in empirically supported techniques of behavioral activation and/or techniques concerning cultural competence. Findings from this study will be used to develop effective training methods for therapists treating culturally diverse individuals seeking treatment for depression. ***In addition, you can earn 9.5 hours of CE credits for participation.*** These benefits outweigh the slight possibility that you may feel some discomfort during the study.

Are subjects paid or given anything for being in the study? No financial compensation is provided in return for your participation.

6. Study Costs

Will I be charged anything for participating in this study? You or your agency will be charged a fee for receiving the training that occurs with this study

7. Confidentiality

What happens to the information collected? All information collected about you during the course of this study will be kept confidential to the extent permitted by law. We may decide to present what we find to others, or publish our results in scientific journals or at scientific conferences, but these findings will be presented without any identifying information on the participants. Only the Principal Investigator and trained research personnel will have access to your personal information. The Institutional Review Board at UW-Milwaukee or appropriate federal agencies like the Office for Human Research Protections may review your records.

Each participating therapist will be given an ID number and all questionnaires will be identified with that ID number only. Data storage will occur in a secured online data storage system and at Dr. Kanter's laboratory at the University of Wisconsin – Milwaukee. A sheet linking your name, and ID number will be stored in a secure, locked file cabinet separate from all other research data at UWM. This record linking your name to research data through the I.D. number will be destroyed after one year. After the record is destroyed there will be no way to link your name to your responses. The data in the computer will be referenced by code number only and destroyed after a period of 10 years. Audiotaped sessions will be stored electronically on a password-protected computer, will be labeled with your ID number, and will be kept indefinitely.

8. Alternatives

Are there alternatives to participating in the study? If you do not want to participate you are free to not sign this informed consent or withdraw from the study at any time. Doing so will not affect your ability to participate in future studies through University of Wisconsin-Milwaukee or PracticeGround.

9. Voluntary Participation and Withdrawal

What happens if I decide not to be in this study? Your participation in this study is entirely voluntary. You may choose not to take part in this study. If you decide to take part, you can change your mind later and withdraw from the study. You are free to not answer any questions or withdraw at any time. Your refusal to take part in the study will not change any present or future relationships with the University of Wisconsin Milwaukee or PracticeGround.

10. Questions

Who do I contact for questions about this study? For more information about the study or the study procedures or treatments, or to withdraw from the study, contact:

>Jonathan W. Kanter, Ph.D.
>University of Wisconsin – Milwaukee
>PO Box 413
>Milwaukee, WI 53211
>414-229-3834

Who do I contact for questions about my rights or complaints towards my treatment as a research subject? The Institutional Review Board may ask your name, but all complaints are kept in confidence.

>Institutional Review Board
>Human Research Protection Program
>Department of University Safety and Assurances
>University of Wisconsin – Milwaukee
>P.O. Box 413
>Milwaukee, WI 53201
>(414) 229-3173

11. Signatures

Research Subject's Consent to Participate in Research:
To voluntarily agree to take part in this study, you must sign on the line below. If you choose to take part in this study, you may withdraw at any time. You are not giving up any of your legal rights by signing this form. Your signature below indicates that you have read or had read to you this entire consent form, including the risks and benefits, and have had all of your questions answered, and that you are 18 years of age or older.

_____
Printed Name of Subject/ Legally Authorized Representative

_____   _____
Signature of Subject/Legally Authorized Representative   Date

Research Subject's Consent to Audio/Video/Photo Recording:

It is okay to audiotape me while I am in this study and use my audiotaped data in the research.

Please initial: ____Yes ____No

Principal Investigator (or Designee)
I have given this research subject information on the study that is accurate and sufficient for the subject to fully understand the nature, risks and benefits of the study.

_____   _____
Printed Name of Person Obtaining Consent   Study Role

_____   _____
Signature of Person Obtaining Consent   Date

Appendix D
Role Play Instructions

<u>At the beginning of the role play assessment:</u>
Hi,

How are you doing?

My name is _____ from Dr. Kanter's lab. I am the role-play assessor for the assessment that you will take for the next hour. Before we start, I would like to orient you to the activities that we are going to do, provide some instructions for the role-play, and give you a chance to ask questions if you have any.

First of all, I just want to let you know that this is not a test. The main aim of this role-play assessment is for us to measure your familiarity with the materials. Whatever level you are at is fine by us.

I have two role-plays that we are going to go over in the next hour. Each role-play should take about 25 minutes. You do not have to take the entire 25 minutes if you do not want to, but we will stop you if you go over the allocated 25 minutes. "I will periodically give you a reminder of the time."

We will take a break in between role-plays, when I will read the instruction for the next role-play and to give you a chance to ask any questions you may have.

Do you have any questions now?

Do you have the therapist instruction in front of you? I'm going to read the instruction for each role-play.

<u>Role Play 1</u>
This is what you learned about your client over the phone when setting up your first session:

Rosa is a 40-year-old Puerto Rican woman who immigrated to the US mainland when she was 30. She lives in New York with her husband and 3 children (12 yrs, 10 yrs, and 5 yrs). She is currently unemployed but worked as a nurse's assistant for about 7 years. Now that she has lost her job, she is very worried about financial issues and making the mortgage payments, which require both her and her husband to be generating income. She presented with symptoms of major depression and no other co-morbid disorders.

For this role play, it is the beginning of Session 1. Your task is to start therapy, briefly gather key information about your client in a manner consistent with assessment in Behavioral Activation and provide a rationale for Behavioral Activation. Try to do this assessment and present the model for treatment in approximately 25 minutes.

<u>Role Play 2</u>

It is session 7. You have started behavioral activation. So far, your client successfully went to the career center and received training on how to post her resume online and find possible job openings. Her assignments last week were to 1) post her resume online, 2) go for a 20 minute run, and 3) watch a movie with her husband. Your task is start the session, review her homework, and schedule one or two new activities. Try to spend 25 minutes total on these tasks.

Appendix E
Role Play Manual

BEFORE THE ROLE PLAY

<div style="border:1px solid">

In setting up for the role play, ask yourself the following questions:

☐ Do you know the name of the therapist with whom you will be doing the role play?
☐ Do you have the number of the conference call line?
    ☐ Do you know how to record once the other person is on the line?
☐ Do you have all of the following?
    ☐ The Manual
    ☐ Checklist for prompts?
    ☐ Stopwatch? Wristwatch? Timer on cell phone?
☐ Do you have the date and time of the next assessment (if a pre or post)?
☐ Have you asked the participant if they have the Therapist Instructions before beginning the role play?

</div>

Calling into the conference line:
You will receive the conference call number from Gaby before the role play. You will also receive your participant code to join the conference call. Once you call into the line you will be prompted to enter your participant code. Gaby will also give you instructions on how to record the call.

Before beginning the role play, give these instructions to the therapist:
Hi,

How are you doing?

My name is _____ from Dr. Kanter's lab. I am the role-play assessor for the assessment that you will take for the next hour. Before we start, I would like to orient you to the activities that we are going to do, provide some instructions for the role-play, and give you a chance to ask questions if you have any.

First of all, I just want to let you know that this is not a test. The main aim of this role-play assessment is for us to measure your familiarity with the materials. Whatever level you are at is fine by us.

I have two role-plays that we are going to go over in the next hour. Each role-play should take about 25 minutes. You do not have to take the entire 25 minutes if you do not want to, but we will stop you if you go over the allocated 25 minutes. "I will periodically give you a reminder of the time."

We will take a break in between role-plays, when I will read the instruction for the next role-play and to give you a chance to ask any questions you may have.

Do you have any questions now?

Do you have the therapist instruction in front of you? I'm going to read the instruction for each role-play.

HYPOTHETICAL CLIENT INSTRUCTIONS

General instructions for client:

1. Stay on script.
2. If therapist asks questions that require an answer not scripted, do not make it up. Instead, come up with a reasonable way to not answer the question, such as "I don't know", "I don't remember", and so forth as appropriate.
3. Your number 1 priority in conducting the role play is to deliver the prompts!

Client background information:

You are a 40-year-old Puerto Rican woman who immigrated to the US mainland when you were 30. You live in New York with your husband and 3 children (12 yrs, 10 yrs, and 5 yrs). You are currently unemployed but worked as a nurse's assistant for about 7 years. You presented in therapy with symptoms of major depression and no other co-morbid disorders, however you do not consider yourself to be depressed. You are tired all of the time, you do not have energy to do the things that you used to like to do, sometimes you have "crying spells", and you feel that you are not a good mother and wife anymore because you have let go of many responsibilities in the last few months. You have never felt this way before in your life.

All of these things started happening in your life after a neighbor, who is a witch and hates you, "te echo una *brujeria*" (put a hex on you) that brought you a lot of bad luck including losing your job. Before this, you considered yourself to be a "good mother and wife" and you would spend your day taking care of the children and doing house chores when you were not working. Lately, however, the frequency of these behaviors has decreased significantly. You stopped cooking and many chores are left undone because you only have energy to stay in bed or watch television. Now that you have lost your job, you are very worried about financial issues and making the mortgage payments, which require both you and your husband to be generating income. Now, your husband works and you take care of the home and children.

ROLE PLAY 1: PROVIDING THE RATIONALE AND INFORMAL INTERVIEWING (25 minutes)

Read these instructions for the THERAPIST (Study Participant):

This is what you learned about your client over the phone when setting up your first session:

Rosa is a 40-year-old Puerto Rican woman who immigrated to the US mainland when she was 30. She lives in New York with her husband and 3 children (12 yrs, 10 yrs, and 5 yrs). She is currently unemployed but worked as a nurse's assistant for about 7 years. Now that she has lost her job, she is very worried about financial issues and making the mortgage payments, which require both her and her husband to be generating income. She presented with symptoms of major depression and no other co-morbid disorders.

For this role play, it is the beginning of Session 1. Your task is to start therapy, briefly gather key information about your client in a manner consistent with assessment in Behavioral Activation and provide a rationale for Behavioral Activation. Try to do this assessment and present the model for treatment in approximately 25 minutes.

Instructions for the HYPOTHETICAL CLIENT (Role Player):

To signal that the role play is starting you can say "*please begin when you are ready*." The first thing the therapist might do is to ask you why you came in today. In response to "why are you here?" You should say *"Recently, my life has been terrible. My neighbor is a witch and she hates me and she put a brujeria on me so a lot of bad things are happening to me."*

The therapist may ask "how has that been making you feel?" (or some variation of this). Give a surface level answer that does not really get into emotions. Say *"I have been feeling like I have been having a lot of bad luck. My life is out of control. It's not what it used to be, I am not the same person I was before."*

The therapist may pick up that that is a vague response and really inquire about *feelings*. When the therapist asks you how you've been feeling, talk <u>only</u> about emotions. Say *"I've been feeling down for the last 2 months." (NEVER USE THE WORD DEPRESSION!)* You don't have to say all of these things (listed below) in a long breath. Let the therapist ask you questions and give him/her the information asked for. If there is something critical the therapist did not ask about, you can add it in by saying *"I've also been feeling…"*
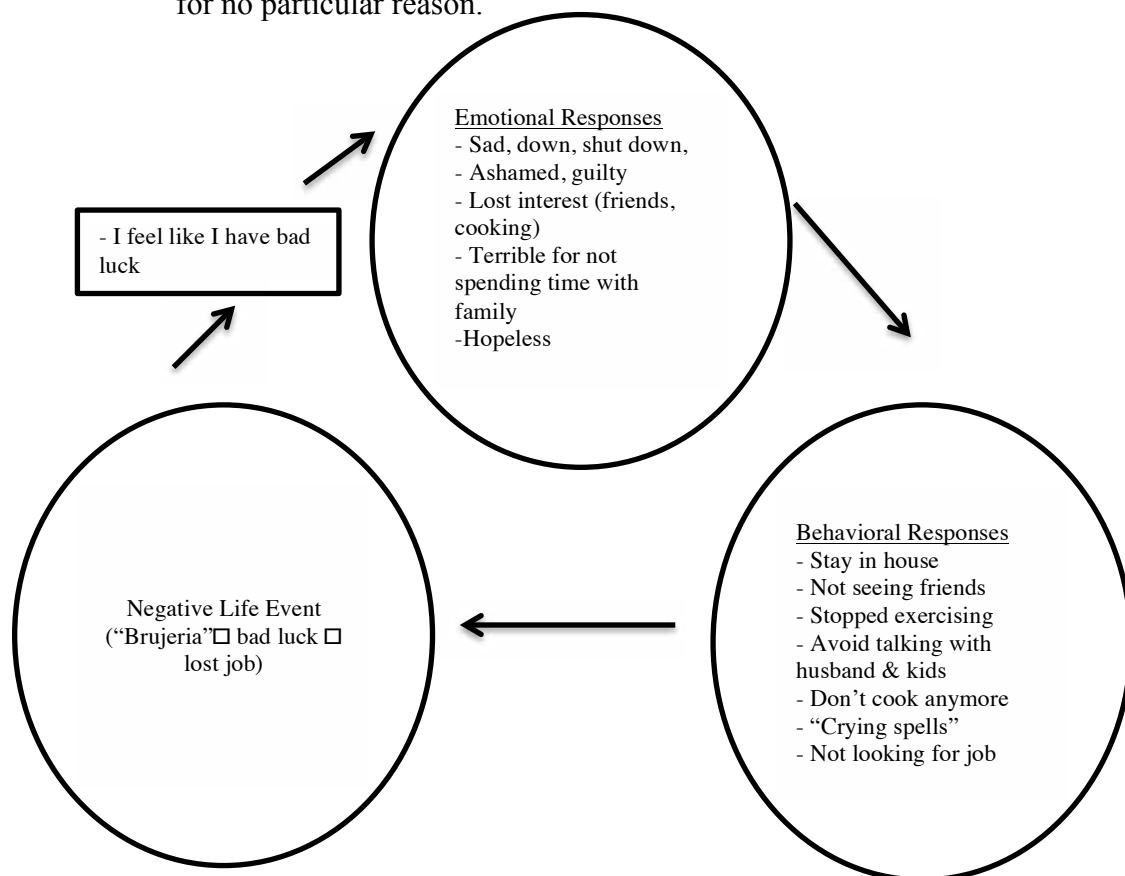- **Emotional Responses**: You feel sad, down, completely shut down. You feel ashamed for getting to this point. You have lost interest in things that you used to enjoy, like going for a walk or playing with your children. You feel guilty since you no longer have a job and can no longer provide for your family financially.

Although you spend most of your time with your children, you feel terrible because you do not often spend *meaningful* time with them.

If the therapist asks about what has changed since you started feeling this way, <u>only</u> talk about behavior. You should only talk about behaviors if asked directly – do not volunteer information! Again, don't say this in one breath and let the therapist ask you questions. If something is critical that the therapist haven't asked about, add it by saying *"I have also stopped…"*

- **<u>Behavioral Responses</u>**:
    - o The first thing you should mention when talking about behavior is that you want your life to be how it used to be before. You can say: *"I am so tired of feeling this way. I cannot find a way out. I just want my life to be how it used to be before. I don't have any more hope. I don't think things can ever get better for me. I just want my old life back."*
    - o In general, you don't really leave the house very much, and you haven't been out seeing friends and family members at all lately. You have stopped exercising, something that used to bring a sense of accomplishment. You often avoid talking to your husband or playing with your children. You do not really cook for your family anymore, you tend to just buy fast food or prepare instant food. You have been avoiding looking for a job because it makes you feel worse about yourself and you are hopeless about finding one. You cry more often, sometimes it seems for no particular reason.

Emotional Responses
- Sad, down, shut down,
- Ashamed, guilty
- Lost interest (friends, cooking)
- Terrible for not spending time with family
-Hopeless

- I feel like I have bad luck

Negative Life Event
("Brujeria"☐ bad luck ☐ lost job)

Behavioral Responses
- Stay in house
- Not seeing friends
- Stopped exercising
- Avoid talking with husband & kids
- Don't cook anymore
- "Crying spells"
- Not looking for job

Prompts to be given *AFTER* YOU TALK ABOUT CHANGES IN YOUR BEHAVIOR AND *BEFORE* THERAPIST GIVES TREATMENT RATIONALE (*note: give this prompt within the first 10 minutes of the role play)

Prompt	Therapist Ideal Response
1) I AM NOT A GOOD MOTHER *(a) "I am not a good mother."* (Give part a of the prompt, separately from part b. Give part b only if the therapist asks you what you mean by this.) *(b) "I do not do the things a good mother does. I don't cook and clean for my children like a good mother does. I don't have energy to play with them like I used to. They probably think I am mad at them and that makes me a bad mother."* (Give part b of the prompt after the therapist asks more questions about what you mean when you say not a good mother)	Therapist should inquire about what a "good mother and wife" looks like. Therapist should inquire about why exactly client does not believe she fits the model of a good mother or wife. Therapist might ask where she learned that those qualities are the ones that a good wife or mother has. Therapist should ask what an ideal mother and wife does (response stays the same as what is currently in role play)

Prompts to be given *ONLY IF THERAPIST MENTIONS ACTIVATION*:

Prompt	Therapist Ideal Response
1) HOW CAN BA HELP ME? *"How would doing activities improve my bad luck? All of this is the result of my neighbor putting a "brujeria" on me. I am not sure if this therapy is going to help me because these are things that are out of my control. I just have to live with my circumstances and accept the spell that was put on me."*	"I understand that my view of the things you are experiencing is different from how you think about it. There are many reasons sometimes why we feel this way. In your case it's the result of a hex. I have been doing this kind of work for a long time and I have found that sometimes people feel the same way you are feeling for many different reasons. But with many clients that have felt this way before it has helped to get them to start doing the things that they have stopped doing in their lives. Sometimes it is very hard and takes a long time to get back to that point, but we'd work together to get you to that point. Regardless of why all of these things started happening in your life, what matters is what we do about it. We should not focus on what is out of your control (the hex, bad luck), but rather what you still have control over (cooking, cleaning). I'd like to suggest to you that we try this therapy called Behavioral Activation to see if it works for you. If it doesn't we can try something

	else."
2) JUST DO IT CHALLENGE *"From what I've heard, it sounds like you are telling me to just do it. Just try to be more active and everything will be okay. But that is what I was trying to do. I tried to force myself to look for a job, to exercise more, to spend quality time with my husband and children. But I still have not been able to do any of it and still feel very down."*	"That is why I will be here to help you. You and I will work as a team to help you re-engage in life again. I will use my knowledge, tips and tricks about how to increase your success with activation. We will look at what behaviors to activate, how challenging should they be, specifically when and where you will activate, what will we label as success, how to reward yourself for success, how to get others involved to support you, predicting what kinds of obstacles may arise and how to overcome them, and lots of other things to really be strategic and smart about getting you active so you will be successful."
3) OUTSIDE-IN CHALLENGE *"I think if I could feel just a little bit better, a little less down, I'd be able to be more active. Shouldn't we do something to change all of these negative feelings first before I do all of these activities?"*	"The problem with this approach is, if we focus too much on waiting for your feelings to change, it could take a long time. It is hard to change our feelings. For instance, if you feel sad and I just told you 'try not to feel so sad', how do you think that will work? It's pretty hard isn't it? But I can say to you, get up and walk across the room, and you could do that whether you are feeling sad or not. So the strategy that I am offering is sort of the opposite, instead of inside-out it is outside-in. It is probably new to you. What I'm going to suggest is for us to focus on changing your behaviors first and monitor how changing your behavior affects how you feel."
4) BIOLOGICAL BASIS FOR DEPRESSION CHALLENGE *(a) "I feel that all of these things started happening in my life as a result of the brujeria. But, I have also heard of other people feeling the same way I do on TV ads and in magazines. It seems like they are telling people that feeling this way is caused by a chemical imbalance. They say that something is not right in their brains.* **Is this what you think?"** *(b) "Oh so you are saying that we should focus on the chemicals rather than the behavior like you mentioned a*	"I want to suggest that there are different ways to change your brain. Your brain and your biochemicals, are responsive to your environments and your behavior. So you can change your brain by changing your behavior, and that is what I would like to suggest we try to do. Research has found that changing your behavior can change the biochemicals in your brain similar to how anti-depressants change your brain."

little bit ago? *note: If the therapist doesn't' dwell on chemicals, then only part (a) is sufficient. If they therapist does endorse that it's all about chemicals, give part (b)	

*If the therapist does not mention Behavioral Activation, getting active, doing more activities, etc., there is no point in giving the prompts. However, if the therapist mentions some loose association between "doing things" (or any variation of this) and how that will help with your feelings, try to ask more questions so they delve into activation more so that you can deliver the prompts.

You could ask the following:
- o "Can you tell me more about what you mean?"
- o "I don't think I understand what you mean, can you explain it more?"

The idea here is that you want to ask vague enough questions so that you are not leading the therapist, but you want to open the door for the therapist to talk about activation so you can deliver the prompts.

Possible questions the THERAPIST might ask (not in any particular order):

Therapist Questions	*Client Response*
What brought you here today? (problem)	*"Bad things are happening in my life. My life is not what is used to be. I've been feeling this way for 2 months."*
What bad things are happening in your life?	*"I lost my job. I don't feel like me anymore. I am not the happy person I was before."*
What do you think has been making you feel this way? (cause) OR What triggered your depression?	*"All of these negative things started happening in my life after my neighbor, who is a witch and hates me, put a brujeria on me."*
What is "brujeria"?	*"It's like witchcraft. When someone who has sort of special powers doesn't like you and wants bad luck to happen to you, they can put a brujeria on you. When someone puts a brujeria on you, negative things start happening in your life."*
What's going on in your life right now?	*"My life is not what it used to be. Everything has changed. I am not the person that I was before, when I didn't feel this way."*
How have you been feeling?	*At first:*

	"I have been feeling like I have been having a lot of bad luck"
	When they ask more questions:
	"Sad, down, guilty for the job loss; losing interest in things I used to do."
	"No matter how hard I try, I don't feel better. I am sad all of the time, I cry a lot and I don't do what I used to do. I also I lost my job. I used to be a nursing assistant and all this has me feeling very down."
	(look at what's been written on pages 5-6 for emotional responses)
What have you been doing?	*"Not a lot. I mostly stay at home. I watch a lot of TV and sleep a lot."*
	(look at what's been written on pages 5-6 for behavioral responses)
Are there activities that you used to do but stopped doing?	*"I am not a good mother anymore. I used to take care of the house and my children. I used to exercise. And before, I would spend time with my friends and my family."*
Are there activities that you want to start doing?	*"I need to get a job again. I would like to start looking for one, but I feel overwhelmed. I feel like it's out of my control because of the brujeria."*
Have others noticed changes in you?	*"I cry all of the time – while I am doing the dishes, when I am watching TV, when I am cooking dinner. The tears just fall. And my children are always asking me why I am crying. I try to change the subject, but they know I am in a lot of pain. It makes me feel guilty that they see me cry because I want to be a good mother and I don't want them to think I am crying because of them."*
What do you wish to gain from therapy?	*"I just want to be happy"* or *"I want my life to be how it used to be before"*.
What would you do if you were a happy person?	*"I would spend more quality time with my family, work, exercise, reconnect with friends, and be more grateful."*
What have you been doing more of?	*"Sleeping; watching TV."*
Do you notice any things that improve your mood?	*"Yes, talking to my mother makes me happy."*

	"Preparing dinner for my family makes me feel accomplished." *"Going to the doctor is something that is important for me. I had been meaning to go for a while."*
Do you experience any routine disruptions? OR Have you noticed changes in your routine?	*"My sleeping is out of order at times. Sometimes I go to bed early, other times I stay up late. The same thing with waking up in the morning. Sometimes I wake up early, other days I wake up pretty late."*
What things are important to you? OR What do you value?	*"I would like to be a good mother. I want to be responsible, loving and fun for my children."* *"I want to be a loving, caring, supportive wife. I have not lived up to this value because I have been feeling sad and down and have not been spending quality time with my husband. When we have time to talk privately, the conversation is always about the finances, the children, or house chores."* *"I want to be able to financially provide for my family. I want to be able to have a job that I enjoy. That will gives us some financial security. I'd like to be a dedicated, responsible nurse's assistant."*

*Note: The therapist might give you a lot of information when they describe depression. Be agreeable ("uhhh-hmmms"; "yes that makes sense", or "yes I can see that"). The only points you are to disagree with are when giving the prompts. For example, if the therapist asks what your children's names are, make something up. Give answers that keep the role play moving forward.

ROLE PLAY 2: ACTIVITY SCHEDULING (25 MINUTES)

Read these instructions for the THERAPIST (Study Participant):

It is session 7. You have started behavioral activation. So far, your client successfully went to the career center and received training on how to post her resume online and find possible job openings. Her assignments last week were to 1) post her resume online, 2) go for a 20 minute run, and 3) watch a movie with her husband. Your task is start the

session, review her homework, and schedule one or two new activities. Try to spend 25 minutes total on these tasks.

Instructions for the HYPOTHETICAL CLIENT (Role Player):

In this session, you will tell the therapist that you went for a run but you did not watch a movie with your husband and you did not post any resumes online. It is the therapist's job in this session to figure out why you were not able to complete your homework, to troubleshoot ways to complete the tasks next week, and assign some new homework for you.

When asked about posting your resumes, you will say that you remembered to do the resume assignment. In fact, you made several reminders on your cell phone, agenda, and the fridge. You also did not have any problems using the computer or accessing the internet/website. You went to the career center and received training on how to put your resume online and to find possible job openings. Your husband was supportive and said that he would watch the children while you were working on the computer. You also knew that once you posted your resume online, you would feel much better and accomplished.

You should explain that the only problem was that you experienced many negative feelings whenever you tried to post your resume. Just thinking about the plan made you nervous. Editing your resume made you feel like a failure and think that you will never find a job. It also made you sad and down – it reminded you how devastated you were to be laid off. Sometimes, you just felt too tired to do this task. As a result, it was easier for you to avoid posting your resume online. You felt a little better if you just distracted yourself by doing something else, like sitting in front of the TV, or thinking about something else, rather than trying to find a job.

When asked about watching a movie with your husband, say that when your husband asked you to watch the movie, you were really upset and you were stuck thinking about the brujeria has changed your life. You kept thinking about your neighbor, how much you don't like her, and how you wished you had never met her. You thought about all the little things that have changed since the brujeria, and how things were never going to change. You were so deep in thought it was like you were in a trance almost. You just sat there, thinking and brooding, and couldn't get out of it enough to say you would watch the movie with your husband. Your husband, after asking, looked disappointed and then left you alone.

After the therapist reviews these previous assignments, ideally, the therapist will collaborate with you in choosing new activities to schedule. Hopefully the therapist will encourage you to try again to schedule the activities you failed at. But, some therapists might choose other activities for the client. The role player's task is to play along with therapist. Refer to the answers provided on the filled out "BA Activity Homework Sheet" on pages 12-13 for possible things to say to the therapist if the therapist tries to schedule any of those activities with you. However, there might be things not on the list that the

therapist might want to discuss. If that is the case, give answers that are consistent with the role play.

If the therapist asks you which activities you'd like to work on for the next week, suggest that you want to try again with the resume and with watching a movie. However, there is some flexibility in choosing the activities depending on the demands of the therapist.

*Note: If the therapist just chooses the activities for you, then just play along with whatever activities they chose.

BA Activity Homework Sheet				
Activity	**W/W/W/W**	**Obstacles**	**Solutions to obstacles**	**Outcome**
Picnic	- Sunday at noon - Park nearby - Family	- Forgetting	- Ask family members to remind you	
Job Application	- Edit resume + post online - Home - 8pm (Monday – Friday) - 1 hour/day	- Distraction from kids	- Husband will watch the kids	
Run for 20 minutes/ day	- Trail in the park - 3 days/week (Mondays, Wednesdays, Fridays) - 8 am - Alone	- Weather	- YMCA	
Take kids to park	- At least once a week - Tuesday at 4pm	- Distracted by house chores	- Ask kids to remind her - Schedule house chores in advance - Ask help from sister	
Cook healthier meal	- At least 5 days/week - Dinner and lunch	- No time to cook	- Prepare in advance	
Go out with girlfriends	- Friday night - Dinner at 7pm - Café Lulu - 5 close friends	- Nobody takes care of children	- Hire a babysitter - Ask help from sister	
Call parents	- Weekend - 11am	- Forgetting	- Setting alarms in cell phone	
Gardening	- Once a month - 1st of every month - 10am - Alone/with husband	- No tools	- Borrow tools from parents	
Read books	- Twice a week - Sunday at 3pm - Wednesday at 11am	- Can't afford books	- Borrow from the library	

Prompts to be given:

Prompt	Therapist Ideal Response
1) I'VE BEEN THINKING A LOT (RUMINATION) *"When my husband asked me to watch a movie, I just kept thinking and thinking about my problems. I thought about all of this bad luck that has taken place in my life. I thought about how I used to be before the brujeria and how different my life is now. Sometimes I just thought in circles for long periods of time and didn't realize how much time had passed. Thinking about my situation made me feel nervous. It made me feel like I am stuck in a hole that I will never be able to get out of. All of the thinking made me feel like a failure. I am not the good wife and mother that I was before – I'm a failure."*	"The process that you are describing to me of going in circles with your thoughts is something that sometimes is called rumination. The first thing I want to help you with is to just notice when you are ruminating. Ask yourself, is this thinking helpful, or am I just going in circles? If you are going in circles, in that moment, with your husband, I would want you to really try to pay attention to everything in your environment around you. Look deeply at your husband. Feel the sofa and your husband's hand in your hand and notice the lights and sounds in the room. Pay deep attention to what is going on around you. Allow yourself to get deeply lost in the movie as a distraction.

Possible questions THERAPIST might ask (not in any particular order):

Therapist Questions	Client Response
How did the homework go last week?	*"Well, it was ok."*
What were you able to finish this past week?	*"I did not post any resumes online and I did not watch a movie with my husband."*
What was the barrier?	Resume: *"It was hard to post my resume online. I sat in front of my computer but then I felt down so I just left my office and watched TV."* Movie: See prompt above.
Did you remember to post your resume?	*"Yes. I remembered. I even set multiple reminders on my cell phone, an agenda, and the fridge."*
Did you have any problems with your computer or the internet?	*"No, I know how to work the computer and get to the right website."*
Did you know how to post your resume?	*"Yes. I went to the career center and received the training on how to put my resume online and to find possible job openings."*
Did your husband support you? OR	*"Yes, he was very supportive. He offered to take care of the children while I was working on posting my resume."*

Did your husband watch the kids for you?	
Did you remember why you were posting your resume online?	*"I know that I said I wanted to post my resume online because it's something that is important to me and to my family."*
Did you think about how posting your resume would have made you feel?	*"I was aware that if I would have posted my resume online, I would have felt much better and accomplished."*
How did watching TV make you feel in that moment instead of posting your resume?	*"I felt better immediately but just for a short period of time. I usually felt bad later on."*
So, why do you think that you were not able to watch the movie?	*(go back to rumination prompt)*
So, for next week, what kind of activities do you think we should focus on?	*"Well, there are a few things that I would eventually like to do again. I'd like to:* - *apply for jobs* - *go for a 20 minute run per day* - *go on a family picnic* - *take the kids to the park* - *cook healthier meals* - *go out with my girlfriends* - *call my parents* - *do some gardening* - *read books*
Let's pick 2 or 3 things to schedule in for next week. What do you think they should be?	The therapist will likely want to schedule the activities that you were not able to complete last week for the next week with the tips they gave you. You can say: "Now that we have discussed some things that got in the way last week, I think I'd like to try posting my resume and watching a movie with my husband again. *Note: the therapist might want to schedule other activities with you not related to what you were not able to complete last week. That's ok. Just go with that the therapist tells you if he or she picks the activities for you.

Appendix F
BA Knowledge Test

Providing the Rationale		
1	Identifies and discusses negative life events • *What kind of questions that a BA therapist asks to identify negative life events?* • *How do you explain/discuss negative life events based on the three-circle model in BA?*	
2	Identifies and discusses emotional responses (feeling elements of depression) • *What kind of questions that a BA therapist asks to identify emotional responses?* • *How do you explain/discuss emotional responses based on the three-circle model in BA?*	
3	Identifies and discusses behavioral responses (action elements, secondary coping, avoidance) • *What kind of questions that a BA therapist asks to identify behavioral responses?* • *How do you explain/discuss behavioral responses based on the three-circle model in BA?*	
4	Validates emotional and behavioral responses as natural, normal, common (matter of fact) • *How does a BA therapist validate the client's emotional and behavioral responses to negative life events?*	
5	Discusses how responses lead to more negative life events (the spiral or cycle of depression) • *How does a BA therapist describe the cycle of depression using the three-circle model?*	
6	Explains the goal of BA: activation as alternative to natural responses ("breaking the cycle") • *How does a BA therapist explain activation as a strategy to break the cycle of depression?*	
7	Uses the client's language instead of jargon	
8	Seeks feedback and verifies understanding of the rationale • *What kind of questions that a BA therapist asks to verify understanding of the rationale?*	
9	"Just do it: • *What is the ideal BA response when the client thinks that BA only tells them to "just do the activities" like the Nike commercial.*	
10	"Inside out": • *What is the ideal BA response when the client wants to change his/her feeling first before engaging in activities?*	
11	"Broken brain": • *What is the ideal BA response when the client wants to discuss or directly treat the biological aspect of depression (e.g.,, a chemical imbalance)?*	

	Informal Interviewing and Reviewing Activity Monitoring	
1	Assesses behaviors that the client used to do but stopped doing and/or would like to start doing • *What kind of questions that a BA therapist asks to identify behaviors that the client stopped doing or would like to start doing?*	
2	Assesses avoidance behaviors (including subtle) that the client is doing more of • *What kind of questions that a BA therapist asks to identify avoidance behaviors?*	
3	Discusses the relation between activities/life contexts and mood • *How does a BA therapist explain the relationship between activities and mood?*	
4	Discusses/comments on range of feelings, mastery, and pleasure • *How does a BA therapist explain the range of feelings, mastery, and pleasure when people are depressed?*	
5	Discusses/comments on the breadth or restriction of activity • *What are the types of activities that the client is doing or not doing that a BA therapist needs to pay attention to?* • *How does a BA therapist discuss the breadth or restriction of activity?*	
6	Discusses/comments on routine disruptions • *How does a BA therapist discuss routine disruptions?*	
	Values Assessment	
1	Provides a rationale for values assessment • *What is the function of values assessment in BA?*	
2	Defines "values" with specific concrete examples • *How do you define "values"?* • *Please provide some examples of values.*	
3	Defines "goals" with specific concrete examples • *How do you define "goals"?* • *Please provide some examples of goals.*	
4	Develops concrete goals in line with values from different life domains	
5	"Values important to others": • *What is the ideal BA response when the client identifies a value that is more important to others than to her/him?*	
6	"Abstract value": • *What is the ideal BA response when the client's value is very abstract (e.g.," I want to be a good person")*	
7	"Just want to be happy": • *What is the ideal BA response when the client's value is "to be happy" or "to be less depressed"?*	
	Activity Scheduling	
1	Collaboratively works with client to identify activities to work on • *What kind of questions that a BA therapist asks to allow for collaboration when scheduling activities?*	

2	Grades assignments by task difficulties (shaping) • *What is the recommended level of difficulty when scheduling an activity?* • *Please provide an example of shaping.*	
3	Breaks assignments into manageable chunk (chaining) • *Please provide an example of chaining.*	
4	Schedules each activity concretely (defines "WWWW" on homework sheet) • *Please review the activity scheduling sheet.* • *What should a BA therapist cover when scheduling an activity?*	
5	Identifies obstacles to each activity • *When does a therapist need to identify the obstacles for each activity?*	
6	Identifies solutions to each obstacle	
Targeting Avoidance		
1	Helps client distinguish triggers, responses and avoidance patterns (3 circles) • *What kind of questions that a BA therapist asks when identifying the triggers of avoidance?* • *What kind of questions that a BA therapist asks when identifying the responses of avoidance?* • *What kind of questions that a BA therapist asks when identifying the avoidance behaviors?* • *How does a BA therapist explain the three-circle model of avoidance?*	
2	Validates responses and avoidance patterns as understandable and natural • *How does a BA therapist validate the avoidance patterns as understandable and natural?*	
3	Identifies and discusses the short term benefits but long term problems associated with avoidance • *How does a BA therapist discuss short vs. long term benefits of avoidance?*	
4	Develops strategic and concrete activity scheduling (focusing on tip 2 and 3) • *How does a BA therapist use tip 2 and 3 to deal with avoidance?*	
5	Remind client of BA's outside in approach • *What is the "outside-in" approach?*	
6	Rumination • *What does a BA therapist do when rumination leads to avoidance?*	

Additional strategies that may be used for activity scheduling:
- Uses public commitment
- Uses stimulus control/reminder strategies
- Uses skills training strategies

- Adopts a scientific/experimental attitude
- Considers options for more regular check-ins
- Considers the use of arbitrary self-reinforcement
- Considers the use of contracts/contingency management with others
- Assesses degree of engagement in activity
- Breaks down the task
- Emphasizes starting/doing some of activity rather than perfect completion
- Adopts a scientific/experimental attitude

Appendix G
Role Play Adherence Checklist

Instructions:
- *Give a score of 1 if the role play completed the item successfully.*
- *Give a score of 0 if the item was NOT delivered to the therapist.*
- *Write an N/A if the role player was not able to deliver the prompt due to lack of time*

General Administration Tasks		
1	Greeted and introduced self before beginning role play assessment	
2	Gave general instructions to the role play	
3	Read instructions to therapist before beginning of role play 1 and role play 2	
4	Kept time of each role play and reminded study participant periodically of time left in the role play	
5	Stayed within the allocated time for each role play (25 minutes)	
6	Provided appropriate amount of responses (not too much, not too little)	
7	Stayed on script: role player did not make up answer that derailed the role play. Rather, when the therapist asked question the role player did not know, response was "I don't know" (or some variant)	
Role Play 1 – Providing the Rationale and Informal Interviewing		
1	In response to "why did you come in today?", role player explains *brujeria*	
2	Before giving negative life events, emotional responses & behavioral responses, role player explains that brujeria makes her feel that "her life is out of control"	
3	Provided accurate responses for ONLY negative life events	
4	Provided accurate responses for ONLY emotional responses (feeling elements of depression)	
5	Provided accurate responses for ONLY behavioral responses (action elements, secondary coping, avoidance)	
6	Role player lists activities she has stopped (spend time with family and friends) doing ONLY when asked by the therapist	
7	Role player tells therapist which activities she would like to start doing (get a job) ONLY when asked by the therapist	
8	Delivered the "I'm not a good mother" prompt	
9	Delivered the "how can BA help me?" challenge	
10	Delivered the "just do it" challenge	
11	Delivered the "inside out" challenge	
12	Delivered the "biological bases" challenge	
13	Role player does not use the word depression	
14	Role player did not lead the study participant to ask certain questions. Rather, role player went along with everything therapist suggested.	
Role Play 2 - Activity Scheduling		
1	Role player tells therapist that she went for a run but did not watch a movie with her husband and did not post any resumes online	
2	Role player tells the therapist that she remembered to post her resume (had several reminders)	
3	Explained that her husband was supportive when attempting to do the	

	resume	
4	Explained that she knew how to post her resume online	
5	Explained that she knew that she would have felt much better in the long-run if she would have posted her resume, but still decided to avoid	
6	Role player explained that the only obstacle she experienced to working on her resume was many negative feelings (nervous, failure, devastated) every time she sat down to work on it	
7	Role player explained that she decided to watch TV instead of working on her resume because the distraction made her feel better in the present moment	
8	Provided the "rumination" challenge in response to watching a movie with her husband (trans-like state when husband asked to watch a movie with her)	
9	Role player explains that because she was so lost in thought, her husband left her alone and they did not watch the movie	
10	Role player goes along with the client in picking new activities to be scheduled for the following week. If the therapist picks the activities, the role player goes along with them. If asked to pick activities, role player provides 3 listed in the filled out "BA Activity Homework Sheet"	

Appendix H
Shifting Cultural Lenses Coding Sheets

0-10 Minute Interval Rating

None (0)   A Little (1)   Some (2)   Quite a bit (3)   A great deal (4)

Please make ratings for each time interval.

	Global Interval
C. Learning the client's perspective	
T. Communicating the therapist's perspective	
C. 1.Integration of client's views	
C.2. Work towards buy-in	
C.3. Negotiation of a shared narrative	
D. Clinician's negative behaviors	
F. Facilitating client's story	

Please indicate what about their social world might be important. Also point out possible themes of what matters to the client. Be sure and refer to what the client says or to low level inferences.

Social World Indicators	*What Matters to the Client*

Appendix I
Therapist Demographic Questionnaire

1. Gender
___M
___F

2. Age: _____

3. Ethnicity (check all that apply):

___White/ Caucasian/ European American
___Black/African-American
___Non-white Hispanic
___South Asian
___Middle Eastern
___East Asian
___Southeast Asian
___Native American
___Pacific Islander
___Other: _____

4. What is your highest degree?
___High School
___Associate's Degree
___BA/BS
___MA/MS/MPH
___PhD/PsyD
___MD

5. Are you currently a student/intern/trainee in the mental health field?   Yes   No

a. If you are currently in training, how many years have you treated psychotherapy clients?
___ 1
___ 2
___ 3
___ 4
___ 5
___ 6 or more

b. If you are currently in training, which option best describes your position?
___ Graduate student
___ Pre-degree internship
___ Post-degree/pre-licensure internship/fellowship/residency
___ Other (please specify): _____

6. What type of license do you hold?
___ None

___ Licensed Clinical Social Worker
___ Marriage and Family Therapist
___ Psychiatric Nurse Practitioner
___ Psychologist
___ Psychiatrist
___ Other (specify) _____

7. How many years since your (first) license have you been providing clinical services?
_____

8. Which best describes your work setting?
___ Inpatient unit
___ Residential program
___ Partial hospitalization/day program
___ Outpatient mental health clinic
___ Community mental health service program
___ Training clinic
___ Group private practice
___ Individual private practice
___ Other (please specify):_____ _____

9. How many hours per week do you spend providing psychotherapy to clients?
___ 0-5 hours
___ 6-10 hours
___11-20 hours
___ 21-30 hours
___ 31-40 hours
___ 40+ hours

10. Which treatment modalities do you **regularly** provide? (Check all that apply)
___ Individual
___ Couples
___ Family
___ Group

11. What is the age range of clients that you **regularly** treat? (Check all that apply)
___ Children (0-12)
___ Adolescents (13-17)
___ Adults (18-65)
___ Older adults (65+)

12. Which ethnic/minority populations do you **regularly** treat? (Check all that apply)
___ White/Caucasian/European American
___ Asian-American/Pacific Islander
___ Middle Eastern
___ Black/African American

___ Non-white Hispanic or Latino/a
___ Native American
___ Gay/Lesbian/Bisexual/Transgender
___ Other (please specify): _____

Do you provide psychotherapy in a language other than English? Yes   No
If Yes,

a. please specify language(s)_____
b. what percent of your caseload receives psychotherapy in another language (0-100 percent)? _____

13. Do you currently supervise training psychotherapists?   Yes   No

14. Which of the following presenting problems do you **regularly** treat? (Check all that apply)
___ Major depressive disorder/dysthymia
___ Bipolar disorder/spectrum
___ Anxiety disorders
___ Trichotillomania, skin picking
___ Psychotic disorders (including schizophrenia)
___ Somatoform disorders (including hypochondriasis)
___ Chronic physical illnesses
___ Sleep disorders
___ Eating disorders
___ Pervasive developmental disorders/learning disorders/mental retardation
___ Substance use/dependence
___ Marital, relationship difficulties
___ Adjustment disorders
___ Axis II personality disorders (including borderline personality disorder)
___ Other (please specify): _____

15. How technologically savvy/skilled would you describe yourself as being?
___ Not at all. Do not use a computer.
___ Slightly. Use a computer for limited purposes, but do not often use email or the internet.
___ Moderately. Use email and the internet regularly, though I am often not comfortable with unfamiliar uses.
___ Very. Use email and the internet regularly for many purposes and feel comfortable learning new uses.

16. Do you have access to a computer in your office? Yes   No

17. Do you have access to the internet in your office? Yes   No

18. Do you use a PDA (e.g.,, Palm pilot)? Yes   No

19. Do you have a smartphone (e.g.,, iPhone, Blackberry)? Yes   No

20. How much experience in Behavioral Activation do you have?
___ None
___ Some. I have done some reading and tried some techniques.
___ Moderate. I have attended a workshop, read a treatment manual, and use it regularly with my clients.
___ Extensive. I have received supervision in BA and feel very comfortable with the techniques.

21. How comfortable do you feel in your ability to be culturally competent with clients from diverse backgrounds?
___ Very limited comfort. I rarely encounter clients from diverse backgrounds through my clinical work.
___ Some comfort. I have worked with a few clients who are from diverse backgrounds.
___ Moderate comfort. Many of the clients that I work with are from diverse backgrounds.
___ Extensive comfort. Issues of culture are very salient in my clinical work and almost all of the clients that I work with are from diverse backgrounds.

Appendix J
Level of Implementation and Confidence Utilizing BA Skills

I am confident I can do BA if I choose to
- o *Not at all*
- o *Mostly, no*
- o *Somewhat*
- o *Mostly, yes*
- o *Completely*

How many clients did you see this week?

How many of these had depression as a significant problem?

This week, with how many clients did you try:

> Providing a BA rationale with a "circle" model?
> Assessment of activation targets through informal interviewing?
> Assessment of activation targets through values assessment?
> Assessment of activation targets through activity monitoring?
> Generating an activity hierarchy?
> Assigning activation assignments?
> Reviewing homework assignments?
> Using reminders to maximize activity completion?
> Using skills training to maximize activity completion?
> Using contingency management or contracts to maximize activity completion?
> Targeting avoidance or rumination to maximize activity completion?

In general, if you tried a technique, how confident did you feel with:
(0 – did not try; 1 – completely lacking confidence; 2 – somewhat lacking confidence; 3 – neutral; 4 – somewhat confident; 5 – very confident)

> Providing a BA rationale with a "circle" model?
> Assessment of activation targets through informal interviewing?
> Assessment of activation targets through values assessment?
> Assessment of activation targets through activity monitoring?
> Generating an activity hierarchy?
> Assigning activation assignments?
> Reviewing homework assignments?
> Using reminders to maximize activity completion?
> Using skills training to maximize activity completion?
> Using contingency management or contracts to maximize activity completion?
> Targeting avoidance or rumination to maximize activity completion?

This week, with how many clients did you use the following forms:
> Values Assessment?
> Activity Monitoring?
> Activity Hierarchy?
> Activation Homework Sheet?

BA techniques are a good fit for my clients:
- o *Not at all*
- o *Mostly, no*
- o *Somewhat*
- o *Mostly, yes*
- o *Completely*

BA forms are useful for my sessions:
- o *Not at all*
- o *Mostly, no*
- o *Somewhat*
- o *Mostly, yes*
- o *Completely*

If any, please describe any difficulties you encountered applying BA techniques.

If any, please describe any positive experiences resulting from applying BA techniques.

Overall, how satisfied are you with implementing BA techniques this week?
- o *Did not try*
- o *Quite dissatisfied*
- o *Mildly dissatisfied*
- o *Neutral*
- o *Mildly satisfied*
- o *Very satisfied*

Appendix K
The Multicultural Awareness, Knowledge, and Skills Survey

The Multicultural Awareness, Knowledge, and Skills Survey (MAKSS) is a 60-item survey designed by Michael D'Andrea, Judy Daniels, and Ronald Heck, all from the University of Hawaii. Respond to all 60 items on the scale, even if you are not working with clients or actively conducting groups. Base your response on what you think at this time. Try to assess yourself as honestly as possible rather than answering in the way you think would be desirable. The MAKSS is designed as a self-assessment of your multicultural counseling awareness, knowledge, and skills.

1. Culture is not external but is within the person.
Strongly disagree   Disagree   Agree   Strongly agree

2. One of the potential negative consequences about gaining information concerning specific cultures is that students might stereotype members of those cultural groups according to the information they have gained.
Strongly disagree   Disagree   Agree   Strongly agree

3. At this time in your life, how would you rate yourself in terms of understanding how your cultural background has influenced the way you think and act?
Strongly disagree   Disagree   Agree   Strongly agree

4. At this point in your life, how would you rate your understanding of the impact of the way you think and act when interacting with persons of different cultural backgrounds?
Strongly disagree   Disagree   Agree   Strongly agree

5. How would you react to the following statement? While counseling enshrines the concepts of freedom, rational thought, tolerance of new ideas, and equality, it has frequently become a form of oppression to subjugate large groups of people.
Strongly disagree   Disagree   Agree   Strongly agree

6. In general, how would you rate your level of awareness regarding different cultural institutions and systems?
Strongly disagree   Disagree   Agree   Strongly agree

7. The human service professions, especially counseling and clinical psychology, have failed to meet the mental health needs of ethnic minorities.
Strongly disagree   Disagree   Agree   Strongly agree

8. At the present time, how would you generally rate yourself in terms of being able to accurately compare your own cultural perspective with that of a person from another culture?
Strongly disagree   Disagree   Agree   Strongly agree

9. How well do you think you could distinguish "intentional" from "accidental" communication signals in a multicultural counseling situation?
Strongly disagree   Disagree   Agree   Strongly agree

10. Ambiguity and stress often result from multicultural situations because people are not sure what to expect from each other.
Strongly disagree   Disagree   Agree   Strongly agree

11. The effectiveness and legitimacy of the counseling profession would be enhanced if counselors consciously supported universal definitions of normality.
Strongly disagree   Disagree   Agree   Strongly agree

12. The criteria of self-awareness, self-fulfillment, and self-discovery are important measures in most counseling sessions.
Strongly disagree   Disagree   Agree   Strongly agree

13. Even in multicultural counseling situations, basic implicit concepts, such as "fairness" and "health," are not difficult to understand.
Strongly disagree   Disagree   Agree   Strongly agree

14. Promoting a client's sense of psychological independence is usually a safe goal to strive for in most counseling situations.
Strongly disagree   Disagree   Agree   Strongly agree

15. While a person's natural support system (i.e.,, family, friends, etc.) plays an important role during a period of personal crisis, formal counseling services tend to result in more constructive outcomes.
Strongly disagree   Disagree   Agree   Strongly agree

16. How would you react to the following statement? In general, counseling services should be directed toward assisting clients to adjust to stressful environmental situations.
Strongly disagree   Disagree   Agree   Strongly agree

17. Counselors need to change not just the content of what they think, but also the way they handle this content if they are to accurately account for the complexity in human behavior.
Strongly disagree   Disagree   Agree   Strongly agree

18. Psychological problems vary with the culture of the client.
Strongly disagree   Disagree   Agree   Strongly agree

19. How would you rate your understanding of the concept of "relativity" in terms of the goals, objectives, and methods of counseling culturally different clients?
Strongly disagree   Disagree   Agree   Strongly agree

20. There are some basic counseling skills that are applicable to create successful outcomes regardless of the client's cultural background.
Strongly disagree   Disagree   Agree   Strongly agree

At the present time, how would you rate your own understanding of the following terms:

21. Culture
Very limited   Limited   Good   Very good

22. Ethnicity
Very limited   Limited   Good   Very good

23. Racism
Very limited   Limited   Good   Very good

24. Mainstreaming
Very limited   Limited   Good   Very good

25. Prejudice
Very limited   Limited   Good   Very good

26. Multicultural Counseling
Very limited   Limited   Good   Very good

27. Ethnocentrism
Very limited   Limited   Good   Very good

28. Pluralism
Very limited   Limited   Good   Very good

29. Contact Hypothesis
Very limited   Limited   Good   Very good

30. Attribution
Very limited   Limited   Good   Very good

31. Transcultural
Very limited   Limited   Good   Very good

32. Cultural Encapsulation
Very limited   Limited   Good   Very good

33. What do you think of the following statements? Witch doctors and psychiatrists use similar techniques.
Strongly disagree   Disagree   Agree   Strongly agree

34. Differential treatment in the provision of mental health services is not necessarily thought to be discriminatory.
Strongly disagree   Disagree   Agree   Strongly agree

35. In the early grades of formal schooling in the United States, the academic achievement of such ethnic minorities as African Americans, Hispanics, and Native Americans is close to parity with the achievement of White mainstream students.
Strongly disagree   Disagree   Agree   Strongly agree

36. Research indicates that in the early elementary school grades girls and boys achieve about equally in mathematics and science.
Strongly disagree   Disagree   Agree   Strongly agree

37. Most of the immigrant and ethnic groups in Europe, Australia, and Canada face problems similar to those experienced by ethnic groups in the United States.
Strongly disagree   Disagree   Agree   Strongly agree

38. In counseling, clients from different ethnic/cultural backgrounds should be given the same treatment that White mainstream clients receive.
Strongly disagree   Disagree   Agree   Strongly agree

39. The difficulty with the concept of "integration" is its implicit bias in favor of the dominant culture.
Strongly disagree   Disagree   Agree   Strongly agree

40. Racial and ethnic persons are underrepresented in clinical and counseling psychology.
Strongly disagree   Disagree   Agree   Strongly agree

41. How would you rate your ability to conduct an effective counseling interview with a person from a cultural background significantly different from your own?
Very limited   Limited   Good   Very good

42. How would you rate your ability to effectively assess the mental health needs of a person from a cultural background significantly different from your own?
Very limited   Limited   Good   Very good

43. How well would you rate your ability to distinguish "formal" and "informal" counseling strategies?
Very limited   Limited   Good   Very good

44. In general, how would you rate yourself in terms of being able to effectively deal with biases, discrimination, and prejudices directed at you by a client in a counseling setting?
Very limited   Limited   Good   Very good

45. How well would you rate your ability to accurately identify culturally biased assumptions as they relate to your professional training?
Very limited   Limited   Good   Very good

46. How well would you rate your ability to discuss the role of "method" and "context" as they relate to the process of counseling?

Very limited   Limited   Good   Very good

47. In general, how would you rate your ability to accurately articulate a client's problem who comes from a cultural group significantly different from your own?
Very limited   Limited   Good   Very good

48. How well would you rate your ability to analyze a culture into its component parts?
Very limited   Limited   Good   Very good

49. How would you rate your ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons from different cultural/racial/ethnic backgrounds?
Very limited   Limited   Good   Very good

50. How would you rate your ability to critique multicultural research?
Very limited   Limited   Good   Very good

51. In general, how would you rate your skill level in terms of being able to provide appropriate counseling services to culturally different clients?
Very limited   Limited   Good   Very good

52. How would you rate your ability to effectively consult with another mental health professional concerning the mental health needs of a client whose cultural background is significantly different from your own?
Very limited   Limited   Good   Very good

53. How would you rate your ability to effectively secure information and resources to better serve culturally different clients?
Very limited   Limited   Good   Very good

54. How would you rate your ability to accurately assess the mental health needs of women?
Very limited   Limited   Good   Very good

55. How would you rate your ability to accurately assess the mental health needs of men?
Very limited   Limited   Good   Very good

56. How well would you rate your ability to accurately assess the mental health needs of older adults?
Very limited   Limited   Good   Very good

57. How well would you rate your ability to accurately assess the mental health needs of gay men?
Very limited   Limited   Good   Very good

58. How well would you rate your ability to accurately assess the mental health needs of gay women?
Very limited   Limited   Good   Very good

59. How well would you rate your ability to accurately assess the mental health needs of handicapped persons?
Very limited   Limited   Good   Very good

60. How well would you rate your ability to accurately assess the mental health needs of persons who come from very poor socioeconomic backgrounds?
Very limited   Limited   Good   Very good

Appendix L
Latino Values Questionnaire

T or F   1. A man's strength comes from being a good father and husband.

T or F   2. Individual achievement is the most important goal in life.

T or F   3. One's family is the main source of one's identity.

T or F   4. One must sometimes take risks in one's family to gain the respect of elders.

T or F   5. Spiritual beliefs are seen as a personal choice that can vary from person to person independent of one's family's beliefs.

T or F   6. In initial interactions with someone, it is important to be friendly, likeable and expressive.

T or F   7. One must maintain a sense of independence from one's family so as not to get enmeshed.

T or F   8. A woman must be a source of strength for her family.

Appendix M
Acceptability Questionnaire

Post Session 1 Survey [for Group 1]
These questions ask about the *before training preparation* you were asked to complete.

In this section, you were assigned a video as well as four readings. Was the video helpful? Was there anything that was not clear or needs further attention?

Were the readings helpful? Was there anything that was not clear or needs further attention?

Please rate the quality of this section of the class:
o Poor
o
o
o
o Excellent

Please rate the usefulness of this section of the class:
o Not useful at all
o
o
o
o Extremely useful

These questions ask about Session One which covered the history of BA and cultural competence.

This section of the class focused on the history of BA. Was this helpful? What are you likely to remember and incorporate into your practice?

Was anything about the section of the class on the history of BA that was not helpful? Anything you would recommend be changed or presented differently?

Please rate the quality of this section of the class:
o Poor
o
o
o
o Excellent

Please rate the usefulness of this section of the class:
o Not useful at all
o
o
o
o Extremely useful

FOR GROUP 1 ONLY: This section of the class focused on cultural competence. Was this helpful? What are you likely to remember and incorporate into your practice?

Was anything about the section of the class on cultural competence that was not helpful? Anything you would recommend be changed or presented differently?

Please rate the quality of this section of the class:
o   Poor
o
o
o
o   Excellent

Please rate the usefulness of this section of the class:
o   Not useful at all
o
o
o
o   Extremely useful

Post Session 2 Survey
These questions ask about the section of the class that reviewed *strategies targeting avoidance.*

This section of the class focused on strategies targeting avoidance. Was this helpful? What are you likely to remember and incorporate into your practice?

Was anything about the section of the class on strategies targeting avoidance that was not helpful? Anything you would recommend be changed or presented differently?

Please rate the quality of this section of the class:
o   Poor
o
o
o
o   Excellent

Please rate the usefulness of this section of the class:
o   Not useful at all
o
o
o
o   Extremely useful

Post Session 3 Survey
These questions ask about the section of the class on 5 tips for activity scheduling.

This section of the class focused on five tips to maximize the effectiveness of activity scheduling. Was this helpful? What are you likely to remember and incorporate into your practice?

Was there anything about activity scheduling that was not helpful? Anything you would recommend be changed or presented differently?

Please rate the quality of this section of the class:
o   Poor
o
o
o
o   Excellent

Please rate the usefulness of this section of the class:
o   Not useful at all
o
o
o
o   Extremely useful

Post Session 4 Survey
These questions ask about the section of the class that reviewed *assessment in BA*.

This section of the class focused on *assessment in BA*. Was this helpful? What are you likely to remember and incorporate into your practice?

Was anything about the section of the class on *assessment in BA* that was not helpful? Anything you would recommend be changed or presented differently?

Please rate the quality of this section of the class:
o   Poor
o
o
o
o   Excellent

Please rate the usefulness of this section of the class:
o   Not useful at all
o

o

o

o Extremely useful

Post Session 5 Survey
These questions ask about the section of the class on *presenting the BA rationale.*

This section of the class focused on *presenting the BA rationale.* Was this helpful? What are you likely to remember and incorporate into your practice?

Was anything about the section of the class on *presenting the BA rationale* that was not helpful? Anything you would recommend be changed or presented differently?

Please rate the quality of this section of the class:
o Poor

o

o

o

o Excellent

Please rate the usefulness of this section of the class:
o Not useful at all

o

o

o

o Extremely useful

These questions ask for general feedback about the class.

Can you comment on the format of the class overall, including the online modules, Cultural Competence content, integration of CC into BA, and role-plays? Anything that worked well or did not work well?

Can you comment on the personalized homework (asking you to complete the forms and schedule activities) aspect of the class? What worked well or did not work well?

Can you comment on the length of time of each session (90 minutes), the length of time between classes (1 week) and the total number of sessions (5)?

Do you have any additional advice for how to make this class in this format better, more interactive, and more effective for someone like you?

In general, what do you not like about the BA techniques covered in this class? Are there aspects of this treatment that you will find difficult incorporating into your practice?

In general, what do you not like about the CC techniques (if received during training) covered in this class? Are there aspects of this treatment that you will find difficult incorporating into your practice?

Please summarize what you have learned from this course. What are the topics you found of particular interest? Which are you likely to use in future practice?

Were there any new techniques that you have not had experience with before this training? If so, what were they? Would they be useful in your practice? Why/ why not?

Were there any topics that were introduced in this course that you are surprised you have never heard of before? If so, what are they? Will they be useful in your practice?

Appendix N
Feasibility Questionnaire

Self-paced Materials

What portion of the readings assigned before the beginning of the training did you complete?

- o I did not do any of the reading
- o I skimmed through the reading
- o I did some of the reading (less than half)
- o I read half of the reading
- o I did almost all of the reading (more than half)
- o I read all of the reading

If you did not do the entire reading, list the reason(s) why.

Did you watch the interactive cultural competence self-paced?

If you did not watch the video, list the reason(s) why.

Training Sessions

How many training sessions did you attend?

If you missed a session, list the reason(s) why.

Role Play Assessments

How many role play assessments did you complete?

If you did not complete all 3 assessments, list the reason(s) why.