

A STUDY OF BILINGUAL THERAPIST EXPERIENCES OF LANGUAGE, TRAINING,
AND BURNOUT

by

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(Under the Direction of Edward A. Delgado-Romero)

ABSTRACT

Bilingual (Latino/a and Asian American) therapists (n = 130) completed an online survey assessing language variables, training variables, and experiences of burnout. Burnout was measured by using the Maslach Burnout Inventory (Maslach & Jackson, 1981) which breaks burnout into the progressive elements of emotional exhaustion, depersonalization, and reduced personal accomplishment. Results indicated that no significant correlation existed between therapist age, sex, specialized training, second language fluency, or therapist comfort working with culturally and linguistically diverse clients and burnout. A predictive discriminant analysis revealed that age and sex, taken together as a collective construct, predicted membership in the high/medium emotional exhaustion group. Implications for future research addressing language, training, and burnout experiences are discussed.

INDEX WORDS: Bilingual Therapists, Maslach Burnout Inventory, Burnout, Language, Training, Emotional Exhaustion

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DEDICATION

Finishing this dissertation represents finishing a huge milestone on the journey to obtaining my degree. This dissertation is dedicated to all of those people in my life who have believed in me along this journey: my parents Debbie and Jeff Shumaker and Floyd Clouse; my advisors at Arizona State, Drs. Patricia Arredondo and Judith Homer; my advisor at the University of Georgia, Dr. Edward Delgado-Romero; my main support person in the doctoral program, Jessica Parrillo; and my ever-patient, always-encouraging, and forever-loving husband, Joshua Nasrallah. You have all led me to where I am today, and I am grateful for your support.

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Chapter 1

Introduction

Statement of the problem.

The field of psychology has recognized (e.g., APA, 1993; 2003) that practitioners should be culturally competent and incorporate multicultural awareness, knowledge, and skill into treatment of culturally diverse clients. A major part of providing multiculturally competent services is the availability of mental health professionals who competently speak the language of the client (Alegría et al., 2007; Ramos-Sánchez, Atkinson, & Fraga, 1999). With the growth in the number of people living in the United States who speak a language other than English, it is especially important for mental health professionals to be adequately trained to competently serve linguistically diverse clients. With the increase in demand for services provided to linguistically and culturally diverse populations, bilingual mental health professionals may experience professional issues such as lowered job satisfaction, turnover and burnout. High rates of burnout could negatively impact both therapist and client and ultimately severely compromise the delivery of multiculturally competent services.

According to a 2007 estimate from the US Census Bureau, of the major ethnic groups who speak a language other than English, about 15% of the population of the US is Hispanic or Latino and about 4% are of Asian American/Pacific Islander heritage. The Hispanic/Latino/a¹ population is one that is growing at an accelerated pace, in fact the Latino population is expected

¹ The pan-ethnic terms Hispanic and Latino/a, although often used interchangeably, are not equivalent. In this paper the term Latino/a will be used as it is more politically progressive and inclusive.

to reach 24.4% by the year 2050. The Asian population is also growing rapidly, but not at the same pace or in the same numbers as Latinos. The Asian American/Pacific Islander population is expected to reach about 11% by the year 2050. Language is an important variable in working Latino/a and Asian American/ Pacific Islander clients². At the time of the last census in 2000, 3.6% of the population identified as Asian, and 12.5% as Hispanic or Latino. Eleven percent of the population are foreign born and of those 26.4% were born in Asia, 2.8% in Africa, and 51.7% in Latin America. About 18% of the US population identified that they speak a language other than English at home. About 8% out of all those who identified speaking a language other than English at home, identified speaking English less than “very well.” About 11% identified speaking Spanish at home and of those 5% said they speak English less than “very well.” Four percent speak other Indo-European languages at home and 1.3% of those identify speaking English less than “very well.” Finally, 2.7% of the population said they speak Asian and Pacific Island languages and of those 1.4% speak English less than “very well.” (US Census Bureau, 2000). In addition, some individuals may speak English fluently, but have a preference for speaking a language other than English

While African-Americans make up a large percent of the population, they are purposely excluded here in order to focus on those groups who are most likely to require mental health services in a language other than English. The two largest groups in the US that might require bilingual mental health service providers are Latinos/as and Asian American/Pacific Islanders. In order to competently serve the linguistically diverse, psychologists must be fluent in languages other than English and must be aware of cultural dynamics in therapy.

² Not all Latino/as speak Spanish (variations and slang) and some speak indigenous or creole languages. For the purposes of this paper – we restrict the conversation to the issue of Spanish in therapy.

Of particular concern to this study is the potential for exploitation of those therapists who are able to provide services in a language other than English. Bilingual therapists may feel “pigeon-holed” into only working with a large caseload of bilingual clients, many of whom may also have limited economic resources. Additionally, often very little or no compensation exists for bilingual therapists even though possessing multiple language abilities is clearly a valuable talent. Bilingual therapists may feel in a double-bind in that they are often the only provider for a vulnerable population and at the same time they may feel overwhelmed and over-extended (Rivas et al., 2004). Thus the potential for professional burnout, and a subsequent worsening of the problem of a lack of qualified bilingual therapists, may intensify.

Purpose of the study.

Burnout is defined as a psychological syndrome in response to chronic stress and being emotionally drained. Burnout is comprised of emotional exhaustion, depersonalization, and reduced personal accomplishment and occurs with people who work with other people including mental health professionals. Possible consequences of burnout include higher job turnover, low morale, physical exhaustion, and marriage and family problems (Maslach, Jackson, & Leiter, 1996). Burnout is a syndrome that leaves the victim emotionally depleted, which in turn leads to the victim treating the people they work with as impersonal objects, and finally burnout leaves the victim with a sense of diminished personal accomplishment. Although turnover is a problem, equally if not more problematic is the mental health provider who provides services while being burned out (McCarthy & Frieze, 1999). After a review of the literature, no studies were found to have addressed the relationship between burnout and bilingual mental health professionals. There exists a scarcity of literature assessing whether higher rates of burnout might exist among bilingual mental health professionals. Increases in the number of people who speak a language

other than English in the home, and thus the likely increase in the number of linguistically diverse clients seeking mental health services, as mentioned above, indicate that more research is needed to investigate the link between burnout and bilingual therapists.

Several theoretical assumptions served to guide the course of this study. First, mental health professionals must be healthy psychologically in order to serve their clients in an ethical and competent way. When therapists are overworked, for example working too many hours, receiving no support, and serving especially difficult clients, they can feel burnt out. Burnout, as experienced by therapists, has negative psychological and physical consequences. The second theoretical assumption is that certain therapist variables make a person more vulnerable to experiencing burnout and its effects. The literature supports this assumption and will be discussed in later sections. The third theoretical assumption is that awareness, prevention, and interventions, targeting vulnerable therapists can reduce burnout and lead to healthier therapists who are best able to serve their clients. The fourth and final theoretical assumption is that awareness and prevention of burnout among bilingual therapists is professional responsibility and a key component of multicultural competence. These theoretical assumptions will appear throughout this research and serve to guide hypothesis, discussion, and implications.

Since providing therapy in a language other than English requires specialized knowledge regarding vocabulary, culture, and values, and the linguistic diversity of the population in the United States is increasing, researchers studied the relationship between language, professional training, and burnout of bilingual mental health professionals.

Research Questions.

This study asked the following questions: (a) do mental health professionals who provide services in a language other than English have higher rates of emotional exhaustion and

depersonalization and lower rates of personal accomplishment on the Maslach Burnout Inventory (Maslach & Jackson, 1981)?; (b) do bilingual therapists feel like their training has prepared them to work competently with linguistically diverse clients?; (c) what other variables related to the bilingual therapist may be related to burnout?

Research Hypothesis.

This study hypothesized that: (a) the younger the mental health professional, the higher the aspects of burnout will be; (b) the less specialized training in working with linguistically diverse populations, the higher the burnout; (c) females will have higher rates of burnout compared to males; (d) lower rates of second language fluency will result in higher rates of burnout; and (e) lower rates of therapist comfort in working with linguistically diverse individuals will result in higher rates of burnout.

Chapter 2

Review of the Literature

Language Characteristics.

Bilingual is defined as “using or able to use two languages especially with equal fluency” (Merriam-Webster, 2008). One’s primary language, sometimes referred to as L1, is the language they learned to speak at home, the first language spoken by a person, the dominant language, and the language in which the individual is usually most proficient. The secondary language (L2) is the language learned after the primary language, the non-dominant language, and the language in which the individual is usually least proficient. While most agree on the concepts of primary and secondary language, trying to further define and assess the concept of bilingualism is difficult because of its complexity. Some believe that to be bilingual, an individual must be fluent in both languages. Others believe that any use of a second language constitutes bilingualism (Silva, 2000). Some people may be more or less proficient in specific domains related to their primary and secondary languages. For example, a person can be fluent in reading in their second language, but not fluent in writing. Also, a person can be non-fluent in areas in their primary language, and fluent in their second language (Santiago-Rivera & Altarriba, 2002).

Linguistically speaking, researchers have defined two types of bilinguals. The compound bilingual has one meaning system that can be evaluated in two different languages. The compound bilingual generally grows up learning the two languages simultaneously and encodes words and experiences in both of the languages. Therefore, memories of the words and experiences for the compound bilingual can be expressed in either language. The coordinate

bilingual, on the other hand, has two separate language systems with their own meanings, experiences, and words. The coordinate bilingual usually learns the second language after having learned the first language. Researchers also recognize that there is likely a certain degree of interdependence between the two language systems (Silva, 2000).

In the context of bilingualism, it is often difficult to assess language ability. Standardized tests may not assess implicit knowledge that a speaker possesses and can be culturally biased. On the other hand, a language history questionnaire asks the speaker to rate herself or himself on the ability to read, write, speak in a second language. Altarriba (2002) suggests a language proficiency assessment for bilingual clients. The assessment asks the client questions about length of time living in the United States, language spoken at home with family and language spoken as a child, age when the client learned to speak and read each language, and ratings of comprehension and conversational skills (Santiago-Rivera & Altarriba, 1992).

Phonology, orthography, syntax, word order guidelines, semantics, and pragmatics are all aspects of language that are stored as a mental representation. For a bilingual person, the above aspects of language are stored for each language and the goal becomes to use of aspects of each language independently. Additionally, word storage capacity for one's primary and secondary language may differ. With time, the second language lexically connects with words in the first language. As the person becomes more proficient, more direct links are made between the primary language and secondary language until eventually the person is able to directly access concepts in memory from the second language (Santiago-Rivera & Altarriba, 2002).

Therapy Guidelines Related to Language.

Psychologists will increasingly work with bilingual clients in therapy given the increase in population of those who are linguistically diverse. There are specific needs and considerations

when working with bilingual clients and attempting to implement culturally sensitive treatment and interventions. One important way to begin to integrate cultural sensitivity and competence is by incorporating culture and language into therapy (Barona & Santos de Barona, 2003). Failure to take into account considerations of bilingual clients likely has negative consequences for clients. Ramos-Sánchez, Atkinson, & Fraga (1999) contend that the lack of availability of bilingual therapists may be related to the underutilization of services for linguistic minorities living in the US. Lack of a bilingual therapist can serve as a cultural barrier and institutional barrier for the linguistically diverse. Additionally, Alegria et al., (2007) reported in a study examining data from a national household survey of Latino use of mental health services that the lack of availability of bilingual therapists serves as a barrier to accurate diagnosis and treatments. They say that those with limited English proficiency are less likely to seek and therefore receive mental health services. They also contend that for Latinos who do not meet diagnostic criteria for a psychiatric disorder or those who may need preventative services, “ethnicity, nativity, language, and immigration characteristics are substantially related to whether or not they receive care” (p. 81). Puerto Ricans and US-born Latinos reported higher rates of mental health services use. Language barriers, which may be related to insurance barriers, play a significant role in rates of mental health service use among Latinos (Alegria et al., 2007).

Additionally, language is considered a barrier in treatment for many speakers of languages other than English because it is often central to understanding the client’s worldview including symptom attribution, sources of treatment, and influences on the decision to seek treatment (Santiago-Rivera, 1995; Fuertes, 2004). Clients who attempt to speak in a language other than their primary language may be more concerned with pronunciation and grammar than with communicating therapeutically significant material (Santiago-Rivera, 1995). Taboo words

presented in the primary language may elicit more anxiety than in the second language and it may be easier to discuss embarrassing topics in second language. Words conveying emotions that are used in the first language are stored at a deeper level, have been experienced in more contexts, and have been applied in more ways. A client could experience detachment from an experience by describing it in a language other than the one in which it occurred (Bowker & Richards, 2004; Santiago-Rivera & Altarriba, 2002). “Certain experiences are intimately connected to the first language learned and cannot be ‘recoded’ in another language, no matter how proficient and cognitively integrated a second language is in the bilingual individual” (Santiago-Rivera & Altarriba, 2002, p. 34). Also, since some words do not directly translate, bilingual individuals may not be able to fully express themselves in therapy that is conducted in the second language. Clinical terminology, or technical therapy words, may also not have direct translations, which could leave gaps in expression of clinical conceptualization.

In a study specifically examining language switching for the Mexican American bilingual client, Ramos-Sánchez (2007) examined emotional expression of the Spanish-English bilingual client with bilingual European American and Mexican American therapist. This study is based on the assumption that the dominant language is obviously integrally linked with emotion, but the secondary language plays an important role too, especially depending on the context in which the event or problem occurred. This researcher found that language switching, as exhibited by the European American bilingual therapist resulted in more emotional expression on the part of the bilingual client. She speculated that this may have been due to the language switching on the part of the European American therapist being unexpected by the client thus resulting in a perception of the therapist trying to be more caring, respectful, and empathetic. Language switching may have been more expected in the case of the Mexican American therapist. Ramos-

Sánchez (2007) posits that “language switching is an effective, culturally relevant practice that can be used by European American counselors to enhance the therapeutic relationship and deepen the counseling process with Latino clients” (pg. 164).

Additionally, researchers who studied therapists’ experiences of working in English with proficient bilingual clients found the following:

Some therapists implied that the distance between them and the clients would have felt greater if clients had spoken a first language that was very unfamiliar to the therapist.

Therapists felt less confident about being able to empathize with the client when the language or culture of origin was less familiar. Most therapists felt less anxious, indeed relieved if they had some knowledge of the client’s language and culture (Bowker & Richards, 2004, p. 470).

They added that for clients who were speaking in therapy in their second language, an ‘extra layer,’ including checking on comprehension and understanding, was added through which the client had to struggle to express himself or herself. Researchers concluded that the importance of bilingual practice issues should be emphasized separate from cultural awareness ((Bowker & Richards, 2004).

In addition to technical language issues, the interaction of language and culture in therapy needs to be considered with bilingual clients. For Spanish-speaking clients, considerations include use of *cuento*, or folktale, therapy; allowing or encouraging language switching by the client; taking into account the acculturation level of the client, thinking about how language switching is affected by acculturation levels; and use of metaphors or *dichos* (Santiago-Rivera, 1995). Therapists should ideally further consider culture as it relates to the environmental and

sociopolitical contexts in which the client lives. These contexts often include ideas and practices of discrimination and may increase stress in the bilingual client (Fuentes, 2004).

A psychologist should incorporate language and culture into therapy to the fullest extent possible, including assessing fluency in both languages. The consequence for not doing so could be misdiagnosis or causing harm to clients. Misdiagnosis may result for Spanish-dominant clients, for example, when speaking in their secondary language as they may show more motor activity due to the pressure to express themselves in the less familiar language, experience long pauses and speech disturbances such as mispronunciations and stuttering due to uncomfortableness/unfamiliarity with the second language, use words in the second language that have less meaning and emotion associated with them, and experience a different “sense of self” in the first language (Santiago-Rivera & Altarriba, 2002). It should be noted that some authors contend that rather than being seen as a barrier or limitation in conducting therapy, bilingualism should ideally be seen as a strength and a valuable resource to tap in to life experiences (Santiago-Rivera & Altarriba, 2002).

Language is also tied closely to superordinate value orientations in Latino culture. For example, *personalismo* reflects a value orientation where the person, or client, is valued more than any undertaking or duty at hand, including not adhering to time constraints, in order to develop a warm and genuine relationship with the therapist. *Respeto* entails the therapist respecting the client’s level or status as demonstrated through proper use of formal language. *Dignidad* incorporates *personalismo* and *respeto* that results in expression of the belief that any person is worthy of dignity and respect. Many Latinos may want to be perceived as *simpatico*, which means that they are perceived as friendly and easy going. This can relate to their preference to avoid confrontation in communication. The term *confianza* includes the

characteristics of trust, intimacy, and familiarity in a relationship and *cariño* represents the presence of charm or charming language in communication (Santiago-Rivera, Arredondo, Gallardo-Cooper, 2002). These concepts represent important value orientations for many Latino clients and should be taken into account when working with them in therapy. Spanish language therapy training then ideally consists of more than simply speaking the language.

Alegria et al., (2007) summarize a potential cultural conflict between many Latinos values and traditional psychotherapy values. Traditional psychotherapy values individualistic goals before the goals of the collective. Those with collectivistic orientations, including many Latinos, may be reluctant to share family information for fear of bringing shame to the family. A culturally competent therapist must understand this potential value conflict. Alegria et al., (2007) share that early orientation about mental health will help empower Latino clients to communicate expectations and encourage a better understanding between client and therapist of the process at hand.

The Asian American/Pacific Islander population includes a large group of individuals who may be bilingual and thus seek therapy services in the US in a language other than English. Large within group differences exist for the Asian American/Pacific Islander population since there are at least 40 subgroups of Asian Americans/Pacific Islanders. There are also a variety of languages spoken by people who identify as Asian American or Pacific Islander. Hundreds of Asian/Pacific Islander languages exist with several existing in the same country extending from part of Russia to Mongolia, China, India, Japan, North and South Korea, Taiwan, Philippines, Thailand, Laos, and Vietnam, to name a few. However, many Asian American/Pacific Islanders hold similar cultural values and patterns of behavior (Sue & Sue, 2003). In order to provide culturally competent services to this linguistically diverse group, therapists need to be aware of

Asian American and Pacific Islander values and behavior patterns and how those may be related to language use and behaviors in therapy.

Most Asian American/Pacific Islander cultures have a collectivistic orientation value. A collectivist orientation assumes that the needs of the group or family come before those of the individual. It is possible that many words, conceptualizations, and meanings do not have translations in English. Therefore, an Asian American/Pacific Islander client may not be able to fully express her or himself if during therapy she or he is speaking only English. Additionally, in many Asian American or Pacific Islander cultures, emotionality is considered a demonstration of lack of control and is seen as undesirable. Displays of emotions are usually lacking. As mentioned earlier, for bilinguals, experiences that were encoded in the first language of the individual are more powerful when described and discussed in the first language. Given the lack of expression of emotionality for many Asian American/Pacific Islanders, it is likely that discussing emotional laden material in the second language would further distance this group from the potentially powerful impact of it (Sue & Sue, 2003).

Professional Guidelines Related to Language.

Recognizing the unique needs of culturally and linguistically diverse populations the American Psychological Association (APA) has issues several guidelines for working with these populations. The Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (APA, 1993) state that psychologists should use the language requested by the client, and if the psychologist is not able to communicate in this language, then he/she will refer the client to a competent psychologist who can. The guidelines further state that when problems arise because the linguistic skills of the client does not match those of the therapist, the therapists should again refer the client to a competent therapist whose language

skills do match those of the client. This situation may be exacerbated if the therapists speaks and/or comprehends very little of the clients primary language, and the client communicates largely in that language. If a trained, culturally competent psychologist who speaks the client's language is not available, then a translator with cultural awareness and a professional background should be offered. Translators who have a dual role with the client should not be used (e.g., family members). Furthermore, psychologists should understand the client's cultural and ethnic background and seek out relevant cultural experiences and material to enhance understanding (APA, 1993). Several additional potential problems may arise when using translators. Perez-Stable and Napoles-Springer (2000) contend, "clinical encounters that depend on an interpreter may not achieve the same amount or quality of communication when compared with language-concordant encounters" (p. 509).

The Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (APA, 2003) were designed with the goal of providing psychologists the rationale for why multiculturalism and diversity should be addressed, providing psychologists with the information and research supporting the rationale, providing psychologists with references to further develop their multiculturalism and diversity, and to provide a framework that broadens the scope of the field. Guideline 5 indirectly addresses the therapist's responsibility to "apply culturally appropriate skills in clinical and other applied psychological practices" (p. 390). This guideline states that therapists should apply their awareness and knowledge regarding the client's worldview in psychological practice. Therapists should be aware of effective strategies specific to a client's particular culture which includes communicating in the client's preferred language, which may be a language other than English. Implementing Guideline 5 may also include providing consent forms, assessments, or other

written tools in the language preferred by the client. Additionally, psychologists should follow ethical guidelines regarding the use of translators and should not use translators who are family members of the client, community authorities, or unskilled or unfamiliar with the mental health setting (APA, 2003).

Professional Training in Languages Other Than English.

In a review conducted for this study, the author found that of more than 300 graduate program profiles in clinical and counseling psychology, approximately 57 offer specialty clinics and practica sites with an emphasis on minority/cross-cultural/multicultural. Approximately twenty-five sites offer program concentration and tracks in multicultural/cross-cultural/diversity. Of the programs who emphasize multicultural practica or concentrations, very few specifically target training in working with speakers of languages other than English. Of the few programs that target clinical work with linguistically diverse clientele, most focus on Spanish speaking and Latino populations. For example, Texas A & M University's Ph.D. program in Counseling Psychology offers a formal track/concentration in Mexican American mental health, Seattle Pacific University's Ph.D. program offers clinical opportunities with Latino/a mental health, Pacific University's Psy.D. program offers a formal track/concentration in Latina/bilingual, Argosy University, San Francisco program offers a Psy.D. with clinical opportunities to work with Spanish dialect/cultural diversity, and California Institute of Integral Studies' Psy.D. program offers clinical opportunities in working with Spanish speaking clients (Norcross, Sayette, & Mayne, 2008). There are a limited number of formal training programs in the US that specialize in incorporating language and culture when working with Latino clients. The Psychological Services for Spanish Speaking Populations (PSSSP) program at Our Lady of the Lake University (OLLU) in San Antonio, Texas is one culturally and linguistically relevant

training program. This APA accredited program was implemented by OLLU in 1997 and is designed to assist bilingual mental health providers become equally competent in providing services in English and Spanish. The program includes courses in professional and technical Spanish, language and psychological variables in interviews and assessments with Latinos, seminar in Spanish language professional communication skills, sociocultural foundations of counseling Mexicans and Mexican Americans, normal family processes across cultures, theories of multicultural counseling, and Latino psychology (Biever et al., 2002).

The M.A. in Educational Psychology Bilingual Clinical Program at Montclair State University in Montclair, New Jersey is another culturally and linguistically relevant training program. This program is designed for Spanish-English bilingual psychologists and prepares them to work in mental health settings where there are a large number of Spanish-speaking clients. The specialization to work with bilingual clients includes courses on Mental Health Issues of Hispanics, Individual Intelligence Testing, Projective Techniques I, Clinical Interviewing, Abnormal Psychology, Introduction to Psychotherapy, and Externship in Clinical Psychology (Montclair State University, 2006). In a study designed to evaluate the Bilingual Clinical Program at Montclair State University, Fuentes, Adamés, and Ilia (2006) found that among 15 current students and graduates of the program, all agreed or strongly agreed that they had the ability to secure information and resources to better serve Latino clients. Eighty percent agreed or strongly agreed that they were able to identify the strengths and weaknesses of psychological tests when using them with Latinos (Fuentes et. al., 2006). It should be noted that this program is currently not accepting applications (Montclair State University, 2006).

Alliant International University in California offers a California School of Professional Psychology Language and Cultural Immersion Program in Mexico City. This program takes

place in the summer and lasts for five weeks. The program features lectures on Latin American topics, visits to local clinics and with mental health workers, coursework on Latin American psychologies and philosophies, engagement with indigenous healers, experiential learning activities, and Spanish classes tailored for mental health workers. Alliant International University also offers a Master of Arts degree in Counseling Psychology with Emphasis on Families and Communities at its Mexico City campus (Alliant International University, 2008).

The University of Miami offers a Bilingual and Bicultural Counseling Certificate through their Counseling and Research M.S.Ed. program. The certificate program provides training in issues related to working with Spanish speaking and immigrant clients and in using Spanish in professional work. Students receive supervision with a bilingual supervisor (University of Miami, 2009).

According to the Association of Psychology Postdoctoral and Internship Centers (2008), of the 657 internship sites total in the United States and Canada, there are 387 internship sites with Spanish speaking populations as a minor rotation, and 70 with Spanish speaking populations as a major rotation. Two hundred and two offer multicultural therapy as a major component. There are 51 postdoctoral programs of 114 total that offer work with Spanish speaking populations as a feature of their program (APPIC, 2008).

There are several training programs that offer training in working with Asian American and Pacific Islanders. The Richmond Area Multi-Services Inc. (RAMS) is a mental health agency that emphasizes services for Asian and Pacific Islander Americans. RAMS houses the National Asian-American Psychology Training Center (NAAPT) and offers two formal training opportunities including an APA Accredited Pre-Doctoral Internship, and an externship program for Master's level clinicians. The internship focuses on cultural competency in regard to Asian

American, Pacific Islander, and Russian speaking minorities. The clinical practicum for graduate psychology students and Master's level interns in the fields of social work and marriage and family therapy focuses on Asian, Pacific Islander, and Russian speaking ethnicities through didactic and experiential training. The program is located in San Francisco, California (Richmond Area Multi-Services Inc., 2009).

An additional program that offers specialized training for those wanting to serve Asian Americans and Pacific Islanders is the Cambridge Health Alliance Clinical Psychology Training Program in the Boston, Massachusetts area. Cambridge Health Alliance offers half-time traineeships as post-practicum training for advanced graduate students, a post-doctoral program in clinical psychology, and an APA accredited Pre-Doctoral Internship in Clinical Psychology. The program offers rotations at a Latino Mental Health Clinic where trainees provide outpatient services to Spanish-speaking people and where Spanish proficiency is required. Another rotation is at the Asian Mental Health Clinic which provides multilingual outpatient psychological and psychiatric services to Asian individuals and families. Proficiency in an Asian language is required (Cambridge Health Alliance Clinical Psychology Training, 2009).

One other program that offers training for those wanting to serve Asian/Pacific Islander clients is the University of Colorado Health Sciences Center Psychology Training Program. They house the Asian/Pacific Center for Human Development which is a community mental health clinic in the Denver area. The center provides services in 10 Asian languages and dialects (University of Colorado Health Sciences Center Psychology Training Program, 2009).

A bilingual therapist is either “born” (that is, a native speaker) or “made” (that is, someone who acquires the second language). The majority of psychology training programs in the United States train students in English with access to English speaking populations. There is

limited research on the experiences and training needs of bilingual providers. Of the few studies available Biever and colleagues (2004) found that for therapists who speak Spanish the majority learned it in the home and received limited formal language training. They found that most therapists were concerned over their vocabulary and applying psychological concepts in Spanish. Therapists said courses in bilingual assessment, culture, and methods or techniques for bilingual therapy would be helpful. Upon examining narratives of bilingual therapists, the researchers found that being bilingual and bicultural has benefits and challenges. Benefits included feelings of pride in delivering services in Spanish, possessing a better understanding of the worldview of the clients, and enjoying an added tool to help facilitate the therapeutic process. Challenges included therapists feeling like they lived in two worlds, struggling with lack of training, feelings of isolation, and difficulties with the differences in Spanish spoken by the clients (Biever et al., 2004).

Biever and colleagues (2004), found through examining bilingual therapists reflections on their use of language that conducting therapy in two languages is more demanding, can reduce therapists feeling of confidence in ability to provide best therapy, and can be exhausting. Additionally, bilingual therapists reflected that some concepts simply do not translate, technical or psychological language requires a different level of competency, and there are different rhythms in conducting therapy in one language versus another. However, bilingual therapists reported that they felt a deep regard for clients of similar background and a bond was created between the therapist and client resulting in the therapist wanting to be a supportive role model (Beiver et al., 2004).

Rivas, Delgado-Romero, and Ozambela (2004) noticed the emergence of professional challenges of bilingual counseling on bilingual therapists as a theme, upon reflections of their

experiences as Latino therapists. In their personal narratives they identified the following professional challenges: inadequate training, lack of resources, lack of accreditation criteria, agency policies, and exploitation. The authors recommended that the profession address the training needs and professional development of bilingual therapists, increase the availability of bilingual role models and mentors, and ensure competency in meeting the psychological needs of clients (Rivas et al., 2004).

Burnout.

People experience stress as a part of life. Some stress is even considered to be healthy and essential for growth and development. However, stress is often related to cultural factors such as gender, socioeconomic class, and race/ethnicity. Racial/ethnic minorities in the US can experience increased levels of stress due to several factors. First, increased stress may be related to racial/ethnic background based on the daily experiences of being a member of the “minority group” and having to operate and navigate in a system that privileges those of the dominant White culture, being seen as a token minority who represents all of his or her race, and often being the only one of her or his race/ethnicity in any given situation. Second, racial/ethnic minorities may experience increased stress due to the discrimination and prejudice that they experience as people of color. Third, a disproportionate amount of racial/ethnic minorities live in poverty. Finally, some specific culture customs or traditions, such as arranged marriage, may result in increased levels of stress for racial/ethnic minority individuals (Lewis, Lewis, Daniels, & D’Andrea, 2003).

Ongoing, unreleased stress can build up and result in physical and psychological exhaustion. Other physical effects of chronic stress include: respiratory problems, backaches, high blood pressure, low energy levels, and cardiovascular disease. Effects of chronic stress on

psychological health include increased rates of depression and anxiety. It is evident from the research on stress that effective management of excess stress can keep people healthy, promote personal well-being, and prevent psychological and physical disorders (Lewis, Lewis, Daniels, & D'Andrea, 2003).

Burnout is defined as a psychological syndrome in response to chronic stress and being emotionally drained. It is a process rather than isolated symptoms, and is often experienced on a continuum that varies at different points in the lives of those it effects (Rosenberg & Pace, 2006). The most frequently used measure of burnout is the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1981). Burnout is comprised of emotional exhaustion, depersonalization, and reduced personal accomplishment and occurs with people who work with other people including mental health professionals. People who have a high level of burnout experience increased levels of emotional exhaustion which presents as depleted emotional resources, and the individual feeling like she or he cannot psychologically give any more of herself/himself. People with high levels of burnout also develop depersonalization which is characterized by dehumanized perception of others and negative feelings about one's clients. Reduced personal accomplishment occurs when people begin to evaluate themselves negatively, feel unhappy about themselves, and feel dissatisfied with job accomplishments (Maslach, Jackson, & Leiter, 1981). Burnout is related to higher rates of job turnover, missing more days of work, and low morale. It is also related to physical exhaustion, increased alcohol and drug use, and marriage and family problems (Maslach, Jackson, & Leiter, 1996).

After a review of the literature, no studies were found to have addressed the relationship between burnout and bilingual mental health professionals, or more specifically bilingual mental health professionals. However a PsychINFO (2008) search yielded a considerable number of

studies exist examining the relationship between burnout for a variety of professionals including: Jordanian and Emirati teachers, Florida nurses, small business owners, managers, leaders and followers, non-human services workers, teacher trainees and first year teachers, gifted and talented students, British nursing staff, Dutch dentists, pharmacists, middle school teachers, healthcare professionals, Greek teachers, Finnish nursing staff, teachers in Cyprus, hospice staff, parents, university students, occupational groups in Norway, Swedish human service providers, Chinese human service professionals, and New Zealand teachers. A few studies have addressed burnout as it relates to therapists and/or the cultural identity of individuals. Specifically, studies have addressed burnout as it relates to faculty and administrators of color, marriage and family therapists, counseling psychologists, psychotherapists, female human service professionals, and Borderline Personality disordered clients and their therapists. These studies will be reviewed with more detail in the following paragraphs.

One study by Howard-Hamilton and Delgado-Romero (2002) investigated burnout among faculty and administrators of color at a predominantly White large public university. They found that women experienced higher level of emotional exhaustion compared to men, emotional exhaustion was negatively related to teaching, and that salary was related to emotional exhaustion and depersonalization. They also found that Hispanic/Latina women and African American men reported the highest levels of depersonalization. Hispanic/Latino males reported the highest levels of personal accomplishment while Hispanic/Latina females reported the lowest levels of personal achievement. The researchers also included several recommendations to prevent burnout (Howard-Hamilton & Delgado-Romero, 2002).

In studying burnout as it relates to marriage and family therapists, Rosenberg and Pace (2006) found that levels of depersonalization and emotional exhaustion decrease as clinicians get

older. They posit that this may be because emotional maturity develops with life experience and may serve to shield symptoms of burnout. Also, more experienced therapists have had time to develop effective support systems and coping strategies. They may also find a sense of accomplishment through other roles and identities outside of work so that their sense of personal accomplishment does not depend entirely on performance and achievement in the professional arena. They also found that Master's level clinicians experienced higher rates of personal accomplishment compared to clinician with a doctoral degree. They suggest this may be due the increased freedom of Master's level clinicians to define personal accomplishment compared to doctoral level clinicians who may have more external standards and measures of their merit and ability. Rosenberg and Pace (2006) also found that clinicians who worked in private practice had lower indicators of overall burnout. They suggest this may be due to the "ability of a private practitioner to independently regulate caseload, fees, paperwork, and a general sense of autonomy may buffer the impact of job-related stress associated with symptoms of burnout" (Rosenberg & Pace, 2006, pg. 96). The authors conclude that more racially and ethnically diverse samples should be used in future studies to investigate the extent to which race/ethnicity is correlated with burnout (Rosenberg & Pace, 2006).

Vredenburg, Carlozzi, and Stein (1999), in conducting a study of burnout among counseling psychologists, found that psychologists in private practice reported lower levels of burnout. They also found that a positive relationship existed between client load and personal accomplishment and that no significant relationship existed between client load and emotional exhaustion and depersonalization. Finally, researchers found that males had higher levels of depersonalization than females. They note that research related to the relationship between

gender and aspects of burnout has been mixed, so the nature of the relationship remains unclear (Vredenburgh, Carlozzi, & Stein, 1999).

In a study of psychotherapist burnout, Raqepaw and Miller (1989) found that burnout was not related to age, sex, education level, race, or treatment orientation. They found that burnout was related to satisfaction with her or his workload and whether or not the therapist felt overburdened. Type of setting in which the therapist worked was significantly related to burnout with those in agency settings, versus private practice, reporting more emotional exhaustion and less personal accomplishment. They contend that other than type of setting, demographic variables had little bearing on levels of burnout and that instead burnout is related to how therapists perceive their work (Raqepaw & Miller, 1989).

In a factor analysis study conducted with 135 female human service providers including nurses, supervisors, counselors/social workers, and administrators, Brookings, Bolton, Brown, and McEvoy (1985) examined several factors related to burnout. They found that personal accomplishment was independent of the other factors of emotional exhaustion and depersonalization. They suggested that feelings of personal accomplishment were based specifically on interactions with others and that feelings of emotional exhaustion and dissatisfaction are related to job setting factors and are external to the work itself. Researchers also found that emotional exhaustion and depersonalization loaded heavily on the same factor suggesting more research is needed to examine the relationship between those two elements of burnout (Brookings, Bolton, Brown, and McEvoy, 1985).

Yildirim (2008) in researching burnout and social support among Turkish school counselors found that as support from principals, colleagues and friends decreased, the three dimensions of burnout increased. Support from spouse was significantly related to personal

accomplishment, and family support was significantly related to emotional exhaustion and personal accomplishment. There were no significant correlations between gender, age, marital status and the three dimensions of burnout. Experience was significantly related to depersonalization and personal accomplishment. Yildirim included several recommendations including educational programs designed to inform principals about burnout, provide intervention programs targeting improving social support, and increasing the number of school counselors to reduce unmanageable workloads.

Linehan, Cochran, Mar, Levensky, and Comtois (2000) researched the reciprocal nature of burnout between Borderline Personality Disorder (BPD) clients and their therapists over the course of therapy. Upon studying 23 dyads, they found that the structure of client burnout is very similar to therapist burnout. They also found that “high expectancy for therapeutic success leaves therapists vulnerable to increased emotional exhaustion at a later point” (Linehan et al., 2000, p. 336). Additionally, they found that therapist burnout when working with a BPD client is significantly influenced by the initial level of burnout experienced by the client when working with previous therapists. They found a correlation between pretreatment burnout of the client and emotional exhaustion and depersonalization of the therapist. Researchers suggest that the clients’ previous therapy experience is much more important than originally deemed (Linehan, et al, 2000).

In an analysis of several studies, Maslach and Leiter (2008) reported that several factors have been shown to be related to burnout. Qualitative and quantitative work overload, lack of personal control, insufficient reward, lack of social interaction at work, lack of fairness and equity at work, and job-person incongruity are all related to higher rates of burnout. They also

report that inconsistent scores on the Maslach Burnout Inventory and job-person incongruence are predictors of later burnout (Maslach & Leiter, 2008).

There exists a scarcity of literature assessing whether higher rates of burnout might exist among bilingual mental health professionals. Increases in the immigrant population, and thus the number of linguistically diverse individuals seeking mental health services, as mentioned above, indicate that more research is needed to investigate the link between burnout and bilingual therapists.

Chapter 3

Methods and Procedures

Methodology.

Based on a review of the available literature a survey was created and distributed to mental health professionals who provide services in English and languages other than English. The survey consisted of 60 questions and was written in English. The questions were a combination of multiple choice responses and Likert scale responses. The first 9 questions asked participants about demographic information such as age, ethnicity, sex, primary language, bicultural self rating, age range of clientele, type of setting, and experience. Questions 10 through 17 asked participants about their language experiences including percentage of services conducted in a language other than English, self rating on language fluency, primary language spoken as a child and as an adult, and comfort with using languages other than English and English in different types of settings. Questions 18 through 22 asked participants questions about mental health training experiences in English and in languages other than English. Questions 23 and 24 asked participants to rate themselves on a scale of 1 to 7 regarding comfort in working with clients in English and languages other than English. Questions 25 and 26 asked participants to rate on a scale of 1 to 7 how much they agreed with the statement “General training on how to provide therapy to diverse populations is sufficient to learn to work with culturally diverse and linguistically diverse clients” and “Specific training is needed on how to provide therapy to clients from specific cultures.”

The remaining questions consisted of the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1981). The MBI was developed in the early 1980's to assess occupational burnout. The inventory was developed initially with 605 health and service workers. After a factor analysis, four factors of burnout were validated with 420 helping professionals. The last factor was later omitted and thus three factors remained within burnout, "a syndrome experienced by workers in human service professions including emotional exhaustion (EE: 9 items), depersonalization (DP: 5 items), and reduced personal accomplishment (PA: 8 items)" (Worley, Vassar, Wheeler, & Barnes, 2008, pg. 2). The items of the instrument consist of statements about personal feelings or attitudes. Respondents are asked to answer in terms of the frequency with which they experience the feelings (Maslach, Jackson, & Leiter, 1981).

Upon creation of the scale, Emotional Exhaustion was viewed as the primary manifestation of burnout. Emotional exhaustion includes feelings of being overextended and exhaustion of physical and emotional resources. Emotional exhaustion reflects the stress that is related to experiences of burnout. However, emotional exhaustion fails to take into account the relationship employees have with work since emotional exhaustion decreases an employee's ability to be engaged while serving the needs of recipients of services or clients. Therefore, depersonalization accounts for detachment experienced by workers towards clients, other recipients of services, or parts of the job itself. Personal accomplishment accounts for feelings of competence related to job performance or productivity (Worley, Vassar, Wheeler, & Barnes, 2008).

The MBI was originally developed to be used with human service providers but a slight change in wording (e.g. recipient to student) has led to its use with teachers. A general survey was also created to be used with those working outside of human service sectors and reflected

broader conceptualizations of the three factors. Reliability has been assessed for all three versions of the MBI. The human service survey is the most appropriate form of the MBI for use with mental health professionals, who provide direct services to clients, and thus was used in this study (Worley, Vassar, Wheeler, & Barnes, 2008). Internal consistency coefficients for the MBI are as follows: EE ($\alpha = .89$), DP ($\alpha = .77$), and PA ($\alpha = .74$) (Maslach, Jackson, Leiter, 1997). Reliability estimates are reported to be: EE ($\alpha = .90$), DP ($\alpha = .79$), and PA ($\alpha = .71$) (Worley, Vassar, Wheeler, & Barnes, 2008).

Data Collection.

The survey assessed demographics, language, training, and burnout was created online using Survey Monkey, a tool used for creating web surveys found at www.surveymonkey.com. Once the survey was created, a link was generated that when accessed allowed participants to complete the survey online. While an IP address was attached to each completed survey, survey responses were kept confidential. The survey was distributed for 3-4 months. One hundred and thirty nine surveys were started online, and 130 surveys were completed.

Participants.

Participants were drawn primarily from regional and national psychological associations and organizations. Those organizations with a potentially large amount of members who identify as bilingual therapists were targeted. Participants were gathered from the National Latina/o Psychological Association, the Asian American Psychological Association, the South Asian Psychological Network Association, and the Filipino American Psychology Network, among others, as well as the Council of Counseling Psychology Training Programs. Information about the survey including how to access the link was provided on association listservs or through organization member emails. Participants were directed to the survey web page where they

found the consent form. After the consent was read and agreement indicated, participants were directed to begin the survey. Participants who completed an earlier version of the online questionnaire, distributed as research for a first year project, were not invited to re-take the survey. Responses from the earlier version were included with responses from the updated version in data analysis and discussion. The main difference from the earlier version and the updated version is that the earlier version was given only to mental health professionals who spoke Spanish in addition to English. The language was changed in the updated version to include those who speak any other language in addition to English. A few questions were omitted from the earlier version, and no additional questions were added to the updated version. The Maslach Burnout Inventory questions did not change from the earlier version to the updated version.

Statistical Analysis.

Correlations were primarily examined. Data from the surveys were entered into SPSS 16.0 and correlations were sought. Correlations were examined between the three elements of burnout (Emotional Exhaustion, Depersonalization, and Personal Accomplishment) and other demographic, training, and language variables. Some of the demographic, training, and language variables that were examined include age, sex, primary and secondary language, experience, formal training, and comfort in primary and secondary language.

A predictive discriminant analysis (PDA) was conducted to examine the ability of demographic, training, and language variables to correctly determine or predict group membership (Huberty, 1994). The purpose of a PDA is to determine the ability of the construct (as measured by age and sex of the mental health professional) that underlies the resulting effects

of a grouping variable (low and high/medium emotional exhaustion) to predict group membership.

Chapter 4

Results

Statistical Analysis.

Thirty six percent of the sample was aged 22 to 30, and 40% of the sample was aged 31 to 40. Therefore 76% of the sample was between the ages of 22 and 40, and given that 75% of the sample was female, and that 71% were Latino, the sample was overwhelming young Latina females. Eleven percent of the sample identified as Asian/Pacific Islander, and 9% identified as Caucasian.

Language: In terms of language, 65% said that the language they speak most often is English. Eight percent said they spoke Spanish the most often, 20% identified speaking Spanish and English in equal amounts most often, and 1% spoke Asian languages most often. Twenty eight percent of respondents identified English as their secondary language, 50% identified Spanish as their second language, and 5% identified Asian languages as their second language. Twelve percent identified speaking an Asian language currently in the home. The languages identified as being spoken included Mandarin Chinese, Hmong, the Chinese dialect-Taishanese, Korean, Telugu, Sindhi, Gujarati, Japanese, Taiwanese, and Persian.

Forty two percent reported that English was their home language as a child, 40% identified Spanish, and 4% identified Asian languages as their home language as a child. Sixty five percent of the sample identified English as the language spoken in their home now, 17% reported Spanish, and 4% reported Asian languages as their current home language. Sixty three percent identified feeling most comfortable speaking English in day-to-day activities, 11%

identified Spanish, 10% identified English and Spanish in equal amounts, and 4% identified being most comfortable speaking in day-to-day activities in Asian languages. Sixty percent identified feeling most comfortable providing therapy or psychological services in English, 9% identified Spanish, 11% identified English and Spanish in equal amounts, and 4% identified being most comfortable providing therapy or psychological services in Asian languages.

Work characteristics: Twenty nine percent of the sample identified being employed in a community mental health agency, 11% in a college or university counseling center, 5% in private practice, 3% in a primary or secondary school setting, 14% in academia, and 31% in some combination of the above or another unlisted setting. Thirty five percent of the respondents identified practicing as a professional in the psychology field for 0-2 years, 35% for 3-7 years, 7% for 8-10 years, and 19% for more than 10 years. Thus 77% of the sample had practices for less than 10 years which fits APA's definition of early career professionals. Thirty four percent of participants reported that the percentage of the total psychology related services provided per week conducted in a language other than English was 0-25 percent, 26% of the sample reported 25-25 percent, 24% of the sample reported 50-75 percent, and 14% reported 75-100 percent of their services are provided in a language other than English. Related to changes in services provided in a language other than English, 35% of the sample reported a less than 25% increase, 33% reported a 25% increase, 8% reported a 25-50% increase, 10% reported a 50-75% increase, and 4% reported a 75-100% increase in services provided in a language other than English.

Thirty eight percent of respondents identified having a Master's degree in a psychology or mental health field, 41% reported having a Doctoral degree in a psychology or mental health field. Sixty percent reported that their formal training in the mental health field was conducted in their primary language, while 30% reported that they received formal psychology training on

how to provide therapy in a language other than English. Seventy percent of the sample reported that they received training on how to provide therapy to people of different cultures regardless of language. Twenty five percent received this training at a specialized program at college or university, and 16 % through an internship.

Table 1 provides information on the scaled questions of the survey. In general, 1 indicated low levels of the variable being measured, while a 7 indicated the highest level of the variable being measured. Means and standard deviations are provided.

In terms of the Maslach Burnout Inventory the average score for Emotional Exhaustion was approximately 23, the average score for Depersonalization was approximately 4.5 and the average score for Personal Accomplishment was approximately 39. Cutoffs have been determined by Maslach and her colleagues to separate high, moderate and low risk levels for each of the three types of burnout. The three ranges for EE are: Low (0-16), Moderate (17-26), and High (27-54). For DP, the ranges are: Low (0-6), Moderate (7-12), and High (13-30). Using reversed scored norms, the ranges for PA are: Low (0-8), Moderate (9-15), and High (16-48). For this survey, the scores were on the high end of the medium range for emotional exhaustion, the high end of the low range for depersonalization, and in the middle area of the high range for personal accomplishment (meaning low levels of burnout) according to the MBI manual (Maslach, Jackson, & Leiter, 1996). The expected intercorrelations between the MBI scales were found (that is EE was positively correlated to DP and both EE and DP were negatively correlated to PA). For EE and DP $r(115) = .345, p < .01$. For EE and PA $r(112) = -.169, p > .05$. For DP and PA $r(109) = -.232, p < .05$. The internal consistency of the MBI was high for the subscales of emotional exhaustion and personal achievement with a Chronbach's Alpha of .90 and .79 respectively. The subscale of depersonalization had a Chronbach's Alpha of .60.

Findings of the data related to the research hypotheses are as follows:

Hypothesis 1: younger age will be related to higher levels of burnout. Regarding this hypothesis, the data indicated that there was no significant correlation between a participant's age and levels of burnout $r(118) = -.122, p > .05$.

Hypothesis 2: less specialized training in working with linguistically diverse populations will be related to higher levels of burnout. The data indicated that there was no significant correlation $r(117) = .036, p > .05$. However, a significant correlation existed between formal psychology training on how to provide therapy in a language other than English and lower levels of depersonalization $r(114) = -.250, p < .01$.

Hypothesis 3: Gender will be related to higher levels of burnout such that females will evidence higher levels of burnout than males. The data indicated that there was no significant correlation between a participant's gender and levels of burnout.

Hypothesis 4: lower rates of second language fluency will result in higher rates of burnout. The data indicated that there was no significant correlation between English fluency or Spanish fluency and the three elements of burnout. For EE and English fluency $r(118) = .012, p > .05$. For EE and Spanish fluency $r(119) = .052, p > .05$.

Hypothesis 5: lower rates of therapist comfort in working with linguistically diverse individuals will result in higher rates of burnout. The data indicated that a significant correlation did not exist $r(116) = .003, p > .05$. However, data indicated a correlation existed between participants bicultural self-rating and lower levels of depersonalization $r(115) = -.236, p < .05$.

A Collective Construct of Predictors of Emotional Exhaustion.

In order to describe grouping variable effects, a predictive discriminant analysis (PDA) was conducted (Huberty, 1994). The purpose of conducting a PDA is to determine the ability of

the construct (as measured by Emotional Exhaustion) that underlies the resultant effects of a grouping variable (age and sex) to predict group membership. PDA was utilized to answer the following research question: Does age and sex collectively predict membership in the low or high/medium emotional exhaustion groups?

The analysis examined the relationship between the variables (age and sex) and the probability of having high/medium level of emotional exhaustion. That is, are these variables able to predict membership in the low or high/medium emotional exhaustion groups? The means for these variables (separated by low and high/medium emotional exhaustion) are reported in Table 2.

Following the PDA, an external analysis was conducted (Huberty, 1994). Specifically, the findings were cross-validated using prior probability for groups with a leave-one-out classification analysis (Table 2). The resulting PDA yielded an improved prediction over chance (71.2% of original grouped cases correctly classified; $z = 2.94$, $p < 0.01$). As can be seen in Table 2, there were improvements over chance with regard to the prediction of high/medium emotional exhaustion (78/81 for 96.3% prediction rate; $z = 5.36$, $p < 0.001$) and with regard to the prediction of low emotional exhaustion (5/37 for 13.5% prediction rate; $z = -2.34$, $p < 0.01$).

These results suggest that the variables of age and sex provide good incremental improvement in prediction over chance in determining membership in the high/medium emotional exhaustion group.

Table I

Means and Standard Deviations for Survey Questions on a Scale of 1 (Low) to 7 (High)

	Mean	Standard Deviation
English fluency	6.9179	.30159
Spanish fluency	5.8741	1.45802
Comfort in working with client in a language other than English	5.6822	1.68627
Comfort in working with clients in English	6.7500	.51741
Agreement with the statement “General training on how to provide therapy to diverse populations is sufficient to learn to work with culturally and linguistically diverse clients.”	2.4729	1.54656
Agreement with the statement, “Specific training is needed on how to provide therapy to clients from specific cultures.”	6.2868	1.07670
EE total	23.0588	11.13804
PA total	38.7456	5.76810
D total	4.5214	4.13479

Table 2

Cross-validated (Leave-One-Out) Classification Analysis for the Construct (Sex and Age) to Predict Burnout Outcome (Low versus High/Med Burnout)

Actual group membership	<u>N</u>	Predicted Group Membership	
		Low Emotional Exhaustion	High/Medium Emotional Exhaustion
Low Emotional Exhaustion			
<u>n</u>	37	5	32
%		13.5	86.5
High/Medium Emotional Exhaustion			
<u>n</u>	81	3	78
%		3.7	96.3

Chapter 5

Summary Conclusions and Implications

Summary of the Study.

Multicultural competence has become a requirement in the field of psychology as clinicians have been called to develop multicultural awareness, knowledge, and skills. There are many people living in the United States who speak a language other than English, and it is likely this number will continue to grow. These speakers of languages other than English, should they seek mental health services, will require bilingual or multilingual clinicians who are adequately trained to serve their mental health and language needs. It is therefore important to examine the current training and experiences of bilingual therapists. Shedding light on these experiences and identifying training and language factors related to therapist burnout can lead to advocacy for increased and improved training for bilingual therapists.

For this study, participants were invited to complete an online survey assessing demographic, language, and training variables as well as the Maslach Burnout Inventory (MBI). The MBI assessed for levels of emotional exhaustion, depersonalization, and personal accomplishment. The MBI recognizes that burnout is a progressive syndrome starting with higher levels of emotional exhaustion and progressing to low levels of personal accomplishment. Based on a review of the literature, it was then hypothesized that (a) younger mental health professionals would have higher aspects of burnout; (b) less specialized training in working with linguistically diverse populations would be associated with higher burnout; (c) females would have higher rates of burnout compared to males; (d) lower rates of second language fluency

would result in higher rates of burnout; and (e) lower rates of therapist comfort in working with linguistically diverse individuals would result in higher rates of burnout.

Conclusions.

Roughly 135 people started the survey, and 117 people completed the survey. Most (about 75%) participants were aged 22 to 40 years old and most (about 70%) identified as Latino. The participants were mostly female (75%). About 30% of participants identified working in a community mental health center (CMHC) while another 30% said they worked in multiple settings including a CMHC, university counseling center, private practice, or academia. Most participants said they have worked in the mental health field for less than 7 years (70%) while another 20% identified working in the field for 10 years or more.

About sixty five percent of participants said they feel most comfortable using English in their day to day language and about 60% said they preferred using English in therapy. The amount of participants who had Master's degrees and Doctoral degrees in the field of psychology was equal (40% each). The majority of participants (64%) said that 25-100% of the total psychology related services they provide per week are conducted in a language other than English.

Seventy percent of participants identified that they received general multicultural training. Most disagreed that general training on how to provide therapy to diverse populations is sufficient to learn to work with culturally and linguistically diverse clients. Consequently, most agreed that specific training is needed on how to provide therapy to clients from specific cultures.

Regarding the correlations related to the elements of burnout, the expected hypotheses were not supported. However, it was found that the more a person identified as being bicultural,

the lower their levels of depersonalization. Also, the more formal training a person had, the lower the levels of depersonalization.

In contrast to previous research, no significant correlation was found between age and burnout. This could be due to the large spread in age categories on the survey. For example, participants were asked to identify if they fell into one of 7 age categories. If age were to be used a continuous variable, and if there was a greater range of age amongst participants, a relationship between age and burnout might have been found.

No significant correlation was found between specialized training and the elements of burnout. It may be that specialized training alone is enough of a protective factor to counter high levels of burnout, but not enough of a protective factor alone to explain low levels of burnout. People who have had specialized training have received training on how provide therapy to linguistically and culturally diverse clients. The skills they learned and the training they received likely are related to lower levels (in the non-high range) of burnout, however, more may be needed than specialized training to actually achieve low levels of burnout.

No correlation was found between a person's sex alone and burnout. The research did indicate that sex combined with age is predictive of emotional exhaustion.

No correlation was found between second language fluency and burnout. This could be because nearly 30% of participants identified English as their second language. This hypothesis was based on the assumption that the second language of most participants would be a language other than English. Low fluency in a language other than English would likely result in struggles and challenges providing therapy in that language, which might be related to higher rates of burnout. Since such a large percentage of participants identified English as their second language, the assumption upon which this hypothesis was based was violated. A large percentage of people

identified a language other than English as their primary language, which means they likely are fairly fluent in that language. This would reduce the likelihood of communication troubles based strictly on language.

There was no correlation found between rates of therapist comfort in working with linguistically diverse clients and burnout. This could be because the average rating of therapist comfort was 6.75 out of 7. Such a high rating by most participants might not have been enough of a differentiating factor related to burnout. There also could have been a social desirability component related to the responses that elevated the rating by participants. Participants may have felt pressure to indicate that they are comfortable, since all of them are practicing mental health professionals, when in fact they may not feel entirely comfortable working with linguistically diverse clients.

Implications.

The results of this study highlight several important aspects related to bilingual therapist burnout. Therapists who participated in this study overwhelmingly agreed that more specific training is needed to work with clients who speak languages other than English. Even therapists who speak another language often do not feel prepared to deliver therapy in that language. Words and concepts do not translate directly, and simply transferring a Eurocentric way of doing therapy with a culturally diverse client often does not work. While a few programs exist devoted to psychological training in languages other than English, there are relatively few considering the number of non-English speaking persons residing in the US. The current study can be used to advocate for more specialized training and an increased number of programs devoted to training and therapy in languages other than English. The cultural diversity that exists in the US enhances our society by providing diversity through ways of thinking, living, and being. People

who speak languages other than English deserve the best possible mental health services, which require culturally competent, confident, and prepared therapists trained to do therapy in languages other than English.

The burnout profile of the group of therapists participating in this therapy indicates that they are in the early stages of burnout. Participants exhibited medium levels of emotional exhaustion, the first stage in the burnout progression, lower levels of depersonalization, the second stage, and high levels of personal accomplishment (low levels would indicate very progressed levels of burnout.) While the overall levels of burnout are not extremely high, what is alarming is that the participants in this study, who are at a young age in their careers, are starting to show signs of burnout. This study highlights the need for awareness of this progression and how to prevent it from progressing further.

Based on the literature and comments from participants of this survey, a burnout prevention program for bilingual therapists would entail several key components. First, bilingual supervision is ideally needed. With a bilingual supervisor a bilingual therapist would be able to process communication issues, cultural differences, the sometimes added challenge and stress of providing therapy in a language other than English, as well as the rewards and pride that may come from being able to do so. A second important component of a burnout prevention program would be additional or bonus pay for bilingual therapists. It is important that agencies recognize the extra work and effort that is required to provide therapy in the United States in a language other than English. Even the most fluent non-English speaker often lacks “therapy” vocabulary, or may spend extra hours translating documents or translating sessions that were conducted in one language into case notes in another. Additionally, often bilingual therapists may have large or difficult caseloads with fewer options to tailor the type of client they see since they may be

one of the only therapists able to see clients who speak a language other than English. For these reasons, it is important for agencies to acknowledge that being a bilingual therapist is a valuable talent and it is hard work for the therapist. Monetary compensation is a way for agencies to concretely acknowledge the extra work it takes and what a valuable commodity being able to conduct therapy in another language is.

A third essential component to a bilingual therapist burnout prevention program includes heightened agency awareness and education about the role of a bilingual therapist as well as providing training targeted specifically for them. Agency-wide education related to the skills bilingual therapists have, the challenges and barriers that present themselves in therapy, and the benefit that is had by the agency through employment of bilingual therapists is needed. Agencies can also make training easily accessible to bilingual therapists on topics such as professional/therapy language and vocabulary, treatment planning and interventions with people from specific cultures, family issues, legal issues, burnout assessment and recognition, and other topics that are pertinent to the particular setting or organization.

A fourth component of a burnout prevention program is educating bilingual therapists and others about the signs of burnout so that they can recognize when they are beginning to get burnt out. Discussing with bilingual therapists what emotional exhaustion, depersonalization, and diminished personal achievement look like in their lives as well as the effects this sort of stress has on their personal and professional lives would be useful. Based on the study at hand, younger women have been identified as more vulnerable to higher levels of burnout. Targeting this population will be especially important. Agencies can also provide time and space for bilingual therapists to discuss and find support among one another through agency sanctioned support groups, social hours, or discussion groups.

There are several implications related to the increased specialized training for which is advocated in this study. First, in order to offer improved and increased specialized training for bilingual therapists, collaboration among university departments and across organizations must occur. For example, language departments need to be working with clinical psychology, counseling psychology, and marriage and family therapy departments at universities in order to offer comprehensive and relevant training to those whose professional identity will involve conducting therapy in languages other than English. Psychology professors and future professionals can call on the expertise of language experts to learn technical vocabulary and words for psychological concepts. We can draw on the knowledge of anthropologists to increase understanding of mental health and mental illness in countries other than the US. We can call on the services of business people and industrial organizational psychologists to help us implement organization and agency-wide initiatives that promote the well-being of the bilingual mental health professional and reduce the amount of burnout experienced.

Additionally, bilingual psychology leaders will be called upon to come together to implement training and share expertise. Bilingual supervisors and bilingual licensed mental health professionals will be asked to share what they have learned regarding communication and cultural issues. They will need to share strategies for gathering experience and resources to the emerging bilingual therapist. People with expertise in bilingual therapy can network with younger or less experienced professionals who have the desire to serve bilingual populations, but lack direction, support, or resources about how to get there.

It is interesting to speculate as to the reasons that younger women were predicted to be more vulnerable to higher levels of burnout as was found in this study. My own experiences and intuition as a younger woman suggest that women may be more likely to face sexism and

discrimination in the workplace compared to men. Women may be more vulnerable to restrictive stereotypes in the workplace that negatively impact access to support and resources. This coupled with lack of experience and lack of establishment and connections that younger professionals may face would seemingly contribute to a group of people who have higher levels of emotional exhaustion, depersonalization, and lower levels of personal accomplishment.

Many of the implications mentioned require implementation of programs, training, and increasing resources. However, programs, training, and resources require money. At the present time, funding would seem to be a major barrier to implementing many of the changes highlighted in this study. While this is clearly a necessary consideration, I am unable to provide a solution as to where to find funding to improve training, programs, and resources for bilingual therapists. It will be a continual challenge for professionals to seek funding for the valuable changes highlighted in this study.

Participants were invited to type in comments at the end of the survey. Their comments are truly revealing and will help inform a discussion on future research, further implications, and speculation about burnout among bilingual therapists.

One participant commented that:

I believe that some of the stress or frustration I may have felt in the past working with clients may have been directly related to a lack of training or feeling that there was a lack of training on my part. This led me to go back to school which has somewhat lowered my anxiety and frustration levels and increased my competence.

This comment raises several questions related to bilingual therapists feeling inadequately trained. For this person, since obtaining more training and education led to increased feelings of competence, the question is raised, do those therapists who are Master's level clinicians feel even

less adequately prepared, given that they may have had less coursework, practicum experiences, internship experiences, and dialogue in an academic setting regarding how to conduct therapy in a language other than English. Certainly there exist Master's programs or individuals who receive excellent training on how to provide therapy in another language, however, it is also possible that Master's level clinicians who provide therapy in a language other than English need extra support and access to training after they have obtained their degree in order to feel that they are practicing competently. Doctoral level clinicians who also do not feel adequately prepared to provide therapy in a language other than English would also benefit from access to resources, training, and support to increase feelings of competence.

Another participant noted that:

I am currently switching from a full-time therapist to Hispanics to a regular paramedic. I feel unsupported in my community. Relations between agencies are not truly collaborative. I have to do clerical, intakes, case management, therapy and program administration (presentations, conferences, reports) all alone. I feel exhausted and on the verge of burnout. I think I am an effective therapist, supervisor and clinician. I do not have the skills to write grants and do all the other many necessary tasks to make my job easier!!

This comment highlights how burnout for some therapists is likely related to having to take on a case management role in addition to a therapist or supervisor role in the setting in which they work. This is likely due to a lack of people in support roles who can provide these indirect services in a language other than English. In addition to advocating for increased and improved training on how to provide direct therapy in a language other than English, advocacy is needed for increased and improved training for those in administrative, case management, or other

support roles. It is likely that more specialized training for those in direct and indirect contact/roles will allow for an environment where each feels optimally competent and able to serve the clients' needs in the best possible way. The following participant sums up the problem when this person writes "Besides providing psychotherapy in Chinese and conducting Chinese-speaking treatment groups, I also assume the role of case manager more often than not (e.g. interpreting for clients during psychiatrist visit, translating English letters)."

The following comment by one participant relates to inadequacy of training programs and pressure to serve *all* of the linguistically diverse clients at a particular agency.

Being a bilingual (almost tri) and bicultural therapist is generally rewarding, but I feel most training programs are woefully inadequate. Also there is pressure from the community to serve everyone, even clients who may not be appropriate or who cannot pay.

It is likely that this therapist is the only bilingual therapist or one of few bilingual therapists at her/his agency. Being the only bilingual therapist at an agency can lead increased caseload and decreased feelings of support. Additionally, this comment highlights how pressure from the community to serve everyone might lead to the therapist feeling uncomfortable asserting boundaries related to payment, types of clients, or diagnosis, especially if the therapist is the only bilingual therapist in the *community*. In general, there is a need to increase the number of clinicians who can provide therapy in a language other than English, which leads back to the inadequate training that some bilingual therapists feel exists. This cycle will likely only become worse, with more linguistically diverse clients needing served while therapists feel overwhelmed and undertrained. Awareness of the problem is needed now, as well as an appropriate response

from programs and training venues. The following respondent sums up part of the problem by stating:

There are too few Koreans in the mental health field as most simply would rather work harder at something more gratifying and making more money. So as a result, the few in the Korean group providing therapy are burned out...I am considering quitting soon from my psychotherapy part time job at a community health center as a result...

One participant noted:

This has been an interesting experience. Almost 10 years after getting my PhD I am, for the first time, feeling burnt out. Yet, answering these questions, I realize I still am energetic, love my job, and feel like I'm making a difference. It seems like this might be a good time for me to stop and address my burnout before I lose the joy.

This comment speaks to the benefit of being aware of signs of burnout, the need to assess for them, and engage in preventative or remediation efforts. Had this clinician not become aware of feeling burnout out by taking the MBI, he/she may not have recognized the need to do something about it. Others who have not taken the survey, which explicitly draws attention to issues related to burnout, would likely benefit from this awareness as well. This would suggest a need for all clinicians to assess for burnout throughout their careers as well as have access to resources and support to deal with feelings of burnout once they are occurring and prevent it from happening. Directors, supervisors, and other persons in positions of power in those settings in which bilingual therapists are employed would likely greatly benefit from general awareness about the challenges and experiences facing bilingual therapists as well as how to help clinicians assess for burnout and to support those who feel burned out.

The following comment highlights one participant's feelings related to being *the* one who raises multicultural awareness as well as conforming to a Eurocentric way of providing therapy.

For me work with clients isn't exhausting, rather it's the highlight of my day. What is exhausting is feeling like I'm the perpetual 'canary in the coal mine'; the young rebel rouser who is continuously one of a few or the only one who opens discussions about the importance of race, class, immigration history, and language in the lives of our clients. That process, along with the tension that comes with feeling as if I have to hide certain processes I undertake in my work with clients that do not match the analytic model of the constrained, 50-minute hour, is what exhausts me...

People of color, and people who are bilingual and bicultural, are not the only ones who are responsible for multicultural awareness, knowledge, and skills. We, as mental health professionals, are all responsible to incorporate our own and our clients' worldviews, ways of being, and aspects of diversity into our work and conceptualizations. Not all therapists and certainly not all clients will optimally benefit or fit into the prescribed parameters of the Eurocentric conceptualization of "therapy." The challenge becomes sharing the responsibility and reaching those who may not already incorporate multiculturalism into their practice.

The needs of bilingual therapists may be different for those who learned a language other than English as their second language (or those who speak a language other than English as their first language). As one participant commented, "This is my first year conducting therapy in Spanish. I find it both rewarding and draining to work inter-culturally, as there is much I do not understand, both in language and custom." The needs of this therapist will likely be different from the needs of the bicultural therapist who identifies speaking a language other than English fluently. This comment also speaks to the

heterogeneity that exists in the group labeled “bilingual therapists.” Bilingual therapists have varying levels of language fluency, training, comfort, and biculturality. With each of these differences, the needs of the therapists will differ as well. Future research should examine the varying needs of bilingual therapists and with-in group differences. Resources and support should be offered with the varying needs of bilingual therapists in mind.

Promoting better understanding of what burnout is, how it develops, and how it is manifested in multicultural settings will better aid psychologists and researchers in preventing burnout from occurring. Failure to do so may lead to frustration, disillusionment, and dissatisfaction which may end up deterring bilingual therapists from entering the field. The following participant shares,

I was explicitly trained to work with Latino children on my practicum and internship, in English and Spanish. However, if I had the option to do it again, I would not have taken the training as I am given harder cases and spend most a good deal of my time forcing myself to work in a language which I am not as good at.

Bilingual therapists provide a great service yet many feel unsupported. It’s time to listen to the needs of the valuable bilingual therapists and respond accordingly.

While the purpose of this study was to assess bilingual therapist burnout as well as highlight what may be contributing to it, it is of great importance to give voice to those bilingual therapists who are resilient in the face of many challenges. Additionally, it should be reiterated that being bilingual is a great asset and skill. Bilingual therapists are able to reach clients who may not otherwise have access to services. Through their language skills they are able to create a freeing space for the linguistically diverse client where she/he can focus on the real work of therapy rather than the correct vocabulary word or pronunciation. Bilingual therapists often

identify as bicultural as well. This biculturality allows for clients to feel connected, heard, valued, and accepted.

Future research.

One participant commented that “Some of the statements related to energy have changed since the birth of our child. It is important to consider how family environment (i.e. children, spouse etc), impact energy and burnout.” This is an excellent point and can be used to guide further research related to therapist burnout. While work and health information are a part of the MBI, examining other environment and family factors that relate to therapist burnout and resiliency is recommended for future research.

Resilience is spirit, buoyancy, and pliability. It is important to honor those bilingual therapists in the field who are resilient and are able to prevent professional burnout. Future research should focus on the protective factors employed by those who are resilient as well as how to prevent burnout from occurring. As one participant noted,

I may be an exception to some extent but I really don't feel burned out. I love my job and my clients. However, I also work with highly functional clients. And, I don't take things personally (at least try not to when possible). I am happy with putting the most I can in a day and going to bed healthy. I try not to worry much about anything and mostly focus on accomplishing tasks needed to bring goals to fruition and live with the consequences.

When things go awry, you just have to learn to let go and let be. They will eventually work out any way.

This participant highlights some of the protective factors that contribute to her resiliency including not personalizing things, keeping worry in check, and a positive attitude.

Understanding more in depth exactly what contributes to resiliency for this participant and others will lead to preventions efforts for a potentially debilitating syndrome; burnout.

While there was space in this survey for participants to type in comments, future research in the area of bilingual therapists and burnout should include more qualitative research. Ideally, face-to-face interviews could be conducted with bilingual therapists to gain a more in-depth understanding of contributors to burnout and resiliency. Not only would interviews allow for more in-depth information about burnout to be gathered, but this format is consistent with many Latino value orientations which place value on a personal relationship before discussing personal content. Interviews may also be more consistent with collectivist value orientations where it is seen as inappropriate to discuss personal issues with those outside of the family. An interview format would allow for the development of rapport and a relationship before asking participants to divulge personal information related to burnout.

In the future, research related to burnout can be conducted in other Latin American, South American, and Asian countries. This research would allow researchers to decipher if there are variables related to working with specific populations that may be contributing to burnout apart from language variables. Studying with-in country ways of healing, conceptualizations of mental health and illness, and effective culturally sensitive treatments would add to the body of knowledge about culturally competent therapy which is a large role for the bilingual therapist.

Being bilingual and being bicultural are two separate phenomena. A person can be bilingual and not bicultural and vice versa. Future research might address the impact of these two concepts on burnout more in-depth. For example, how does being bicultural impact burnout apart from being able to speak the language? What are the specific ways that being bicultural

might impact therapy with a culturally diverse client? How does burnout for someone who is bilingual but not bicultural differ from someone who is bilingual and bicultural?

Future research might also address how setting or area of the county impacts burnout. For example, do therapists in small towns or areas where there are not many bilingual therapists differ in burnout from therapists in areas where there are many bilingual therapists? On the one hand, small towns or areas where there are not many bilingual therapists may not have many clients in need of psychological services in a language other than English which could result in lower levels of burnout. However, these communities might also lack resources and support. Increased isolation as a bilingual therapist could also result in higher levels of burnout. Future research might address these types of questions.

Future studies might also examine how the socioeconomic status and educational level of clients impact burnout for bilingual therapists. Ethnic minority clients often live in poverty and have limited access to resources. Might there be client variables for the bilingual therapist that impact levels of burnout? Also, does the specific language in which the therapy is being conducted impact burnout? For example, does Spanish/English bilingual therapist burnout differ from Mandarin/English bilingual therapist burnout?

The issue of accents for bilingual therapists as they related to stereotypes, burnout, and stress is also content for future studies. Many people whose first language is not English have accents when speaking in English. It may be that the presence of an accent impacts rapport, communication, and feelings of efficacy all of which could be related to burnout. Conversely, many therapists who speak a language other than English as their second language will exhibit an accent when conducting therapy in that language. It might be interesting to involve the perceptions of clients in future research on how accents influence therapy. Clients might also be

included in research on language fluency, biculturality, and effectiveness as they relate to burnout.

Limitations.

One major limitation of this study is the biased lens through which this researcher developed the survey and study at hand. There exist many differences between people whose first language is English and people whose second language is English (or viewed another way, between those who speak a language other than English as their first language and those who speak a language other than English as their second language). This researcher learned Spanish as my second language beginning in middle school. My primary language is English meaning this is the language in which I am most fluent and in which I feel most comfortable communicating in day-to-day activities as well as therapy. The survey questions were designed with the unconscious assumption in mind that most bilingual therapists speak English as their first language. Upon examination of the results of this study, I realize that this assumption is not true and many bilingual therapists know a language other than English as their first language. Their experiences, barriers, challenges, and rewards are likely dramatically different from those of the person who learned a language other than English as a second language and is now conducting therapy in that language. This limitation should be considered in future research when designing survey questions and care should be taken as to not assume that the needs or experiences of both types of bilinguals will be the same or that most bilingual therapists speak English as their first language. Ideally, future research would include collaboration of both types of bilinguals, someone whose first language is English and someone whose first language is a language other than English, in order for the experiences of both to be attended to in the survey design, research questions, and hypothesis.

Rewording some questions in the survey as well as rewording some of the research hypothesis would have reduced some of the aforementioned erroneous assumptions upon which the hypothesis were based and would have likely yielded different results. For example, targeting bilinguals at different ages and levels of experience may have yielded different results related to age and burnout. Further defining “specialized training” may have provided different results related to increased specialized training and lower levels of burnout. As it stands in the survey, specialized training included a university program, work program, internship, or summer program. Defining and targeting in-depth language and cultural training related to work with a specific population would have been a more accurate description of the type of training I hypothesized would be related to lower levels of burnout. Finally, instead of asking which language therapists felt most comfortable providing therapy in order to examine the correlation between comfort in language and burnout, I should have asked participants to rate their perceived confidence and effectiveness when working with clients in a language other than English. However, social desirability would have still presented as a potential issue.

One limitation of this study is that many of the items in the survey are self report items. For example, biculturalism, language fluency, and levels of comfort working with culturally and linguistically diverse clients were all self report items. Participants themselves may be inaccurate reporters of such information. Thus rather than measuring technical language ability, the questions in this study measured more self-perception of language fluency.

Additionally, the MBI does not have normative data for bilingual therapists. Without this valuable normative data, conclusions drawn from use of the survey with bilingual therapists are limited. For example, the norms for the aspects of burnout with bilingual therapists may be

higher than with other human service professionals. Future research should include gathering normative data for the MBI when used with bilingual mental health professionals.

The use of participants from professional organizations that are centered on ethnic minority issues may also be a limitation. That is, professionals who join such groups likely have a strong ethnic identification and therefore may already be sensitized to issues of burnout. Alternatively, these groups may also serve as a resource, social support and buffer to stress and burnout such that the experiences of bilingual mental health providers outside of these groups may well differ.

This study does not also measure factors such as racial identity, acculturation and the experience of racism. These factors may well impact the extent to which a person is susceptible to burnout. Future research should include these factors. Finally, this study only addressed those mental health practitioners who spoke Spanish or an Asian language. Thus the experiences of bilingual mental health providers who speak other languages are not included. For example, a professional who works with Somalian refugees is not included in this study. The experiences of such providers, along with an examination beyond pan-ethnic categories (for example of the many different Asian languages) should be a focus of future research.

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Appendix A

E-mail for Survey Participants

Dear Mental Health Professional:

This e-mail is being sent to bilingual mental health professionals. I am writing to request your participation in completing a survey to gather information about the training experiences, language experiences, and burnout of professionals in the field of psychology who work with culturally and linguistically diverse populations. Ultimately the data from this survey will be used to assess the nature of specific training in the area of bilingual therapy and advocate for increased and improved training in order to provide psychological services in a culturally competent manner.

Completion of this survey will take about 20 minutes and participation is completely voluntary. Responses are anonymous. This study has been approved by the University of Georgia Institutional Review Board (IRB 2007-10768-0) and is under the supervision of Dr. Edward Delgado-Romero.

If you chose participate in this survey, please click on the link below to access the consent. After you read and sign the consent, you will be directed to start the survey.

Thank you,

Stephanie Clouse, M.C.
Counseling Psychology doctoral student
The University of Georgia

Appendix B

Consent Form for Participants

Bilingual Therapists Training, Language, and Burnout Experiences

Welcome to "Bilingual Therapists Training, Language, and Burnout Experiences," a web-based survey that examines some language, educational, burnout, and training experiences of professionals in the field of psychology who identify as bilingual and work with bilingual clients. The results of this survey will be used to assess the current nature of training as well as advocate for more specialized training to meet the specific needs and considerations when working with bilingual clients and attempting to implement culturally sensitive treatment and interventions. Before taking part in this study, please read the consent form below and click on the "I Agree" button at the bottom of the page if you understand the statements and freely consent to participate in the study.

Consent Form

This research study involves a web-based survey designed to understand the training experiences, language experiences, burnout experiences, and educational experiences of professionals in the field of psychology who identify as bilingual and work with bilingual clients. The study is being conducted by Stephanie Clouse, M.C., and is supervised by Dr. Edward Delgado-Romero of the University of Georgia, and it has been approved by the University of Georgia Institutional Review Board (2007-10768-0). No deception is involved, and the study involves no known risk.

Participation in the study typically takes 20 minutes and is strictly anonymous. Participants begin by selecting a response for a series of questions about language then training experiences.

All responses are treated as anonymous, and in no case will responses from individual participants be identified. Rather, all data will be pooled and published in aggregate form only. Please note that Internet communications are insecure and there is a limit to the confidentiality that can be guaranteed due to the technology itself. If you are not comfortable with the level of confidentiality provided by the Internet, please feel free to print out a copy of the survey, fill it out by hand, and mail it to me at the address given below, with no return address on the envelope.

Many individuals find participation in this study enjoyable and a valuable way to contribute to in the field of Latino/a psychology. Participation is voluntary, refusal to take part in the study involves no penalty, and participants may withdraw from the study at any time without penalty.

The investigator will answer any further questions about the research, now or during the course of the project. Participants may contact the principal investigator, Stephanie Clouse, at

sclouse@uga.edu; Professor Edward Delgado-Romero, Training Director of the Counseling Psychology program, Department of Counseling and Human Development Services, 402 Aderhold Hall, Athens, GA 30602, or at (706) 542-0500. Additional questions or problems regarding your rights as a research participant should be addressed to The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-3199; E-Mail Address IRB@uga.edu.

If you are 18 years of age or older, understand the statements above, and freely consent to participate in the study, click on the "I Agree" button to begin the survey.

Appendix C

Participant Survey

Bilingual Therapists Training, Language, and Burnout Experiences

This survey begins with some questions about demographic information, followed by questions regarding your language and training experiences. The last section asks questions about your experience with burnout in the field of psychology. Please read each questions carefully, then click on the appropriate response.

1. What is your age?
 - under 21 years
 - 22 to 30 years old
 - 31 to 40 years old
 - 41 to 50 years old
 - 51 to 60 years old
 - 61 to 70 years old
 - over 70 years old
2. What is your ethnicity?
 - Latino/a
 - Asian/Pacific Islander
 - Native American
 - African American
 - Caucasian
 - Other
3. What is your country of origin?
 - type in answer
4. What is your sex?
 - Female
 - Male
 - Other
5. What is the language you speak most often?
 - type in answer in blank
6. What is your secondary language?
 - type in answer in blank

7. On a scale of 1 to 7 of being bicultural, how would you rate yourself? 1 means you identify completely with only one culture, 7 meaning you completely identify with more than one culture.

1 2 3 4 5 6 7

8. In what type of setting are you currently employed?

- Community mental health agency
- College or university counseling center
- Private practice
- Consulting firm
- Primary or secondary school setting
- College or university faculty- Academia
- Other

9. How long have you been practicing as a professional in the psychology field?

- 0 to 2 years
- 3 to 7 years
- 8 to 10 years
- more than 10 years

10. About what percentage of the total psychology related services provided per week are conducted in a language other than English?

- 0 to 25%
- 25 to 50%
- 50 to 75%
- 75 to 100%

11. What have been the changes in the number of psychology related services provided in languages other than English over the past five years?

- less than 25% increase
- 25% increase
- 25 to 50 % increase
- 50 to 75% increase
- 75 to 100% increase

12. How fluent are you on a scale of 1 to 7 in English? One means you are not fluent and have difficulty communicating in English and 7 means you are extremely fluent and can easily communicate in English.

1 2 3 4 5 6 7

13. How fluent are you on a scale of 1 to 7 in a language other than English? One means you are not fluent and have difficulty communicating in the other language and 7 means you are extremely fluent and can easily communicate in the other language.

1 2 3 4 5 6 7

14. What was the primary language spoken at home when you were a child?

- type in answer

15. What is the primary language spoken in your own home now?

- type in answer

16. In which language do you feel most comfortable **speaking in day-to-day activities**?

- type in answer

17. In which language do you feel most comfortable **providing therapy or psychological services**?

- type in answer

18. What is the highest level of formal training you have? (Schooling and degrees)

- Bachelor's degree in psychology field
- Master's degree in psychology or mental health field
- Doctoral degree Ph.D. in psychology or mental health field
- Bachelor's degree in non-psychology field
- Master's degree in non-psychology field
- Ph.D. in non-psychology field

19. Was your formal training in a mental health related field conducted in your primary language?

- Yes
- No

20. Did you receive formal psychology training on how to provide therapy in a language other than English?

- yes
- no

21. Did you receive formal training on how to provide therapy to people of different cultures regardless of language?

- yes
- no

22. If so, what was the nature of that training?

- specialized program at college or university
- specialized training program through work
- internship
- summer or resident training program

23. On a scale of 1-7, with 1 being extremely uncomfortable and 7 extremely comfortable, how comfortable do you feel working with clients in a language other than English?

1 2 3 4 5 6 7

24. On a scale of 1-7, with 1 being extremely uncomfortable and 7 extremely comfortable, how comfortable do you feel working with clients in English?

1 2 3 4 5 6 7

25. On a scale of 1 to 7, 1 meaning that you strongly disagree and 7 meaning that you strongly agree, how much do you agree with the following statement:

General training on how to provide therapy to diverse populations is sufficient to learn to work with culturally diverse and linguistically diverse clients.

1 2 3 4 5 6 7

26. On a scale of 1 to 7, 1 meaning that you strongly disagree and 7 meaning that you strongly agree, how much do you agree with the following statement:

Specific training is needed on how to provide therapy to clients from specific cultures.

1 2 3 4 5 6 7

BURNOUT SURVEY

Work Information - Please estimate the following:

1. Number of hours worked in a typical week: _____
2. Number of evenings spent at work in a typical week: _____
3. Number of weekends worked in a typical month: _____
4. Number of full-time professional staff who report directly to you: _____
5. Number of full-time support staff who report directly to you: _____
6. Number of staff at your level who share same or similar responsibilities: _____
7. Number of people to whom you report directly: _____

Health Information - Please estimate the following:

1. Number of hours spent exercising or participating in physical activities per week: _____
2. Number of hours spent on leisure activities during a typical week: _____
3. Number days missed from work in the last year due to illness*: _____
 *excluding pregnancy
4. Number of vacation days taken from work in the last year: _____
5. Average number of hours of sleep per night: _____

BURNOUT SURVEY CONTINUED

Please read each statement carefully and use the scale to indicate how often the statement applies to your work experience.

SCALE

:

0 = Never

1 = A few times a year or less

2 = Once a month or less

3 = A few times a month

4 = Once a week

5 = A few times a week

6 = Every day

Statements:

1. _____ I feel emotionally drained from my work.
2. _____ I feel used up at the end of the workday.
3. _____ I feel fatigued when I get up in the morning and have to face another day on the job.
4. _____ I understand how clients/students feel
5. _____ I treat some clients/students as if they were impersonal objects.
6. _____ Working with people all day is a strain for me.
7. _____ I deal effectively with the problems of clients/students.
8. _____ I feel burned out from my work.
9. _____ I am positively influencing other people's lives through my work.
10. _____ I am more callous toward people since I took this job.
11. _____ I worry that this job is hardening me emotionally.
12. _____ I feel energetic.
13. _____ I feel frustrated by my job.
14. _____ I am working too hard on my job.
15. _____ I do not care what happens to some clients/students.
16. _____ Working with people directly puts stress on me.
17. _____ I create a relaxed atmosphere with clients/students.
18. _____ I feel exhilarated after working closely with clients/students
19. _____ I accomplish many worthwhile things in this job.
20. _____ I feel like I am at the end of my rope.
21. _____ I deal with emotional problems easily.

22. _____ I feel clients/students blame me for some of their problems.