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## What's the impact of cultural competency education? : exploring clinical social workers' attitudes towards clients health-related beliefs, opinions and psychosocial contexts

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Sheryl J. Jaffe  
What's the Impact of Cultural  
Competency Education? Exploring  
Clinical Social Workers' Attitudes  
Towards Clients' Health-Related  
Opinions, Beliefs, and Psychosocial  
Contexts

### **ABSTRACT**

This descriptive study explored clinical social workers' attitudes towards their clients' health-related opinions, beliefs, and psychosocial context. Individuals who self-identified as having earned a graduate degree in social work and were employed as clinical social workers were recruited utilizing a snowball sampling method. 120 clinical social workers completed an online survey, a modified version of the Health Beliefs Attitudes Survey (Crosson et al, 2004; Dobbie et al, 2002) which included several demographic variables. The results indicated that 117 participants (97.5%) had previously completed some form of cultural competency coursework or training. No statistically significant differences were found for the participants' attitudes towards clients' health-related beliefs and psychosocial contexts across all predictors tested.

**What's the Impact of Cultural Competency Education?**  
**Exploring Clinical Social Workers' Attitudes Towards**  
**Clients' Health-Related Opinions, Beliefs, and Psychosocial Contexts**

A project based upon independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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2012

לא עֲלֶיךָ הַמְּלָאכָה לְגִמּוֹר, וְלֹא אַתָּה בֶן חוּרִין לְהַבְטִיל מִמֶּנָּה  
"You are not obligated to finish the work [of perfecting the world],  
but you are not free to desist from it either."  
*Pirke Avot, 2:21*

### ACKNOWLEDGEMENTS

Throughout my personal and professional journey,  
I am grateful for being surrounded by passionate teachers and energetic mentors.  
I have been honored and humbled to witness the resiliency, creativity, and faith  
exemplified by the patients and clients I have encountered; thank you.

The interest and enthusiastic participation of clinical social workers'  
made this project possible; a special thank you to Karen Skversky, LICSW.

I wish to thank my thesis advisor, Dr. Yoosun Park, for challenging me;  
her rigor inspired me to think and work differently, within and beyond this learning process.  
I am in awe of Marjorie Postal's patience; thank you for sharing your expertise in data analysis.

I am appreciative for having the unique opportunity to work with  
Dr. Joanne Corbin and Dr. Jean LaTerz  
through our involvement in Curriculum Committee on behalf of the Research Sequence;  
thank you for encouraging me to pursue my interests through inquiry and collaboration.

I am especially thankful for the unwavering love and encouragement of my family;  
for the consistently supportive presence and enthusiasm of my friends,  
particularly their diligent humor and wisdom.  
I am inspired by your compassion, determination, and allyship.

Let's all continue learning and growing and pursuing justice.

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## **CHAPTER I**

### **Introduction**

There is a need for greater awareness regarding clinical social workers' attitudes towards their clients' health-related opinions, beliefs, and psychosocial contexts. The purpose of this research and study was to develop a better understanding of those attitudes; in the context of this study, these attitudes are referred to as 'cultural competency.' Having an opportunity to identify various demographic and training factors that might contribute to the development of those attitudes, or cultural competency, is the objective of this study. Cultural competency, the awareness-raising and skills clinical social workers develop in order to care for socio-culturally and racially diverse clients, is rarely explored in quantitative studies (Crosson, Deng, Brazeau, Boyd, & Soto-Greene, 2004). Cultural competency can impact health outcomes, as providers can contribute to health disparity, through the attitudes conveyed during care and treatment (Van Ryn, 2002). Differences in attitudes towards health have the capacity to influence the identification of appropriate interventions and treatment relationships. Furthermore, provider attitudes can be correlated in the improvement of health outcomes (Schofield, 2007). The knowledge developed in this study can inform social work educators and policy makers about the importance of social workers' attitudes toward their clients.

This study was descriptive in nature, as there is limited quantitative data on the topic. Through participant recruitment and data collection, clinical social workers were prompted to

consider their attitudes towards clients' health-related opinions, beliefs, and psychosocial contexts.

Participants were found using a sample of convenience, recruited utilizing a snowball sampling method. 120 clinical social workers, who had completed a graduate degree in social work and currently work as a clinical social worker, completed an online survey. The study asked participants eight demographic questions, including their participation in cultural competency coursework and/or training. This was followed by a modified version of the Health Beliefs Attitudes Survey (HBAS), an instrument originally used to assess medical students' attitudes towards patients' health-related opinions, beliefs, and psychosocial contexts (Crosson et al, 2004; Dobbie et al, 2002).

While there are many components that contribute to client care, healthcare accessibility, and health outcome, there is a gap in research examining clinical social workers' attitudes towards their clients' health-related opinions and beliefs. Recruitment and participation in this study presented a potential opportunity to spark self-reflection and dialogue regarding cultural competency. Beyond catalyzing an important discussion among clinical social workers, this study has the possibility of inspiring shifts in the care provided to clients, and may promote the expansion of ongoing training regarding cultural competency. Gaining awareness of clinical social workers' attitudes may provoke further research and training initiatives focused on the cultural competency of social workers. While knowledgeable and well-intentioned, the attitudes conveyed by clinical social workers have the potential of hindering the treatment of clients. Continuous engagement in cultural competency education, as a means of attunement, has the capacity to promote gradual, albeit meaningful, shifts in the provision of culturally competent clinical social work.



## **CHAPTER 2**

### **Literature Review**

With interests in cultural competency and its role within healthcare provision, this research investigated clinical social workers' attitudes towards their clients' health-related opinions, beliefs, and psychosocial contexts. For the purposes of this study, cultural competency refers to the awareness-raising and skills clinical social workers' develop in order to care for clients that represent United States' diversity (Crosson, Deng, Brazeau, Boyd, & Soto-Greene, 2004). Psychosocial context pertains to cultural sources and psychosocial factors that influence clients' health-related opinions and beliefs. Health-related opinions, beliefs, and psychosocial contexts refer to the client's perspectives of health, illness or problem, healing, treatment, and care (Crosson et al., 2004).

According to the National Association of Social Workers (NASW) Code of Ethics, Section 1.05, revised and approved in 2008, social workers have an ethical obligation to the pursuit of cultural competence, as explained,

- (a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.
- (b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.
- (c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability (NASW Code of Ethics, 2008).

The promotion of cultural competency, as it pertains to pursuing greater social justice and to fostering greater health equity, by reducing factors that contribute to health disparity, is integral to those clinical social workers that engage in direct clinical services. Therefore, studying clinical social workers' cultural competency, and the potential role that training may play on clinical practice is essential.

Clinical social workers' awareness and attunement to diversity is relevant to clients' health and health outcomes, as research suggests that healthcare providers' perceptions have the capacity to influence their attitudes towards clients' health-related opinions, beliefs, and the psycho-social contexts in which they are formed (Crosson et al, 2004). Van Ryn (2002)'s meta-analysis suggests that healthcare providers' behaviors contribute to health disparity, in regards to care and treatment within encounters as well as health outcomes. Differences in attitudes toward health, depending on an individual's socio-cultural identity, have the capacity to influence one's treatment relationships, the identification of appropriate interventions, and the improvement of health outcomes (Schofield, 2007). Socio-cultural identity refers to the social and cultural factors, as influenced by their psycho-social contexts, which might impact an individual's perceptions or attitudes, and contribute to one's health-related opinions and beliefs. Within treatment relationships, internalized dominance and oppression may contribute to positive and negative biases and assumptions, resulting in healthcare providers' stereotyping clients (Balsa & McGuire, 2002). Using the conceptual framework of epidemiologist Michael Marmot, Courtwright (2009) wrote, "social stigma can create health disparities even in cases where access and utilization of medical care is universal and appropriate" (p. 92).

Considering the body of theoretical literature regarding the social and pathological epidemiology of health, as well as research focusing on the bioethical issues of health beliefs,

there are few empirical studies exploring healthcare providers' attitudes towards their clients' health beliefs, beyond retrospective studies focused on health outcomes (Van Ryn, 2002). Quantitative studies on provider attitudes and cultural competency within the field of medicine were useful (Beach, Rosner, Cooper, Duggan, & Shatzer, 2007), as studies exploring this relationship within clinical social work are primarily theoretical and qualitative.

It is important to explore clinical social workers' attitudes towards their clients' health-related opinions, beliefs, and psychosocial context, as clinical social workers often contribute to clients' health and/or healthcare in integral manners. Within social work, cultural competency training often espouses knowledge mastery and practice skills. Generalizations of individuals and communities, and expectations of expertise may impair clinical social workers' capacity to be sensitive and attuned to diversity and personal biases (Nagai, 2010; Ortega & Faller, 2011; Pon, 2009).

Collecting data and gaining greater insight regarding clinicians' attitudes and identifying potential trends and themes influencing clinical social workers' attitudes towards their clients' health-related opinions, beliefs, and psychosocial context, has the capacity to influence the ways in which clinical social workers' go about building rapport, assessing clients, conceptualizing cases and formulating diagnoses. While this research study focused on clinical social workers and their attitudes towards clients' health-related opinions, beliefs, and psychosocial contexts, the data gathered and analyzed may have implications also for social work education, systematic interventions, and policy development and implementation.

## **CHAPTER 3**

### **Methodology**

#### Research Question

What are clinical social workers' attitudes about their clients' health-related opinions, beliefs, and psychosocial context, as measured by the Health Belief Assessment Scale?

#### Research Design

The purpose of this research was to learn about clinical social workers' attitudes towards their clients' health-related opinions and beliefs. The study utilized an online questionnaire operationalized by SurveyMonkey to obtain quantitative, descriptive data. For the purposes of this research project, the research used a modified version of the Health Beliefs Attitudes Survey (HBAS), in addition to the administration of eight demographic questions about study participants (Crosson et al, 2004; Dobbie et al, 2002). HBAS was initially created to assess medical students' incorporation of cultural competency training into their work with patients and can be found in its original form, in the paper by Crosson and colleagues (2004). This researcher's modified instrument use is consistent with the original instrument. The study focused on social workers' attitudes towards clients in four domains: 1) Opinions: importance of assessing clients' opinions; 2) Beliefs: importance of determining clients' health beliefs as part of assessment and treatment; 3) Context: importance of understanding clients' psychosocial and cultural contexts; and 4) Quality: importance of knowing the clients' perspectives within the provision of quality healthcare.

## Sample

This study employed a sample of convenience, which was recruited utilizing a snowball sampling method. Members of this researcher's professional, personal, and academic communities were asked to consider participating in the study, as well as assisting in the identification of other potential participants. As a masters-level art therapist in a hospital and community-based clinic, this researcher developed a professional network that includes a number of clinical social workers. Members of these communities shared the study's recruitment message to other eligible participants, aiding in the recruitment process. The recruitment message included a brief letter about the research and an invitation to participate, which contained an electronic link to the online questionnaire through SurveyMonkey. Recipients of this email were asked to forward the recruitment message to perspective study participants within their personal, academic, and/or professional networks (Appendix A).

## Procedure

The Smith College School for Social Work Human Subjects Review Board approved this research study and all procedures prior to recruiting subjects to participate in this study (Appendix F). Once approved, this researcher recruited participants using the aforementioned sampling strategy. Those interested in participating in the study clicked the electronic link provided in the recruitment message, which brought the perspective participant to the online questionnaire. Prior to the study's demographic questions and survey, potential participants were provided with an informed consent form, explaining the purpose of the study, eligibility criteria, as well as potential risks and benefits of participating in the study (Appendix B). If the perspective participant consented to participating, the participant was directed to an eligibility verification page. The potential participants were asked to indicate whether they are social

workers who are currently engaged in clinical practice and trained at a Council on Social Work Education (CSWE) accredited social work educational program, to confirm eligibility to participate in this study, before proceeding to the 23 item study questionnaire (Appendix C). Perspective participants that did not qualify will be directed to the disqualification page. This page thanked the individual for their time and interest in participating in this study. Anyone who received the recruitment email was provided with this researcher's contact information, ensuring that any questions regarding the research being conducted and/or the online survey could be addressed. The professional, personal, and academic contacts that were sent the recruitment email identify with a variety of social and racial groups, but there was no specific efforts made to recruit for representative or proportional diversity among participants.

#### Data Collection

120 clinical social workers completed an online survey (85.7%), out of 140 participants that began the survey. The study asked participants eight questions related to their demographics and participation in cultural competency coursework and/or training (Appendix D, Appendix E). This was followed by a modified version of the Health Beliefs Attitudes Survey (HBAS), an instrument originally used to assess medical students' attitudes towards patients' health-related opinions, beliefs, and psychosocial context (Crosson et al, 2004; Dobbie et al, 2002).

Participants' clinical experience ranged from 1-42 years. 109 participants (89.3%) reported completing required coursework focusing on cultural competency as part of their MSW program; 13 participants (10.7%) were not required to complete coursework focusing on cultural competency as part of their MSW program. 64 participants (52.5%) completed elective coursework focusing on cultural competency, and 99 participants (81.1%) reported taking workshops/courses/training focusing on cultural competency for continuing education units

and/or at their place of employment since completing their MSW program.

#### Data Analysis

This study used a quantitative research design. Data analysis was conducted using the data from the SurveyMonkey website. These data arrived in an Excel spreadsheet document, compiled with the assistance of the Smith College School for Social Work's professional data analyst, using descriptive and multivariate statistical techniques, and then analyzed by this researcher.

## CHAPTER 4

### Findings

There were 120 participants who completed the online questionnaire and were included in the sample. Their ages ranged from 25 years to 78 years. 97 participants (87.4%) self-identified as female gendered and 14 participants (12.6%) self-identified as male gendered. 106 participants (86.9%) self-identified as White, 6 participants (4.9%) self-identified as Hispanic/Latino(a), 4 participants (3.3%) self-identified as Native American or Alaskan Native, 3 participants (2.5%) self-identified as Asian, 2 participants (1.6%) self-identified as Black or African-American, 1 participant (0.8%) identified as Native Hawaiian or Pacific Islander. One participant replied with multiple responses, indicating multiracial (0.8%). No participants identified as Middle Eastern. 101 participants (82.1%) self-identified as heterosexual, 14 participants (11.4%) self-identified as gay or lesbian, 4 participants (3.3%) self-identified as queer, 3 participants (2.4%) self-identified as bisexual, and 1 participant (0.8%) self-identified as other.

Participants reported ages ranging from 25-78. Participants indicated having clinical experience ranging from 1-42 years; 15 participants (12.2%) indicated that they have 5 years of clinical experience, indicating that this was the mode. 109 participants (89.3%) reported completing required coursework focusing on cultural competency as part of their MSW program; 13 participants (10.7%) were not required to complete coursework focusing on cultural competency as part of their MSW program. 64 participants (52.5%) completed elective



coursework focusing on cultural competency, and 99 participants (81.1%) reported taking workshops/courses/training focusing on cultural competency for continuing education units and/or at their place of employment since completing their MSW program. The results indicated that 117 participants (97.5%) completed some sort of cultural competency coursework and/or continuing education training. Because of the limited number of participants (2.5%) without cultural competency training, a t-test could not be ran and the groups could not be reliably compared.

Aside from eight questions pertaining to demographics and cultural competency coursework and/or training experiences, participants used a likert-scale to respond to fifteen items about their attitudes in three categories: health-related beliefs, opinions, and psychosocial context. To determine internal reliability, a Cronbach's alpha test were ran on each group of items (Table 1, Table 2, Table 3). The items regarding opinions (Table 1) had an alpha of 0.5, which is below the acceptable cutoff, indicating a lack of internal validity. As a result, these items were not combined into a scale. The results of these items instigated consideration of factors that may influence participants' attitudes towards clients' health-related opinions, suggesting opportunities for future exploration and investigation.

Table 1

Importance of Assessing Clients' Perspectives & Opinions (Opinions)						
	<i>Strongly Disagree</i>	<i>Moderately Disagree</i>	<i>Slightly Disagree</i>	<i>Slightly Agree</i>	<i>Moderately Agree</i>	<i>Strongly Agree</i>
Social Workers should ask clients for their opinions about their illnesses	0.0% (0)	0.8% (1)	0.8% (1)	2.5% (3)	14.2% (17)	<b>81.7% (98)</b>
Clients may lose confidence in Social Worker if Social Worker asks their opinion about their illness or problem	<b>54.2% (65)</b>	30.0% (36)	10.8% (13)	4.2% (5)	0.8% (1)	0.0% (0)
Understanding clients' opinions about their illnesses helps social workers provide better care	0.0% (0)	0.0% (0)	0.0% (0)	0.8% (1)	9.2% (11)	<b>89.9% (107)</b>
Social workers can learn from their clients' perspectives on their illnesses	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	10.0% (12)	<b>56.7% (68)</b>

To test internal reliability before combining the Belief items into a scale, the second belief item was reversed, so that a higher score would consistently indicate more culturally competent responses throughout this grouping. The belief scale was created by taking a mean of the four items in Table 2. A Cronbach's alpha test was ran, and indicated that the belief items had strong internal reliability (alpha=.826, N=135, N of items=4).

Table 2

Importance of determining clients' beliefs for history taking and treatment (Belief)						
	<i>Strongly Disagree</i>	<i>Moderately Disagree</i>	<i>Slightly Disagree</i>	<i>Slightly Agree</i>	<i>Moderately Agree</i>	<i>Strongly Agree</i>
It is important to know clients' points of view for the purpose of diagnosis	4.3% (5)	5.2% (6)	2.6% (3)	17.2% (20)	25.9% (30)	<b>44.8% (52)</b>
Understanding clients' opinions about their illnesses helps social workers' reach correct diagnosis	4.3% (5)	3.4% (4)	7.8% (9)	18.1% (21)	31.9% (37)	<b>34.5% (40)</b>
Social workers should ask their clients what they believe is the cause of their illness	3.4% (4)	4.3% (5)	2.6% (3)	12.1% (14)	25.9% (30)	<b>51.7% (60)</b>
Social workers should ask their clients why they think their illness has occurred	6.0% (7)	4.3% (5)	5.2% (6)	16.4% (19)	27.6% (32)	<b>40.5% (47)</b>

To create the Context scale, a mean of the items in Table 3 was taken. A Cronbach's alpha test was ran, and indicated that the context items were within the cutoff, indicating internal reliability (alpha=.605, N=135, N of items=6).

Table 3

Importance of assessing clients' psychosocial and cultural contexts (Context)						
	<i>Strongly Disagree</i>	<i>Moderately Disagree</i>	<i>Slightly Disagree</i>	<i>Slightly Agree</i>	<i>Moderately Agree</i>	<i>Strongly Agree</i>
Social workers should learn about their clients' cultural perspective	0.9% (1)	0.0% (0)	0.0% (0)	0.9% (1)	3.4% (4)	<b>94.8% (110)</b>
Social workers should ask about how an illness is impacting a client's life	0.0% (0)	0.0% (0)	0.9% (1)	0.9% (1)	6.0% (7)	<b>97.4% (113)</b>
Social workers should ask clients for their feelings about their illnesses	0.0% (0)	0.0% (0)	0.9% (1)	0.9% (1)	6.0% (7)	<b>92.2% (107)</b>
Social workers can give excellent care without knowing clients' opinions on their illnesses or problems	<b>44.0% (51)</b>	26.7% (31)	17.2% (20)	6.9% (8)	5.2% (6)	0.0% (0)
Social workers can give excellent health care without knowing clients' understanding of their illness	<b>53.4% (62)</b>	31.9% (37)	7.8% (9)	6.0% (7)	0.9% (1)	0.0% (0)
Social workers do not need to ask about clients' personal lives or relationships to provide good health care	<b>75.9% (88)</b>	17.2% (20)	3.4% (4)	1.7% (2)	0.9% (1)	0.9% (1)

Pearson tests ran to determine whether or not there was a relationship between years of clinical experience and the Belief and/or Context scales found no significant correlations (Table

4). A strong positive correlation was found between beliefs and context (Table 4). T-tests ran to determine if there were differences in the means of the belief and/or context scales based on participants' completion of required cultural competency coursework, elective cultural competency coursework, and continuing education related to cultural competency (Tables 5, 6, 7). No significant differences were found.

Table 4

Pearson Tests				
<i>Correlations</i>				
		Years of Clinical Experience:	Belief Scale	Context Scale
Years of Clinical Experience:	Pearson Correlation	1	-.095	.145
	Sig. (2-tailed)		.310	.121
	N	123	115	115
Belief Scale	Pearson Correlation	-.095	1	.227*
	Sig. (2-tailed)	.310		.014
	N	115	116	116
Context Scale	Pearson Correlation	.145	.227*	1
	Sig. (2-tailed)	.121	.014	
	N	115	116	116

\*. Correlation is significant at the 0.05 level (2-tailed).

Table 5

Independent Samples Tests: T-Tests  
Required Cultural Competency Coursework

		t	df	Sig. (2-tailed)
Beliefs Scale	Equal variances assumed	-.387	114	.700
Context Scale	Equal variances assumed	-1.489	114	.139

Table 6  
 Independent Samples Tests: T-Tests  
 Elective Cultural Competency Coursework

		t	df	Sig. (2-tailed)
Beliefs Scale	Equal variances assumed	1.244	114	.216
Context Scale	Equal variances assumed	.648	114	.518

Table 7  
 Independent Samples Tests: T-Tests  
 Cultural Competency Workshops/Training/Continuing Education

		t	df	Sig. (2-tailed)
Beliefs Scale	Equal variances assumed	-.297	114	.767
Context Scale	Equal variances assumed	-.269	114	.788

## **CHAPTER 5**

### **Discussion**

The purpose of this study was to explore clinical social workers' attitudes towards their clients' health-related beliefs, opinions, and psychosocial contexts. The study illuminated trends regarding clinical social workers' cultural competency, and investigated the relationship between cultural competency education and clinical social workers' attitudes. The results of this study indicated that there were no significant differences in the attitudes of those clinical social workers who completed required and/or elective cultural competency coursework as part of their graduate degree program in social work and those that completed continuing education following completion of their graduate degree in social work.

Of the 140 study participants, 120 participants (85.7%) completed the survey. A total of 117 participants (97.5%) reported having completed some form of cultural competency training, reflecting adherence to the Council on Social Work Education (CSWE) standards. Furthermore, the self-reported attitudes of clinical social workers' suggests that professionals are aligned with the National Association of Social Workers' Code of Ethics, in terms of providing culturally competent care (NASW Code of Ethics, 2008). While the vast majority of clinical social workers reported attitudes that suggest cultural competency, the study found that the years of clinical experience, age, and type of cultural competency education completed had no influence on clinical social workers' attitudes towards their clients' health-related beliefs, opinions, and/or psychosocial contexts.

This study's null findings may be a result of numerous factors. Unexpectedly, the majority of clinical social workers that participated in this study completed cultural competency education. As a result, the attitudes of clinical social workers could not be grouped based on completion of cultural competency training. Without the capacity to compare these groups, this study was primarily descriptive of clinical social workers' attitudes towards clients health-related beliefs, opinions, and psychosocial contexts. While the HBAS instrument used seemed reliable based on its usage in a previous study (Crosson et al, 2004; Dobbie et al, 2002), this study's results suggested that there might be differences in clinical social workers' self-perceptions, in comparison to medical doctors.

This study also illuminated potential differences in the ways in which clinical social workers perceive themselves, in comparison to the ways that their clients experience their attitudes. Because this study utilized a sample of convenience, personal interest in cultural competency may have motivated specific clinical social workers to participate. As a result, participants may have been more invested and engaged in cultural competency education, biasing the study's findings. While the study indicated attitudes suggestive of culturally competent clinical social workers, these results are not universally representative. Health disparities persist and inequities in care continue to impact health outcomes. These challenges suggest the need for further research pertaining to alternative factors influencing cultural competency and clinical social workers' attitudes towards their clients' health-related beliefs, opinions, and psychosocial contexts.

A limitation of this study is generalizability, as the study utilized a sample of convenience; participants were recruited using a snowball method. Participants were not proportionally representative of clinical social workers in the United States (NASW, 2003). Although



participants' demographics on the basis of race/ethnicity and gender were comparable to NASW professional member demographics, the participants represented greater diversity in terms of their sexual orientation (NASW, 2003). Another limitation is that clinical social workers' participation was self-determined; those clinical social workers that participated may be more interested and/or invested in cultural competency within clinical social work practice than those clinical social workers that chose not to participate in the study. Strengths of this study were the robust sample size and the strong rate of study completion among participants.

This study was an attempt to contribute to an arena, which represents a gap in social work literature. It is my hope that this study of clinical social workers' attitudes towards their clients' health-related beliefs, opinions, and psychosocial contexts will provide a basis for further research on this topic. Future studies on the topic may find it valuable to consider other factors that influence clinical social workers' cultural competency. Personal experiences, the content and context of cultural competency education, and the setting and/or population of employment may also be factors in clinical social workers' application and integration of cultural competency. Incorporating greater self-reflection, as it pertains to identity, privilege, and oppression, is important in rectifying some of the inadequacies of cultural competency education. In the future, studying the role of self-reflection and humility within cultural competency education may be valuable. Clinical social workers that avoid acknowledging the complexities of personal, communal, and systematic histories of oppression and disparity may contribute to health inequity (Nagai, 2010; Ortega & Faller, 2011; Pon, 2009). Based on this research, health equity is contingent on cultural competency, substantiating its significance to clinical social work.

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Appendix A  
Recruitment Letter to Professional Colleagues and Friends

Dear Friends, Family, and Colleagues,

My name is Sheryl Jaffe and I am a graduate student studying social work at Smith College. For my master's thesis, I am conducting a quantitative study exploring clinical social workers' attitudes towards their clients' health-related opinions, beliefs, and psychosocial contexts. Very little research has been done on this subject, within clinical social work. I am interested in gaining a better understanding of this, while also gaining an awareness of cultural competency training among those who clinical social work practice.

Will you please help me find participants to complete a brief online survey for my study?

I am seeking clinical social workers that completed a master's degree and/or doctoral degree in social work from a graduate program that is accredited by the Council on Social Work Education (CSWE), and current position's primary responsibilities include providing direct clinical services, for example in medical and/or mental healthcare settings, as well as those individuals that provide clinical services within residential healthcare and/or educational facilities. If the majority of a social workers' responsibilities are non-clinical (i.e. social workers in organizational development, policy, and/or community advocacy) they are not eligible to participate in this study.

The online survey consisted of twenty-three questions, and will take less than fifteen minutes to complete. The survey has been setup in a manner that ensures that participation is anonymous. Please forward this email to anyone you know who might be interested in completing my survey.

If you have any questions, please contact me at [sjjaffe@gmail.com](mailto:sjjaffe@gmail.com) or (202)550-2393.

Thank you for your time and assistance,  
Sheryl Jaffe

--

Sheryl Jaffe  
Master's of Social Work Candidate  
Smith College School for Social Work

Appendix B  
Electronic Informed Consent Letter

Dear Participant,

Hello, my name is Sheryl Jaffe, and I am a graduate student at Smith College School for Social Work. This survey is a quantitative study exploring clinical social workers' attitudes towards their clients' opinions and health beliefs. This research will be used for my master's thesis, as well as future presentation and possible publication.

To participate in this research you must identify as a graduate of a master's degree in social work program, that is accredited by the Council on Social Work Education (CSWE), and currently employed as a clinical social worker, where your primary responsibilities include providing direct clinical services for individuals, families, and/or groups. Clinical social workers employed in medical and/or mental healthcare settings are encouraged to participate.

This brief survey will take less than fifteen minutes to complete. You will be asked eight demographic question and 15 survey items, with multiple answers for each question. Participants are encouraged to answer each question with the response that best fits the question.

There is the potential risk that in the experience of self-reflection emotions can arise that you may want to further explore. If you do not want to complete the survey, you may decline to complete the survey by closing the survey window at any time, and your answers will not be included.

There will be no financial or material compensation for participating in this study. You may, however, benefit from having the opportunity to self-reflect on your attitude towards clients' and consider your perception of health. You may also benefit from knowing that you are helping to address an issue that is fill a gap in the professional literature on this topic.

This survey is completely anonymous. As an online data collection platform, Survey Monkey encodes the data, and the data sent to the researcher is unidentifiable. Therefore while I, my research advisor, and the statistical consultant will have access to the data we will only be able to view the answers to the survey with no identifiable information of the participants. The data collected in this study will be presented in the aggregate in presentations and/or publications, which will further minimize the risks of identification. Data from this survey will be kept in a secure location for a period of three years as required by Federal guidelines and data stored electronically will be protected. Data will be destroyed when it is no longer needed.

Your participation is voluntary. You may withdraw from this study at any time during the survey by simply closing your browser and not completing the survey. If you choose to withdraw by not completing the survey, your data will not be included in the research. Only completed

surveys in which all questions are answered will be used for the study. Once the survey is completed and your answers are submitted, you can no longer withdraw. I will have no way to exclude your answers, as there is no way to identify which answers are yours.

BY CHECKING "I CONSENT" BELOW YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

If you have additional questions about taking this survey or if you have any concerns about your rights you may contact me via email at [sjjaffe@gmail.com](mailto:sjjaffe@gmail.com) or the Chair of the Smith College School for Social Work Human Subjects Review Committee (413) 585- 7974. Please print a copy of this consent for your personal records.

Thank you,  
Sheryl Jaffe

--

Sheryl Jaffe  
Master's of Social Work Candidate  
Smith College School for Social Work

- I Consent.
- I do not Consent.

Appendix C  
Study Instrument: Screening Question

1. Do you qualify to participate in this study?

- Yes, I earned a graduate degree in social work from a CSWE accredited program, and the majority of the responsibilities are clinical (direct client/patient services).
- No, I do not meet the aforementioned criteria for inclusion in this study.

Appendix D  
Study Instrument Part 1: Demographic Questions

2. Age
  - Drop-down menu: 20, 21, 22, 23, 24,... 80
3. Gender
  - Drop-down menu: Female, Male, Transgender, Other
4. Race
  - Check one or more boxes: American Indian or Alaskan Native; Asian; Black or African-American; Hispanic or Latin(a/o); Middle-Eastern; Native Hawaiian or Pacific Islander; White; Multi-racial; Other
5. Sexual Orientation
  - Drop-down menu: Bisexual, Gay or Lesbian, Heterosexual, Queer, Other
6. Years of Clinical Experience
  - Drop-down menu: 1, 2, 3, 4, 5,...45, Other
7. Did you complete required coursework focusing on cultural competency as part of your MSW program?
  - Yes
  - No
8. Did you complete elective coursework focusing on cultural competency as part of your MSW program?
  - Yes
  - No
9. Have you taken workshops/courses/trainings focusing on cultural competency (for Continuing Education Units and/or at a place of employment) since completing your MSW program?
  - Yes
  - No



Appendix E  
Study Instrument Part 2: Modified Health Beliefs Attitudes Survey

<b>Importance of Assessing Clients' Perspectives &amp; Opinions (Opinions)</b>						
	1 Strongly Disagree	2 Moderately Disagree	3 Slightly Disagree	4 Slightly Agree	5 Moderately Agree	6 Strongly Agree
Social Workers should ask clients for their opinions about their illnesses						
Clients may lose confidence in Social Worker if Social Worker asks their opinion about their illness or problem						
Understanding clients' opinions about their illnesses helps social workers provide better care						
Social workers can learn from their clients' perspectives on their illnesses						
Social workers should make empathic statements about their clients' illnesses						

<b>Importance of determining clients' beliefs for history taking and treatment (Belief)</b>						
	1 Strongly Disagree	2 Moderately Disagree	3 Slightly Disagree	4 Slightly Agree	5 Moderately Agree	6 Strongly Agree
It is important to know clients' points of view for the purpose of diagnosis						
Understanding clients' opinions about their illnesses helps social workers' reach correct diagnosis						
Social workers should ask their clients what they believe is the cause of their illness						
Social workers should ask their clients why they think their illness has occurred						

<b>Importance of assessing clients' psychosocial and cultural contexts (Context)</b>						
	1 Strongly Disagree	2 Moderately Disagree	3 Slightly Disagree	4 Slightly Agree	5 Moderately Agree	6 Strongly Agree
Social workers should learn about their clients' cultural perspective						
Social workers should ask about how an illness is impacting a client's life						
Social workers should ask clients for their feelings about their illnesses						

<b>Importance of assessing clients' psychosocial and cultural contexts (Context)</b>						
	1 Strongly Disagree	2 Moderately Disagree	3 Slightly Disagree	4 Slightly Agree	5 Moderately Agree	6 Strongly Agree
Social workers can give excellent care without knowing clients' opinions on their illnesses or problems						
Social workers can give excellent health care without knowing clients' understanding of their illness						
Social workers do not need to ask about clients' personal lives or relationships to provide good health care						

Final Page / Disqualification Page

Please click 'done' to before closing this window to exit this survey.  
Thank you for participating in this study!

Appendix F  
Human Subjects Review Committee Approval Letter



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**School for Social Work**  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

April 13, 2012

Sheryl Jaffe

Dear Sheryl,

Nice job! Your project is now approved by the Human Subjects Review Committee. Your application now reads like an ideal HSR application!

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

This is an exciting area and I wish you the best of luck in your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'David L. Burton'.

David L. Burton, M.S.W., Ph.D.  
Chair, Human Subjects Review Committee

CC: Yoosun Park, Research Advisor