

# Clinical Training with Undocumented Latinx Immigrant Minors: Case Examples and Reflections using the Multicultural Developmental Supervisory Model (MDSM) as a Framework

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As of 2017, the number of international immigrants worldwide increased from 220 million to 248 million, and will continue to rise [16]. Growing diversity worldwide requires a stronger emphasis on multicultural competency among mental health professionals. Learning multicultural competency skills is a career-long commitment that begins in

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practicum training and is modeled and reinforced through supervision. The Multicultural Developmental Supervisory Model (MDSM) is an evidence-based model that focuses on supervisory dyads and multicultural competence [12]. Using the MDSM [12] as a guide reflective of our training, four graduate supervisees share their supervision experiences in learning to conduct clinical interviews in Spanish with undocumented Latinx immigrant minors in government custody in the United States, a rising population with unique clinical considerations. Our supervisor includes her experience in training and fortifying beginning mental health professionals' skills in conducting these evaluations. In this contribution, we illustrate our trajectory from different training developmental stages, including the process of conceptualizing clinical cases, and transitioning languages in conducting clinical interviews, as well as considering our own cultural identities in clinical work. While our experience focuses on bicultural and bilingual training in the U.S., this aspect of clinical training is growing increasingly relevant around the world, especially in Europe where 54% of the population is multilingual [10]. Although we used the MDSM model as a helpful framework in guiding our multicultural development, empirical research is needed to examine the utility of this model.

**Keywords:** immigration, minors, supervisee-supervisor, multicultural competence.

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Clinical supervision is an important component of multicultural competence for mental health professionals in training. Indeed, “it is during clinical training and supervision that multicultural competence is initially developed and applied, which sets a foundation for lifelong practice” [7; 11], thus allowing supervisees to find their own voice in clinical interviewing. Additionally, competent supervision working with various cultures is crucial in the development of self-efficacy in supervisees working with culturally-diverse populations [8]. Although multicultural competence is also gained through coursework, supervised clinical training bridges the gap between theory and practice [7].

Given the continuously changing demographics worldwide, mental health professionals need to be adequately trained to serve individuals from diverse backgrounds – including immigrants [2]. Europe, Asia, and North America have the highest number of international migrants worldwide at 78, 80, and 58 million respectively. In the United States (U.S.) a large number of those migrants are of Latinx origin, prompting creation of the National Latinx Psychological Association (NLPA; [18]) and their professional guidelines for serving Latinxs clients. These guidelines emphasize the importance of ethics, competence, and consideration of within-group heterogeneity in the immigrant group being served. Furthermore, NLPA guidelines call for “culturally and

linguistically responsive supervision” [18; 21]. In accordance with these guidelines, supervisory models that focus on multicultural competence provide a framework to foster necessary competencies for clinical practice; one such model is the Multicultural Developmental Supervisory Model (MDSM; [12]). The MDSM is a model of supervision emphasizing multicultural competence at every level of interaction between a supervisor and a supervisee, and is based on previous models of supervision [12]. Although the MDSM focuses on the supervision process between same-ethnic dyads, we posit that the model is applicable to members of other ethnic groups as well when cultural humility is considered. The MDSM integrates four supervisory models, yet only two will be discussed: The Integrated Development Model (IDM; [22]) and Multicultural Counseling Competencies (MCC; [21]). The other two models focus on supervisors’ developmental stages and in depth examination of supervisees’ Latino identity development, and as so, are outside the scope of this paper. Although both are important in clinical training, this paper aims to discuss the supervisees’ reflection on their clinical training in relation to working with Latinx immigrant children.

The IDM is a comprehensive model of supervisee development; it identifies three developmental levels (*beginner*, *emergent*, and *advanced*) over eight dimensions: skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment plans and goals, and professional ethics [12; 22]. According to the IDM, *beginner* supervisees are highly anxious and motivated, but have low autonomy and self-awareness; thus, supervisees are highly dependent on their supervisor who assumes the role of expert or teacher. *Emergent* supervisees have fluctuating motivation and confidence, including variations in autonomy and dependency; thus, supervisees may benefit from supervisors that are flexible and ready to prompt for self-reflective practices. *Advanced* supervisees have stable motivation and are relatively autonomous, seeking supervision when needed, and are aware of their strengths and weaknesses. They work on creating a professional identity and focusing on the client, the process, and their own internal reactions [12; 22]. Although supervisees may be at an *advanced* level with certain populations or in certain contexts, they may be at the *beginner* level in others.

Further, MCC emphasizes the need to consider culture in training programs and supervision approaches. This includes helping supervisees become aware of their own assumptions, values, and biases; developing an awareness of the worldview of the client; and providing appropriate recommendations [12; 21]. For example, it is essential for supervisors to recognize and adapt to supervisees’ developmental needs, expected outcomes of supervision, and language proficiency, adjusting as needed to provide culturally effective supervision to each supervisee [12; 20].

In addition to cultural competence emphasized by the MDSM framework, cultural humility is integral in working with clients from different cultural backgrounds and cross-cultural dyads. Tervalon and Murray-García introduced and operationalized cultural humility as a life-long commitment to self-evaluation and critique, amending the power differential between the physician and the patient, and creating symbiotic partnerships with communities to benefit individuals and defined populations [23]. Cultural humility is a key process within the construct of cultural competence that may foster fruitful cross-

cultural interactions [9]. Cultural humility may normalize the process of becoming aware of an unfamiliarity or bias instead of seeing it as a failure [19]. When supervisors employ cultural competence and cultural humility, power differentials can be attenuated to allow supervisees to find their voices, improve the supervisory alliance, and act as a model for how to approach cultural differences with clients [15; 19].

One important attribute of cultural humility is self-awareness, which encompasses the awareness of one's own "strengths, limitations, values, beliefs, behavior, and appearance to others" [13, p. 211]. This attribute was vital in our clinical work not only in our interactions with clients from various Latin American regions, but also in the supervisory dyad. While four of the authors of this paper (the supervisor and three supervisees) are of Latinx descent, it is critical to highlight that the Latinx community is not a monolith. The supervisor is a first-generation American of Cuban heritage whose first language was Spanish. One of the emergent supervisees is a Mexican immigrant woman who was undocumented for most of her childhood and whose first language was Spanish. The second emergent supervisee is a Mexican-American woman, child of immigrant parents, whose first language was Spanish. The beginner supervisee is a first-generation Puerto Rican woman who, although is a heritage Spanish speaker, did not speak Spanish often due to her fear of being judged for speaking it "incorrectly". The advanced supervisee is a European-American who learned Spanish in school. It took engaging in self-awareness of our individual strengths and limitations to produce the necessary dialogue within the supervisory dyad, between supervisees, and with clients to conceptualize the clinical information provided by the immigrant youth within their cultural context.

### **Supervisee–Supervisor Experiences**

Using the MDSM as a guide reflective of our clinical training experience, the following section focuses on the experiences of a team of four graduate supervisees at various levels and their supervisor. Specifically, our experiences come from conducting clinical interviews with undocumented Latinx immigrant minors in government custody in the U.S. Our supervisor, a licensed clinical psychologist, is called upon by clinicians working at governmental shelters housing immigrant minors to conduct psychodiagnostic evaluations. The purpose of the evaluation is to conceptualize the minors' symptoms, make a diagnosis(es), make treatment recommendations, and inform on placement. Supervision is conducted in a group, with input from all present parties. Our supervisor is present in the room while we interview the minors, asking questions as needed, and checking and editing the written report. It is important to note that we did not provide therapy services during these evaluations nor did we collect data for research purposes due to the delicate nature of interviewing undocumented minors who may already be in vulnerable situations. Likewise, our supervisor did not collect empirical data to analyze our progress during our clinical training, nor was there specific criteria or a checklist that the supervisees had to meet, rather this manuscript comments on supervision and training in a naturalistic, albeit unique, context. Our progress through each level of autonomy was based on an ongoing discussion with our supervisor including our comfort level and motivation. As such, the following manuscript is not an empirical, quantitative study.

While our case examples are unique to the U.S., similar bilingual and bicultural training experiences are like to become the norm worldwide given increasing

diversification. We begin by discussing key considerations in our work with immigrant minors in line with cultural humility. Then, we delineate the process of learning, moving through different developmental stages – from beginning to near autonomy. Next, we discuss the process of transitioning languages in interviewing (i.e., English to Spanish), given that our clinical training in academia has been primarily in English. Finally, we address the reasons the supervisees' experiences have been enriching to their multicultural training – suggesting the utility of this training process for multicultural competence and acquisition of knowledge.

### **Utilizing Cultural Humility in Clinical Work with Immigrant Minors**

Working with immigrant minors calls for key considerations during the evaluation process given the unique needs of this population. Foremost, it is important to provide a thorough informed consent because some individuals may have little or no knowledge of factors to consider in providing consent [24]. Additionally, it is important to consider the minor's developmental level and ability to understand the information being relayed. Unique to undocumented immigrant minors, we emphasize that we do not work for Immigration and Customs Enforcement (ICE) and do not have the power to deport or report individuals for deportation in order to mitigate any immediate fears of deportation that may interfere with the minor's comfort in sharing their story [3; 6; 25]. Moreover, we disclose to minors that we do not have the power over their immigration case, including their length of stay in the U.S. This is done so minors are forthcoming rather than exaggerate or minimize their symptoms in the hopes of changing their legal situation. Further, we assure them that participating in the evaluation will not result in any monetary costs to the minor. Lastly, we inform the minors that we will write a report that will be sent to their clinician and encourage both the clinician and the minor to sit together to discuss the content and the treatment recommendations. Together, these practices help build rapport with the minor [3].

When working with immigrant minors that are not proficient in the language(s) in the country to which they migrated it is important to consider ahead of time whether an interpreter will be needed to conduct the evaluation in the minor's primary language [3]. The use of interpreters carries its own considerations because information or the cultural context may be lost in the process of interpretation [24]. Yet, even when speaking the same language as the examiner, minors may use colloquialisms to describe an event or emotion. As such, evaluators must be careful to ask minors to clarify ambiguities rather than making assumptions.

### **Training Process in Clinical Work with Latinx Immigrant Minors**

The authors of this article had varying levels of clinical, linguistic, and cultural competence prior to initiating work specifically with Latinx immigrant populations. We also came to the clinical team with differing levels of cultural and linguistic familiarity with the Latinx clients we serve. Further, our ethnic, cultural, and linguistic diversity meant different levels of proximity to our supervisor's own identity as a first-generation American and heritage Spanish speaker. Given the dynamic nature of the IDM across clinical scenarios, we all started our training journey with this specific population at the *beginner* level.

As beginners, we became familiar with the clinical interview process including its idiosyncrasies specific to Latinx undocumented immigrant minors. This stage includes discussing referral information and directions of inquiry before the interview, observing our supervisor and senior peers conduct clinical interviews, as well as participating in case conceptualizations in group supervision after every clinical interview. Yet, one of the most important lessons of the *beginner* stage is learning how to build rapport with clients, though building rapport is more of an implicit skill not easily or explicitly taught. For example, minutiae such as asking a client if they would like the disclosure form read to them, or if they have a signature, rather than assuming they can read and write could be overlooked or generalized as “every client is different” in explicit training. For this reason, our supervisor scheduled sessions of observation, to ensure trainee’s exposure to the informed consent process, and a wide range of clients, circumstances, and presenting problems.

After having witnessed and participated in the process of a clinical interview several times, we are then asked to score the client’s self-report questionnaires, and incorporate them into a clinical report, the rest of which is written by a more senior student or the supervisor. After writing the self-report section of the report, our supervisor and the more senior student give corrective feedback. Incorporating a more senior student in the process allows beginner students to shadow the journey of an older student in a similar position. Indeed, the senior student is often able to provide feedback from a different perspective from the supervisor, having recently been in the more beginner student’s shoes.

After several experiences writing portions of the clinical report, we are then tasked with writing the entire report. At this stage, the beginner student takes their own notes, which are supplemented by notes transcribed by the interviewer (i.e., either the supervisor or the more senior student). This step is essential in preparing supervisees for the final task of conducting the clinical interview because it allows the supervisees to learn the essential information to acquire from the client to accurately assess and diagnose, and ultimately, to answer the referral question. This step also accustoms supervisees to the language and skill of writing clinical reports. Again, each report is reviewed and corrected by the more senior student, first, and supervisor, second, except for the first report which is reviewed solely by the supervisor. This series of steps has the purpose of providing supervisory experience to the more senior student, meanwhile allowing the supervisor to understand the beginner student’s independent style. In the event that corrections by the more senior student dilute the beginner student’s voice in the report, corrections can be rejected and returned, or can be further discussed, reinforcing the collaborative nature in clinical interviewing training. It has been our experience that at this stage in the process we begin approaching the *emergent* developmental level, accompanied by elevations in motivation and confidence as we began to undertake more challenging tasks [12]. Yet, it is important to note that all supervisees did not reach this stage at the same time – some felt ready after two months while others requested six months of observation. As noted earlier, the advancement through each developmental level is an ongoing discussion not based on time-specific criteria or a predetermined checklist of qualifications.

The next step in our training is to conduct the clinical interview, with our supervisor observing, beginning with the preparation of our own interview questions. During the first

couple of interviews our supervisor is focused on our ability to navigate through a clinical interview smoothly. Indeed, it is less essential an individual know which questions to ask during an evaluation, and more imperative the supervisee can do so with the finesse required of a successful clinical interview. The following illustrative example denotes a supervisee's experience in learning how to ask questions at the beginning of her training.

**Emergent Supervisee:** *"I found that the way I phrased questions during clinical interviews sounded assuming at times, which could be damaging to building rapport. For example, instead of asking the client about whether they experienced traumatic events during immigration, I phrased it as "You didn't experience any traumatic events, right?" Our supervisor spoke with me about it in a respectful manner, suggesting instead I re-word my questions. After that conversation, I realized I had done this at numerous points in the interview when asking about difficult topics (e.g., substance use, gang affiliation); thus, this exchange allowed me to clearly see how to improve my questioning style."*

Because of the supervisor's constructive feedback, the supervisee became cognizant of their interviewing style and, therefore, developed better strategies that would both build rapport and elicit information fundamental to understanding the client's clinical presentation. Through this supervisory feedback, the trainee became aware of her own assumptions, values, and biases and the worldview of the client, following the MCC model of the MDSM [12; 21]. Furthermore, in the case of missed information, our supervisor interjects with questions of her own, modeling key questions that may have been overlooked by more beginner interviewers. Notably, this occurs with decreasing frequency as training continues and autonomy becomes more established. However, even in the *advanced* level, our supervisor continues to provide comments, corrective feedback and praise, which allows us to acknowledge our evolving strengths and weaknesses. The following is an example from a supervisee describing her experience in conducting her first clinical interview followed by our supervisor's reflection on the topic:

**Emergent Supervisee:** *"Despite being initially nervous about conducting my first clinical interview, I found that writing reports provided a mental map for asking questions. After my first interview, my supervisor provided praise and commented on areas I could inquire about in the future. For example, the client in this case had a history of using substances to cope with negative emotions. It was unclear as to whether he would resort to substances again if he was under peer pressure or distress, given that he would soon be released from government custody and live in a new country with unfamiliar caregivers. Near the end of the interview, my supervisor asked the client questions to determine his future substance use risk. I now keep these questions in mind when interviewing minors with prior substance use."*

**Supervisor:** *"The most difficult aspect of a developmental model of clinical training for me, the supervisor, is remembering to stop myself from interjecting when the trainee is growing from one developmental level to the next. Many times, I have found myself needing to apologize to a trainee for taking over a portion of the interview. When I have succeeded in stopping myself from asking what I consider to be the next logical question, I am often rewarded by hearing the trainee ask that very question themselves. My interruption would have thwarted the very development I have been trying to foster."*

## Case Conceptualization

As the supervisee moves along in their training, they become more involved in the process of case conceptualization and recommendations. This portion of supervision allows each of us to explain our reasons for considering a diagnosis and discuss key information obtained during the interview that provide support for our conceptualization. Per the IDM of the MDSM [12; 22], the dimensions of case conceptualization and treatment plan and goal are at the forefront. In working with Latinx undocumented immigrant minors, it is important to consider factors that may influence the current clinical presentation: pre-migration stressors and reasons for migration (i.e. violence in home country, abuse, gang involvement, substance use), the migration journey, separation from caregivers, and the experience of being held in government custody. Immigrant minors' life experiences place them at risk for developing psychopathological symptoms, including symptoms related to trauma, depression, and anxiety [17]. In line with NLPA recommendations, we consider each case individually and provide treatment recommendations that are tailored to each minor – further considering whether the minor will remain in custody or be released to a caregiver soon [18]. We discuss with our supervisor until we agree on the case conceptualization, diagnoses, and recommendations – all based on information obtained during the interview, the self-report measures, and collateral information. The following example illustrates a supervisees' experience in practicing case conceptualization with a supervisor:

**Emergent Supervisee:** *“Case conceptualization has been the most difficult skill for me to learn thus far. After one of the first interviews I conducted, my supervisor asked me to summarize the case in one sentence, which I found difficult to do. Because I could not initially identify the most pressing concerns, I asked my supervisor to summarize the case in her own words, and she provided a model of how to conceptualize succinctly. After every interview, I summarize the case in my own words and share my thought process with our supervisor with greater confidence.”*

The final step culminates with the transition to peer-supervisor, which helps solidify concepts, skills, and the process. Yet, regardless of one's level of autonomy we always have our supervisor present to consult with. Indeed, this model of supervision creates a supervisor-supervisee and peer-supervisor-supervisee relationship that allows each supervisee to slowly and comfortably transition through the IDM developmental levels.

**Supervisor:** *“Vertical supervision teams are a gift to the supervisor – not only do we get to learn from the client, but we get to learn from the fresh perspective of the junior trainee and the more seasoned, yet different from our own, perspective of a more senior student. It is also an important opportunity to observe and shape the supervision style of students – that is an aspect of clinical training that we often neglect.”*

## Transitioning to Interviewing in Another Language

Mental health professionals who speak more than one language are becoming more needed as the world becomes more diversified with the constant flux of immigration; however, not enough professionals are bilingual or feel comfortable in their dual-language

abilities [4]. For example, the growing population of Latinxs in the U.S. presents a need for more Spanish-English bilingual mental health professionals. Yet, the reality is that most Spanish-English bilingual therapists feel more comfortable using English simply because it is the language used in their professional training. Thus, even bilingual mental health professionals may not practice in their non-English language, suggesting a need for training in providing services in other languages [1; 4]. Although the exact number of bilingual mental health professionals worldwide is not available, the U.S., for example, experiences a dearth of bilingual clinicians [14]. With over half of Europeans being able to speak an additional language and bilingualism projected to grow in many areas worldwide, the need for bilingual, competent mental health providers is likely expected to increase [5; 10].

In our experience, the transition from interviewing in English to Spanish began in observing our supervisor conduct an interview in Spanish. Indeed, our supervisor's ability to speak Spanish made the linguistic transition attainable, further serving as an effective method for scaffolding the language that is appropriate to use in clinical contexts. As stated by Field and colleagues, "the ability to speak Spanish [between supervisor and supervisee] can be an important relational piece in the supervisory relationship as well as an essential aspect of culturally competent supervision" [12, p. 50]. The following example illustrates a non-native Spanish supervisee's experience in sharing her concerns about interviewing in Spanish:

**Advanced Supervisee:** *"Given that Spanish is not my first language, I was very nervous to conduct interviews in Spanish. I did not feel confident because my Spanish is 'textbook-Spanish' and I do not know all of the colloquial terms. Our supervisor encouraged me to disclose that Spanish was my second language to our clients prior to every interview and to let them know that if at any point they did not understand me, I could clarify, and vice versa. Both my supervisor and I have observed that such disclosure has helped with building rapport with immigrant minors. Most importantly, she never assumes I do not know certain vocabulary or translates a client's discourse for me unsolicited. This puts learning into my own hands, fomenting independence, and bolstering my confidence in my Spanish language skills."*

Yet, the ability to further develop Spanish-speaking skills in supervision is not circumscribed to only non-native Spanish speakers. As per the MCC within the MDSM, a culturally competent supervisor is able to recognize and adapt to the language proficiency of each supervisee, and grow as a supervisor in the process [12; 20]. The following is an illustrative example:

**Supervisor:** *"Serving clients in a second language seems to be an equalizer for all members of our vertical supervision team. Just like the advanced and beginner supervises, I am insecure about my Spanish – acquired mostly from my grandparents and never refined through formal education. I have found it helpful to share that insecurity with trainees and even with clients, admitting when I don't know a word they have used or when I can't think of the Spanish word that I want to use. These moments of humility tend to personalize the clinical and training experiences, in my experience. The discomfort all of us share surrounding bilingualism is also a proxy for the insecurity we share about multiculturalism. In almost every interview, a client uses a culturally laden word or phrase that leaves at least some of*

*our team in the dark. These moments are important reminders that sharing a language may not be the same as sharing a culture and that humility in that context is needed.”*

## Conclusion

This article described the learning process of four supervisees and their supervisor in conducting clinical interviews with Latinx undocumented immigrant minors. After providing necessary background, we provided a step-by-step process of navigating each developmental level (*beginner to advanced*), then discussed the process of case conceptualization with a unique population, and concluded with describing the transition of interviewing from English to Spanish. Through the article, we provided case examples from both the supervisee and the supervisors' perspective, highlighting how the IDM and the MCC of the MDSM reflected our experiences in clinical work. The style of supervision we outlined provides an easier transition into clinical work. Indeed, steadily increasing responsibilities in the interviewing process prevents supervisees from feeling overwhelmed, incompetent, or anxious to ask questions. Foremost, this gradual transition allows the supervisee to understand how to conduct an interview and the importance of assessment measures and collateral information, and how to incorporate these during conceptualization in clinical reports. Thus, when supervisees interview on their own, they have developed a consistent flow of questions, transitioning smoothly during the interview, and ultimately obtain the necessary information to answer the referral question. Given the unique circumstances of immigrant minors, this process establishes a better understanding of both the challenges and experiences of this population, and prepares supervisees to ask questions that address these topics with sensitivity. Still, to our knowledge, the MDSM [12] has not been empirically tested for its effectiveness in supervision processes in dyads. Future research should focus on empirically assessing its utility with diverse supervisory dyads, including those working with diverse populations.

In sum, this supervision process we outlined in accordance with the MDSM, served as a supplement to our graduate training, and not only prepared us to serve Latinx immigrant minors in the future, but will aid in training other incoming students as well. Providing services to individuals with diverse backgrounds and unique clinical needs, such as immigrant populations, is likely to increase worldwide [16]. Thus, emphasizing cultural competence in both clinical training and supervision worldwide will facilitate delivering services to a diverse clientele in cross-cultural settings.

## Executive Summary

- The Multicultural Developmental Supervisory Model (MDSM) is useful in guiding engagement in “culturally and linguistically responsive supervision” [18; 21] when working with Latinx immigrant minors [12].
- It is easier to navigate each developmental level and learn the nuances of working with Latinx immigrant minors with an ongoing dialogue between supervisor and supervisee.
- Through vertical supervision, assessment through a lens of cultural humility is more attainable.

- Transitioning into interviewing in another language must be adapted based on the supervisee's incoming level of other language proficiency but is an important process for non-native and native Spanish-speakers alike.

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## **Клинический тренинг психологов, работающих с нелегальными несовершеннолетними латиноамериканскими иммигрантами: примеры из практики и критический анализ результатов использования концепции Модели супервизии мультикультурного развития (MDSM)**

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По состоянию на 2017 год число иммигрантов во всем мире увеличилось с 220 миллионов до 248 миллионов и продолжает расти [25]. Растущее этнокультурное разнообразие требует пристального внимания к проблемам формирования мультикультурной компетентности у специалистов в области психического здоровья. Совершенствование мультикультурных компетенций у специалистов происходит на протяжении всей карьеры; овладение базовыми навыками работы с представителями разных культур начинается в рамках практикумов, а далее моделируется и подкрепляется супервизиями. Модель супервизии мультикультурного развития (MDSM) – научно обоснованный подход, фокусирующийся на формировании мультикультурных компетенций в супервизионных диадах [6]. В статье представлен опыт четырех аспирантов, прошедших супервизию по модели MDSM, в проведении клинических интервью на испанском языке с несовершеннолетними нелегальными иммигрантами-латиноамериканцами, находящимися в заключении в Соединенных Штатах Америки и представляющих активно растущую популяционную группу, имеющую свои уникальные клинические особенности. Приводится собственный опыт супервизора в проведении тренингов и укреплении мультикультурных навыков у начинающих специалистов в области психического здоровья. В данной статье авторы проиллюстрируют собственную траекторию различных этапов обучения, включая процесс концептуализации клинических случаев и смену языков при проведении клинических интервью, а также значимость учета собственной культурной идентичности в клинической работе. Несмотря на то, что авторский опыт сосредоточен на тренинге компетенций, необходимых в клинической работе с представителями билингвальных культур, обучение мультикультурным компетенциям становится все более актуальным во всем мире, особенно в Европе, где 54% населения говорят на нескольких языках [23]. Хотя авторы оценивают модель MDSM как результативный метод мультикультурного развития, необходимы эмпирические исследования, позволяющие доказать эффективность применения этой модели.

**Ключевые слова:** иммиграция, несовершеннолетние, супервизор-супервизант, мультикультурные компетенции.

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