Development and Validation of a Measurement of Multicultural Competence toward Arab Americans

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Provider cultural competence is an integral facet in the provision of adequate, consistent, and fair mental health services, specifically services provided to members of minority groups. The purpose of this study was to develop and pilot test a self-administered measure of the multicultural competency of mental health providers toward Arab Americans. Current conceptualizations of cultural competence are discussed, and a comprehensive framework for viewing cultural competence is presented. This framework is the basis for the development of a measure assessing mental health providers' knowledge, attitudes, and skills in practice with Arabs and Arab Americans. The process through which this measure was developed and modified is presented, including the utilization of an Arab American focus group. The measure was pilot tested with a non-probability sample of nineteen mental health providers in central Virginia. Internal consistency reliability for the overall scale was .753. Reliability estimates for the three subscales ranged from .569 to .745. Construct validity was supported with a significant correlation to the established Multicultural Counseling Knowledge and Awareness scale. The continued development and validation of this measure is an important step in addressing a notable gap of culturally specific interventions and measurements in the area of cultural competence.

Key words: Arab Americans; cultural competence; measurement development

The movement toward cultural competence in practice and education is burgeoning in professions such as social work, psychology, nursing, and psychiatry. Cultural competence has become a fundamental piece of practitioner training and worldview and as such requires a valid and reliable method of measurement. Much of the research is centered on the conceptualization of cultural competence,

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with different professions taking slightly different approaches (Abrams & Moio, 2009; Arredondo et al., 1996; Garran & Rozas, 2013; Kohli, Huber, & Faul, 2010; Sue, 2001, 2006; Williams, 2006). A classic model stemming from counseling psychology, developed by Derald Wing Sue and colleagues (Sue, 2001; Sue, Arredondo, & McDavis, 1992; Sue et al., 1982) presents a 3 × 4 × 5 model designed to assess cultural competence, the multidimensional model of cultural competence (MDCC; Sue, 2001). This multidimensional model looks at three dimensions: race- and culture-specific attributes of cultural competence (African American, Asian American, Latino American, Native American, and European American), components of cultural competence (awareness of attitudes/beliefs, knowledge, and skills), and foci of cultural competence (societal, organizational, professional, and individual). Sue and colleagues (1992) argued that the model may be applicable to other minority groups. Over the last decade, although other models and conceptualizations have built upon this model, the core tripartite conceptualization continues to proliferate in the literature (Krentzman & Townsend, 2008; Worthington, Soth-McNett, & Moreno, 2007). Sue (2006) defined cultural competence as

> the service provider's acquisition of awareness, knowledge, and skills needed to function effectively in a democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds), and on an organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational; structures that are more responsive to all groups (p. 29).

The word *competence* often implies a finite, attainable goal of distinct factual mastery. This is not the case—cultural competence is a lifelong endeavor that is characterized by a lack of knowing, a lack of awareness, and a lack of skills. Incipient voices argue that semantics matter: a term such as *cultural humility* may be a more accurate conceptualization (Dean, 2001; Johnson & Munch, 2009; Tervalon & Murray-Garcia, 1998). Johnson and Munch (2009) argued that the word *humility* conveys expectations of honesty, reverence, sensitivity, self-critique, and awareness. The goals remain aspirational, not attainable (Sue, 2006).

There are three main arguments that continue to justify a focus on cultural competence. First, the shifting demographic makeup in the United States is moving toward inclusivity and appreciation of diversity (Krentzman & Townsend, 2008; Whaley & Davis, 2007). According to U.S. Census Bureau data (2012), 63 percent of Americans were identified as white (not Hispanic or Latino). These projections indicate that, between 2012 and 2060, the non-Hispanic white group will no longer be the majority (this change will take place in 2043). In 2060, racial ethnic minorities, currently comprising 37 percent of the U.S. population, will make up 57 percent of the population. These statistics clearly indicate that the differential needs of a more multicultural, diverse population will need to be met.

The second argument justifying a focus on cultural competence is related to the aforementioned barriers to service use and access (Whaley & Davis, 2007).

Research, as well as governmental reports, indicates that there exist significant mental health care disparities in the United States, specifically by race and ethnicity (Abdullah & Brown, 2011; Carpenter-Song et al., 2011; Diala et al., 2001; Smedley, Stith, & Nelson, 2003; U.S. Department of Health and Human Services [USDHHS], 2001). Culture and ethnicity are hypothesized to play a role in the patterns of mental health service use in the United States (USDHHS, 2001). This underutilization is hypothesized to be a case of unmet need (Whaley & Davis, 2007). In the Surgeon General's Supplementary Report, *Mental Health: Culture, Race, and Ethnicity* (USDHHS, 2001), four areas in which mental health disparities continue to exist are identified: (a) lack of access to and availability of mental health services, (b) a lower probability of minorities actually receiving mental health services, (c) lower quality care for minorities who receive mental health treatment, and (d) insufficient representation of minorities in mental health research.

Specifically, racial and ethnic minorities seek and remain in treatment for mental illness at a lower rate than their white counterparts (Bauer, Chen, & Alegria, 2012; Carpenter-Song et al., 2011; Diala et al., 2001). Not only do racial and ethnic minorities tend to access professional mental health services at a lower rate than whites, but they also show less follow-through with treatment plans and tend to be less satisfied with services (Carpenter-Song et al., 2011). Additionally, treatment disparities among racial and ethnic minorities are widespread. For example, minorities are often treated with higher levels of antipsychotic rather than antidepressant medication (Carpenter-Song et al., 2011). Additionally, stigma associated with mental illness is vast and far reaching, and can often contribute to a denial of symptoms, a misidentification of symptoms due to somatization, or a lack of perception of need for treatment (Bauer et al., 2012; Corrigan, 2004).

The final argument justifying a focus on cultural competence is one that is centered around the crux of the social work profession: social justice (Krentzman & Townsend, 2008; Whaley & Davis, 2007). Morris (2002) defined social justice as

> the right of each person to have the opportunity—the resources and power—to develop a threshold level of capabilities in order to live a fully human life and to have the social responsibility to respect the dignity of each and every person in her or his own pursuit of achieving the same end. (p. 371)

The "same end," in this case, is equal access to consistent, competent, and effective mental health services. As Sue et al. (1982) argued,

> It is not enough to study solely different cultural groups in the US without understanding the sociopolitical history that minorities have undergone. The history and experiences of the culturally different have been the history of oppression, discrimination, and racism. (p. 47)

Social work as a profession must work to address the injustices that diverse populations face when seeking mental health services. The identity of social work as

a profession is predicated upon a social justice framework and is one of the stated core values of the profession (National Association of Social Workers [NASW], 2008). This mandate toward cultural competence is found in both the Council on Social Work Education's (CSWE's) Educational Policy and Accreditation Standards (EPAS) and the NASW Code of Ethics, principle 1.05, Cultural Competence and Social Diversity. An understanding of and movement toward social justice inherently undergird the notion of multicultural competency. Sue (2001) summated and drew attention to this inextricable linkage: "Multicultural counseling competence must be about social justice—providing equal access and opportunity, being inclusive, and removing individual and systemic barriers to fair mental health services" (p. 801). Social work is required to work toward maximizing the potential of all individuals to lead healthy, dynamic, and accomplished lives.

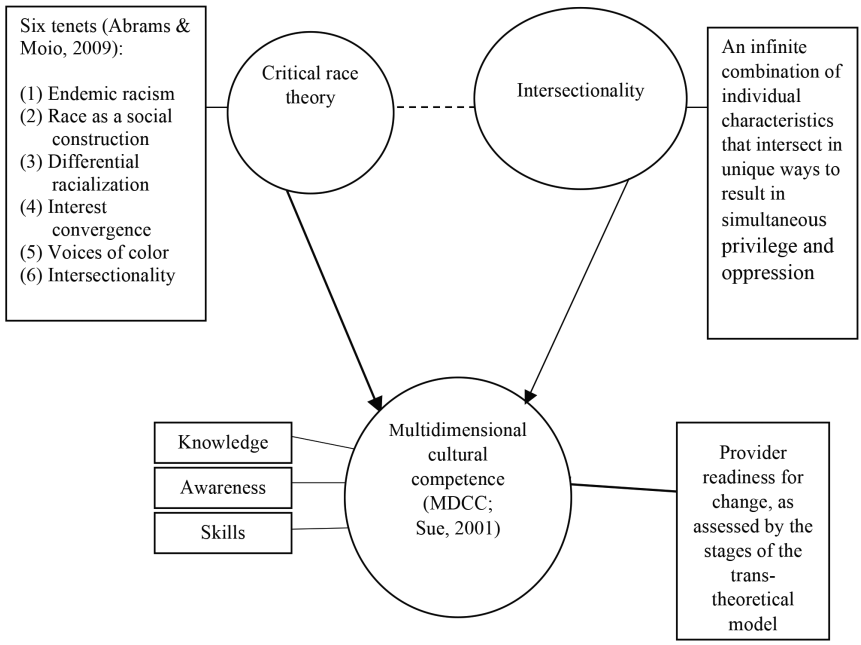
A Comprehensive Cultural Competence Framework

It is this recognition of the systematic and institutional barriers and oppression faced by racial and ethnic minorities on a daily basis that justifies viewing cultural competence within a critical race theory framework, as well as through a consideration of intersectionality. Abrams and Moio (2009) argued that social work practice must include a critical comprehension of the ways in which racism has affected the lives of oppressed individuals at the personal, institutional, and global levels. Additionally, the integration of provider readiness into the conceptualization of cultural competence with regard to racial and ethnic minorities is a positive one. Although the tripartite core of knowledge, awareness, and skills remains intact, integrating the tenets of critical race theory, intersectionality, and provider readiness as encapsulated through the trans-theoretical model can only provide a more comprehensive, integrated, and valid conceptualization of multicultural competence toward all racial and ethnic minorities, including Arabs and Arab Americans (see Figure 1).

Critical Race Theory

Historically, cultural competence has considered racial and ethnic minorities, but its conceptualization has evolved to encompass any group difference, including those pertaining to gender, sexuality, religion, age, ability, language, and nationality. Although this increase in inclusivity is positive, one unintended consequence is the ensuing tendency to equalize oppressions under a *multicultural umbrella*, which may lead to the implementation of a color-blind mentality that does not adequately recognize the existence of institutionalized oppression due to race (Abrams & Moio, 2009). Using critical race theory as the lens through which to view cultural competence enables one to address issues of institutionalized racism on multiple levels: individual, societal, institutional, and global. According to Abrams and Moio (2009), the mission of critical race theory is to examine, critique, and transform the relationship among race, racism, and power. They define six basic tenets of critical race theory. First, there is an acknowledgment that

Figure 1 Cultural Competence toward Racial/Ethnic Minorities



endemic racism exists. Secondly, the notion of race is seen as a social construction developed and perpetuated by those in power. Thirdly, from a historical perspective, differential racialization occurred, with individuals and groups racialized differently according to the societal mores in place at the time. Interest convergence is the fourth tenet of critical race theory, arguing that change will occur only when the interests of those in power converge with those of the oppressed. Fifth, critical race theory advocates for a revision of history to represent the voices of people of color. Finally, an acknowledgment of the importance of intersectionality is paramount within critical race theory.

Intersectionality

Davis (2008) defined intersectionality as "the interaction between gender, race, and other categories of difference in individual lives, social practices, institutional arrangements, and cultural ideologies and the outcomes of these interactions in terms of power" (p. 68). Intersectionality argues that individuals have more than just one characteristic. They exhibit an array of characteristics that result in a unique pattern of intersecting privileges and oppressions; these characteristics include race, sex, gender identity, sexual orientation, and ability, just to name a few. This infinite combination of intersecting characteristics necessitates that cultural competence be an ongoing endeavor. Utilizing critical race theory in

conjunction with intersectionality to conceptualize cultural competence is not only warranted, but is also consistent with the goals of social justice.

Provider Readiness for Change

One noted gap in the literature, specifically in the measurement of cultural competence, is a lack of attention to provider readiness for change as a moderating variable of provider cultural competence (Krentzman & Townsend, 2008). The trans-theoretical model (DiClemente & Prochaska, 1982; Prochaska & DiClemente, 1992; Prochaska, DiClemente, & Norcross, 1992) was initially used with smoking cessation and treatment of other addictive behaviors. However, it has been applied worldwide to a plethora of areas to assess individual readiness for change. Although variations of the trans-theoretical model exist, the most common iteration consists of five steps: pre-contemplation, contemplation, preparation, action, and maintenance. In this case, the targeted behavior for change is a lack of provider cultural competence. Assessing the stage in which the provider may currently be situated and how this relates to his or her current level of cultural competence will be useful to help explain the role that readiness plays in the development of cultural competence. This will also be an integral factor in the development of targeted interventions, which can be specific to the provider's current stage of change.

Multicultural Competence toward Arabs and Arab Americans

The movement toward addressing levels of cultural competence with service providers is a positive step toward the amelioration of racial and ethnic health disparities and a crucial move toward social justice for disenfranchised groups, including racial and ethnic minorities. Cultural competence must go beyond a knowledge and awareness of superficial cultural differences in order to include a comprehension of significant oppression and discrimination. Arab Americans comprise one such disenfranchised group, perhaps made even more so by their relative invisibility that has been mandated by the U.S. government in their classification as white (Naber, 2000). Arab Americans continue to be oppressed through multiple means, including the stereotypes that are perpetuated through negative and inaccurate media portrayals (Erickson & Al-Timimi, 2001), which serve only to sanction their identification as the *other* who has strayed from the defined norm, as identified by those in power (Pharr, 1988).

The majority of research on mental health service use and access focuses on the four major racial and ethnic groups in the United States. There is significantly less attention and research afforded to Arab Americans. There is evidence of mental health service use disparities among Arab Americans, with little known about potential avenues for more comprehensively understanding and addressing these disparities. As previously discussed, one of the identified barriers related to the decision to seek mental health services among racial and ethnic minorities, including Arab Americans is a lack of availability of culturally competent or com-

patible mental health services (Al-Krenawi, 2005; Betancourt, Green, Carrillo, & Ananeh-Firempong., 2003; Carpenter-Song et al., 2011). Arab Americans are increasing in numbers (Nobles & Sciarra, 2000), and they face a unique set of challenges in the wake of the 9/11 events (Padela & Heisler, 2010). These challenges, including a substantial and overt increase in prejudicial and discriminatory behavior, may contribute to the development or exacerbation of symptoms of mental illness. Abdulrahim, James, Yamout, and Baker (2012) argued that experiences of discrimination exacerbate racial and ethnic health inequalities. Specifically, they found that, among Arab Americans, the association between discrimination and psychological distress was stronger for Christian Arabs, Arabs who racially identify as white, Arabs with light skin color, and Arabs living outside the ethnic enclave. Arabs also tend to hold negative views of mental health services (Al-Krenawi & Graham, 2000; Nobles & Sciarra, 2000), with the majority preferring to seek treatment with a layperson or religious figure (Al-Krenawi & Graham, 2000; Aloud, 2004).

In order to move toward the long-term goal of developing effective and sustainable interventions that attend to provider cultural competence, it is incumbent upon the research community to develop valid and reliable measures of cultural competence. The vast majority of measures of cultural competence utilize the MDCC's tripartite framework of knowledge, awareness, and skills (Krentzman & Townsend, 2008), and none of these elements are specific to one particular racial and ethnic group. The goal of this research is the development and initial validation of a measure of mental health provider multicultural competence toward Arab Americans.

Methodology

The first author used a three-stage process to develop and validate a self-administered measure of multicultural competency toward Arab Americans based on the MDCC's tripartite foci of knowledge, awareness, and skills and the competencies set forth in the literature (Arredondo et al., 1996). The first step consisted of drafting the initial pool of questions. The second step consisted of administering these items to a focus group of Arab Americans. The third step consisted of administering the scale to a small sample of providers (pilot) in order to ascertain nascent reliability and validity characteristics, as well as potential trends in the data.

Drafting the Initial Item Pool

The aforementioned competencies (Arredondo et al., 1996) were the basis of both the structure of the scale as well as the content of the questions, thereby lending the measure face and content validity. These competencies are based on the tripartite framework of cultural competence (knowledge, awareness, and skills). Sue and colleagues (1992) depicted these sections as counselor awareness of his or her own assumptions, values, and biases; understanding of the worldview of

the culturally different client; and development of appropriate intervention strategies and techniques. Under the umbrella of awareness fall such precepts as counselor recognition of his or her own biases, values, stereotypes, and limits, as well as a sensitivity to his or her own cultural heritage and background and how this may or may not affect the counseling relationship. Knowledge includes knowledge of racial identity development; the values, history, experiences, and lifestyles of diverse groups; and discriminatory structures and institutional oppression and barriers. Skills include a range of culturally specific strategies, including the appropriate use and interpretation of verbal and nonverbal responses, as well as a willingness to seek out multicultural training.

The ensuing scale included one section titled Multicultural Experiences with Arabs—in Practice and Elsewhere. This was intended to ascertain the origins of individual beliefs about Arabs, whether they came from television, media, books, or actual interactions. The next section was Self-assessment of Multicultural Counseling Competencies and Cultural Humility toward Racial and Ethnic Minorities, Arab Americans. This section included five subscales, three of which represented the tripartite model of cultural competence. The five subscales were awareness (beliefs/attitudes), knowledge, skills, importance of the counseling relationship, and competence versus humility versus safety. The subscale importance of the counseling relationship was included following specific recommendations in the literature (Sodowsky, Taffe, Gutkin, & Wise, 1994). The fifty-eight item scale used a five-point Likert scale in which lower numbers indicated higher levels of cultural competence.

Focus Group

Focus groups have become an increasingly popular methodology in research, intended to garner the opinions and attitudes of a select population. Focus groups can be particularly helpful when working with culturally and linguistically diverse populations whose worldviews, beliefs, and attitudes may differ from the prevailing Western norm (Halcomb, Gholizadeh, DiGiacomo, Phillips, & Davidson, 2007). Following institutional review board approval, this measure was presented to a focus group of Arab Americans. Focus group participants were recruited through membership in a Coptic Christian church in central Virginia. Five women and one man attended, which was within the ideal group size of five to ten (Halcomb et al., 2007), with ages ranging from twenty-six to fifty-six. Participants gave verbal consent to participate upon hearing the rationale for the focus group, as well as the manner in which results would be utilized. The participants were all originally from Egypt, but represented a wide range of acculturation levels, with residence in the United States varying from one year to twenty-nine years. All participants were Coptic Christian and highly educated: four possessed a BS degree, one a BSW, and one a PhD.

Based on the literature surrounding best practices for conducting focus group research with culturally and linguistically diverse groups (Halcomb et al., 2007), the authors incorporated several measures to increase methodological rigor. First, bilingual moderators were used to help promote engagement and facilitate any issues that arose. The facilitator (first author) was bilingual in English and Arabic. Secondly, guidelines indicated that each focus group should consist of a homogenous subsample of participants in order to avoid power differentials and increase comfort. The focus group consisted entirely of Coptic Christian Arabs from Egypt who attended the same church. Within the Arab culture, there exists significant heterogeneity within groups, particularly based on religion and country of origin. Limiting the group to individuals from one country (Egypt) and not only one religion (Christianity), but also one specific sect (Coptic), further increased the homogeneity of the sample. Therefore, the sample recruited is not necessarily representative of the entire population of Arab Americans.

A final recommendation was that the main facilitator should be credible to and respected by participants and could be a member of the cultural or community group. The facilitator should be as ethnically similar to the participants as possible. Although the first author is neither Egyptian nor Coptic, she is Arab and Christian. Among Arabs, religion tends to be more important than country of origin, particularly among a relatively religious group of individuals. Religion is more likely a differentiating factor among Arabs than country of origin, occupation, or marital status (Erickson & Al-Timimi, 2001). Participants were concerned about the social desirability of specific items, particularly involving a reluctance to admit to holding stereotypes or biases toward Arab Americans. They felt that a few of the items sounded accusatory, with a bias assumed from the outset. They suggested either removing the items or finding a way to ask about bias and stereotyping indirectly rather than directly. They suggested adding specific questions about working with Muslim women in traditional dress, particularly related to the difficulty of seeing facial expressions. They suggested a specific focus on an opposite gendered relationship (particularly a female patient with a male therapist). The group also suggested adding a section on working with translators in a counseling setting.

As a result, the previous fifty-eight-item scale was reduced to forty-six items. Additionally, two sections were added: demographics and graduate curriculum. The final scale, Multicultural Counseling Competence toward Arabs and Arab Americans (MCCAA), consisted of sixty-five items, including a thirty-nine-item self-assessment of multicultural competence and a seven-item section on previous experiences with Arab Americans in addition to demographics (fourteen items) and a section on graduate curriculum (five items). Table 1 provides a breakdown of each section.

Additionally, the Multicultural Counseling Knowledge and Awareness Scale (MCKAS) (Ponterotto, Gretchen, Utsey, Riegger, & Austin, 2002) was administered to assess the convergent validity of the MCCAA. The MCKAS has exhibited alpha

Table 1 Multicultural Counseling Competence toward Arab Americans*

Section title	No. of items	Sample item
1: Demographics	14	N/A
2: Multicultural curriculum in graduate program	9	Did your graduate program provide any multicultural counseling coursework that integrated information on Arab Americans?
3: Multicultural experiences with Arabs and Arab Americans	7 (6)	The majority of my knowledge and experience with Arab Americans comes from the Internet or social media.
4: Self-assessment of multicultural competence toward racial and ethnic minorities and Arab Americans	N/A	N/A
4b: Awareness (attitudes/beliefs)	6 (8)	I am aware of how my own racial and ethnic background may play a role in the therapeutic encounter with an Arab American.
4c: Knowledge	12 (22)	I believe that all Arabs are Muslim.
4d: Clinical skills	6 (7)	I am comfortable seeking out consultation or supervision to support my work with an Arab American client.
4e: Importance of counseling relationships	11 (9)	I would respect the wishes of an Arab American female patient to debrief her husband and/or father on my conclusions.
4f: What is cultural competence?	4 (6)	I believe cultural competence should only be about increasing knowledge about diverse groups.

*Upon incorporating focus group outcomes. Numbers in parentheses reflect item numbers prior to modifications based on focus group outcomes.

reliability estimates for the full scale and the knowledge and awareness subscales ranging from .75 to .91 (Ponterotto et al., 2002). This scale has been utilized in both counseling psychology and social work, with abundant evidence of reliability and validity (Krentzman & Townsend, 2008).

Administration to Mental Health Providers

The complete measure (MCCAA and MCKAS) was subsequently piloted among mental health practitioners at five agencies in the central Virginia community. These organizations were identified through recommendations from faculty members and students at Virginia Commonwealth University's School of Social Work. Three e-mail reminders containing an online link to the survey were sent to the agency (via the contact individual) over a two-month period. Participants could elect to enter a lottery to win one of two $25 bank cards. Reliability and validity

analyses were conducted using SPSS 22 to identify the underlying item structure and concurrent validity with the MCKAS. Additionally, bivariate analyses were conducted to explore relationships between key demographic variables and the MCCAA.

Results

Sample Characteristics

Links to the survey were sent to providers at five agencies in central Virginia, and nineteen surveys were completed. Demographics of the nineteen participants indicated that 84 percent were females, 68 percent white, 11 percent African American, and 21 percent identifying as multiracial. Additionally, 42 percent had less than five years of clinical experience and 32 percent were younger than thirty-five. Furthermore, 68 percent of respondents indicated that their graduate program did not provide specific coursework on Arab Americans. Regarding the origins of prior information about Arabs and Arab Americans, the majority of participants indicated (strongly or somewhat agreed) that their knowledge and experience with Arabs came from social interactions (55.6%) as compared with 44.4 percent from TV and movies, 41.2 percent from the Internet and social media, and 33.3 percent from books. Additional information about the sample can be found in Table 2.

Reliability and Validity of the MCCAA

Given the small sample size ($n = 19$), exploratory analyses were run in order to identify characteristics of subscales, including alphas, means, and standard deviations. These analyses were run on section 4, Self-assessment of Multicultural Competence toward Racial and Ethnic Minorities and Arab Americans. This section consisted of five subscales (awareness, knowledge, skills, counseling relationship, and cultural competence). Three subscales were subsequently identified, consistent with the MDCC's tripartite framework of knowledge, awareness, and skills:

The first subscale, awareness, is intended to measure the beliefs and attitudes of providers about working with Arab Americans. This also includes an awareness of the provider's own biases or stereotypes. This subscale consists of six items with an alpha of .745. The mean and standard deviation for this subscale were 1.53 and .52, respectively.

The second subscale, knowledge, is intended to measure knowledge of the values and characteristics of diverse groups, as well as knowledge of institutional oppression and discrimination. This subscale consists of four items, with an alpha of .569. The mean and standard deviation for this subscale were 3.03 and .83, respectively. Eight items that did not contribute to the overall subscale alpha were identified and subsequently deleted to form this subscale.

Table 2 Characteristics of Providers Completing the MCCAA

	n	%
Sex		
Male	3	15.8
Female	16	84.2
Age		
<35	6	31.6
>35	13	68.4
Race/ethnicity		
White	13	68.4
Other	6	31.6
Religion		
Christian	10	52.6
Other	9	47.4
Years in practice		
<5	8	42.1
≥5	11	57.9
Highest degree		
PhD	2	10.5
Master's	10	52.6
Bachelor's	5	26.3
MD	1	5.3
Field		
Social work	6	31.6
Clinical psychology	1	5.3
Counseling psychology	4	21.1
Psychiatry	1	5.3
Other	7	36.8
Had specific coursework on Arab Americans in graduate school	2	13.3
Had multicultural counseling coursework in graduate school with integrated information on Arab Americans	6	40
Received the majority of knowledge of Arabs from*		
TV or movies	8	44.4
Internet or social media	7	41.2
Books	6	33.3
Social interactions	10	55.6
Currently have or have had in the past Arab or Arab American clients	9	50

*Items were considered endorsed if participants selected strongly agree or somewhat agree.

The third subscale, skills, is intended to measure the use of culturally specific strategies, including both verbal and nonverbal forms of communication. This subscale consists of five items, with an alpha of .721. The mean and standard deviation for this subscale were 2.07 and .80, respectively. One item that did not contribute to the overall subscale alpha was identified and subsequently deleted to form this subscale.

The final two subscales, importance of counseling relationship and what is cultural competence, and all items therein did not contribute positively to the overall scale alpha level and were subsequently removed. Overall, three subscales emerged: awareness, knowledge, and skills, consisting of fifteen items in total, an alpha of .753, and a mean and standard deviation of 2.12 and .46 (see Table 3). Additionally, overall scale convergent validity of the MCCAA with the MCKAS (Ponterotto et al., 2002) was found with a correlation of .612 ($p = .007$).

The first three sections, demographics, multicultural curriculum in graduate program, and multicultural experience with Arabs and Arab Americans, will be important to retain in future studies (with a larger sample size) in order to analyze and isolate the predictive or differentiating qualities of these variables. Despite the small sample size, theory and prior literature informed the bivariate analyses that were run in order to look at trends in the data. These bivariate analyses were conducted to examine the possible relationships between relevant demographics, experiential and knowledge questions, and data on the graduate curriculum with the multicultural competence subscales. Although none of the following findings were significant, they can certainly inform conceptualizations of the trends that may exist with a more highly powered sample. Due to an insufficiently powered sample, preconceived hypotheses based on theory and research could not be conclusively addressed, but nonsignificant trends were noted. Individuals older than thirty-five exhibited higher levels of cultural competence. Individuals with more than five years of experience exhibited higher levels of cultural competence toward Arabs, and this remained consistent across subscales. Individuals identifying as Christian exhibited higher levels of cultural competence toward Arabs. Individuals who had gained knowledge and experience of Arabs from TV and movies were less likely to be culturally competent than those who had received knowledge and experience from the Internet and social media.

The next step is to utilize critical race theory, intersectionality, and provider readiness for change to provide a more comprehensive framework for cultural competence and to have this reflected in a measure of cultural competence. In order to do so, this existing measure, currently consisting of forty-one items [demographics (14 items), multicultural curriculum in graduate program (5 items), previous experience with Arabs and Arab Americans (7 items), and multicultural self-assessment of cultural competence toward Arab Americans (15 items)] will likely be revised for use with a larger, representative, and randomly

Table 3 Properties of Scale and Subscales

	No. of items	Alpha	Mean*	*SD*
Overall scale	15	.753	2.12	.46
Awareness subscale	6	.745	1.53	.62
Knowledge subscale	4	.569	3.03	.83
Skills subscale	5	.721	2.07	.80

*Lower numbers indicate higher levels of cultural competence.

selected sample of mental health practitioners. This more comprehensive scale will be administered to a large random sample of providers from multiple professions (social work, psychology, and counseling) living in a geographic locale with a significant population of Arab Americans (northern Virginia). This will enable the use of factor analyses and bivariate analyses as well as multiple regression models to isolate factors that contribute both positively and negatively on cultural competence toward Arab Americans.

Discussion

The majority of research on cultural competence in the clinical encounter focuses on the four major racial and ethnic groups in the United States. This is the first measure to look at levels of cultural competence among mental health practitioners (social workers, psychologists, and psychiatrists) specifically toward Arab Americans. This research represents the first of multiple steps needed to further validate this measure. The next step will be to administer a more comprehensive measure entailing a critical race theory perspective, encompassing the notion of intersectionality, as well as addressing provider readiness for change, to a larger randomly selected group of mental health practitioners. This will yield a sufficient sample size to run an exploratory factor analysis to delineate the underlying factor structure of the measure and to ensure that it is valid and reliable. Additionally, with a larger sample size, multivariate analyses can be used to ascertain the unique role of specific characteristics or variables in the development and presence of cultural competence toward racial and ethnic minorities.

This measure is unique as compared with other measures of cultural competence in that it contains items that are specific to one group. Sue (2001) noted that a gap in the field exists around the lack of culturally specific interventions for different racial and ethnic groups. Current measures of cultural competence strive to be representative of a broad definition of diversity (Krentzman & Townsend, 2008), not one that is limited to race/ethnicity and certainly not one that is limited to one specific race/ethnicity. There are advantages to each approach. Certainly, this measure will have a more limited specified use. However, due to the existence of vast within- and between-group variations found among diverse groups, the construct of cultural competence can be more effectively and accurately ascertained through the use of specific measures.

Limitations of the focus group include the homogeneity found among participants. All participants were from one country, highly educated, and represented one religion. However, the vast within-group variation among Arabs (Erickson & Al-Timimi, 2001), including Muslim Arabs or Arabs from another country, may have detracted from the cohesiveness of the group. Halcomb et al. (2007) posited that homogeneity of the focus group is paramount when working with culturally diverse focus groups.

Limitations of the pilot study included the small sample size. This contributed to insufficient statistical power, preventing further reliability and validity testing.

Additionally, this small sample size limited the ability of the researcher to explore potential factors that may be correlated with the adapted cultural competence scale and subscales. However, this is a goal inherent in the next step of the validation and development of this measure.

Best Practices with Arab Americans

The development and initial validation of this measure of cultural competence toward Arab Americans adds to the literature on the operationalization and measurement of cultural competence. The fact that initial item analyses indicated that the underlying structure of this measure was consistent with the MDCC's tripartite framework of knowledge, awareness, and skills (Sue, 2001) is continued evidence in support of the use of this model when conceptualizing cultural competence. The convergent validity found with the MCKAS (Ponterotto et al., 2002) is further evidence of this underlying structure. This measure will increase the understanding of the process experienced by Arab Americans and other diverse groups when they decide to seek or remain in mental health services. This will enable future research to further elucidate and subsequently address the mechanisms that contribute to and reproduce racial and ethnic disparities in mental health service use and access. Elucidating the factors that contribute to the presence and development of cultural competence will allow researchers to begin to develop effective and sustainable interventions intended to increase levels of provider cultural competence.

Although the long-term goal of this research is the development of effective, sustainable, culture-specific interventions aimed at increasing provider cultural competence, the next steps will consist of modifying this measure to add/modify items that explicitly address the remaining three theoretical orientations that underlie the conceptualization of cultural competence toward racial and ethnic minorities: critical race theory, intersectionality, and provider readiness for change. This scale will subsequently be administered to a larger sample of providers from different disciplines, with the goal of conducting an exploratory factor analysis to identify the underlying core structure and to assess reliability and validity.

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