Mental health provider cultural competence in the provision of services to Arabs

Dalia Y. Khoury

Routledge
Taylor & Francis Group

Mental health provider cultural competence in the provision of services to Arabs

Dalia Y. Khoury

Virginia Commonwealth University, School of Social Work, Richmond, VA

ABSTRACT

Factors contributing to racial/ethnic disparities (among Arabs) in mental health services include a lack of provider cultural competence. A cultural competence measure toward Arabs was developed and administered to providers in Northern Virginia, in order to assess psychometric properties. Factor analyses revealed a unidimensional construct of cultural competence toward Arabs. Additionally, higher levels of cultural competence were significantly related to higher readiness for change, and, specific to Arabs, more previous knowledge and familiarity, and utilization of books for knowledge. A model inclusive of these factors explained 19% of the variance in mean scores. Implications for research, practice, and training are discussed.

Significant racial/ethnic disparities continue to exist in the U.S. with regard to access, quality, and outcomes related to mental health services. There are a number of reasons situated within a complex and multilevel framework as to why these disparities may exist among racial/ethnic minorities, including Arabs. Existing research indicates that a lack of provider cultural competence likely plays a role in the decision of racial/ethnic minorities to seek or remain in treatment. However, this assertion has yet to be explored with Arabs.

Literature review

Because of the continued presence of significant disparities in health, access to health services, healthcare, and health outcomes, racial/ethnic minorities in the U.S. bear a disproportionate burden of both physical and mental illness. There are well-documented mental health service use disparities among racial and ethnic minorities, and the literature explicates a number of reasons the existence of these disparities. These include individual level factors, including: a lack of awareness of availability of mental health services,

CONTACT Dalia Y. Khoury ✉ dalia.khoury@duke.edu 🖅 Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Box 3464, Durham, NC 27701
Dalia Y. Khoury, Department of Social Work, Virginia Commonwealth University.
Dalia Y. Khoury is currently at Department of Psychiatry and Behavioral Sciences, Duke University.

negative attitudes toward mental health services and service providers, a perceived lack of culturally competent service providers, and cultural and religious views about the origins of mental illness (Aloud & Rathur, 2009; Obasi & Leong, 2009), difficulty accurately identifying symptoms of mental illness (Al-Krenawi, 2002; Bauer, Chen, & Alegría, 2012), a desire to preserve self-esteem (Savaya, 1998), level of acculturation (Amer & Hovey, 2007; Jadalla & Lee, 2012) and experiences of racial and ethnic discrimination (Padela, Gunter, Killawi, & Heisler, 2011; Padela & Heisler, 2010). They also include community level and structural factors, such as: societal stigma associated with mental illness (Abdullah & Brown, 2011; Obasi & Leong, 2009; Wood & Newbold, 2012), inadequate resources and financial barriers (Lauber & Rössler, 2007; Obasi & Leong, 2009), particularly for immigrants (Wood & Newbold, 2012), a lack of availability of culturally competent mental health services (Al-Krenawi, 2005; Carpenter-Song, Whitley, Lawson, Quimby, & Drake, 2011; Graham, Bradshaw, & Trew, 2009; Imel et al., 2011; Kulwicki, Miller, & Schim, 2000; Wood & Newbold, 2012), a lack of accessibility to mental health services (Al-Krenawi, 2005), a general mistrust of the mental health system (Al-Krenawi & Graham, 2000; Anglin, Alberti, Link, & Phelan, 2008; Lauber & Rössler, 2007; Obasi & Leong, 2009), and a lack of health insurance (Alegría et al., 2012).

The majority of research on mental health service use and access has focused on the four major racial/ethnic minority groups in the U.S.: African Americans, Asian Americans and Pacific Islanders, Native Americans and Alaska Natives, and Hispanics. There is significantly less attention and research afforded to the wide range of other vulnerable and under-studied groups in the U.S., such as Arabs.

In the contemporary U.S., Arabs (both recent immigrants and long-standing citizens/residents who are of Arab descent) face unique challenges, stigma, and attention. However, they are also a poorly defined group and have received little attention in studies of minority groups. Part of the reason for this may stem from the fact that Arabs have typically been categorized as White, and this mis-categorization almost certainly produces erroneous and misleading research (Abdullah & Brown, 2011; Naber, 2000; Soheilian & Inman, 2009).

Arabs are increasing in numbers. Specifically, the Arab American Institute Foundation (2012) reports that between 2000 and 2010, individuals in the U.S. identified as possessing Arab-speaking ancestry grew by more than 72%. The most recent data from the Arab American Institute Foundation (2012) estimates that there are approximately 3.6 million Arabs living in the U.S. Additionally, Arabs face a unique set of challenges in the wake of 9–11 (Awad, 2010; Padela & Heisler, 2010). These challenges include a substantial and overt increase in prejudicial and discriminatory behavior and hate crimes (Abu-Raiya, Pargament, & Mahoney, 2011; Hanes & Machin, 2014; Ibish, 2001,

2003, 2008), which contribute to the development or exacerbation of symptoms of mental illness (Abu-Ras & Abu-Bader, 2009; Abu-Ras & Suarez, 2009; Amer & Hovey, 2011; Moradi & Hasan, 2004; Padela & Heisler, 2010).

This research estimates the overall levels of knowledge, skills, and awareness held by a select group of mental health providers toward Arabs. It then explores the extent to which various characteristics of individuals, their experiences, and their relationships might be related to self-reported levels of cultural competence among mental health providers (licensed clinical social workers, licensed clinical psychologists, and licensed professional counselors) working in Northern Virginia.

Study methodology

Measure development

This author developed a theoretical framework, titled *Cultural competence toward racial/ethnic minorities*, which encompassed the tenets of critical race theory, intersectionality, readiness for change, and multidimensional cultural competence [MDCC] (Sue, 2006). The development of items in the cultural competence measure was predicated upon these theoretical orientations and precepts. A three-stage process (drafting initial pool of items, focus group, and pilot study) was utilized to develop and validate a self-administered measure of multicultural competency toward Arabs, informed by the MDCC's tripartite foci of knowledge, awareness, and skills, and based on competencies set forth in the literature (Arredondo et al., 1996). This process is described elsewhere (Khoury & Manuel, 2016).

Measure description

The measure consisted of closed-ended questions on demographics, professional characteristics, sources of knowledge about Arabs, social closeness to Arabs, previous exposure to Arabs, determination of knowledge, awareness, and skills toward working with Arabs in a mental health setting, and a determination of desire for change, specifically toward increased cultural competence. Additionally, the Multicultural Counseling Knowledge and Awareness Scale [MCKAS] (Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002) was administered for convergent validity purposes.

Current study methodology

Design

This was an exploratory, descriptive, correlational study examining the existence and potential role of factors that may be related to cultural

competence toward Arabs, specifically among a sample of mental health providers working in Northern Virginia.

Participants and sampling method

This study was approved under the VCU IRB as exempt [HM20000170], meaning that, given the non-sensitive nature of the topic and the minimal risk to participants, a formal written consent was waived.

The available sampling frame consisted of the following licensed mental health practitioners residing in Northern Virginia: clinical social workers, psychologists, and counselors. The sample was restricted to this geographic region, due to the higher population of Arabs residing in that area. According to the Arab American Institute Foundation (2011), Virginia is ranked #11 of states with high Arab populations, with an estimate just under 57,000 Arab residents. From this sampling frame, 1001 individuals were randomly selected across the three professions to participate in the study (334 LCSWs, 334 Psychologists, 333 LPCs).

Response rates

The current focal population, due to their educational level as well as their experience and exposure to research, was hypothesized to be more receptive to surveys and research than the general population. Participants were given the option of completing the survey by mail and were also provided a redcap link to complete it online. The initial request for participation was done via mail. A follow-up email request to these individuals was sent to approximately 17% of participants (those who had emails available on the internet). The final n of 143 was indicative of a 14.3% response rate.

Demographics

Univariate analyses revealed a somewhat homogenous sample of respondents, particularly with regard to sex and race/ethnicity. Please see Table 1 for a final distribution of all demographic variables.

Results

Professional variables

Professional variables in this sample included number of clients during any given week, number of Arab clients (during one's career), type of client (adults, children, families, and couples), field, type of agency, agency, role, and highest degree. Please see Table 2 for a final distribution of these professional variables.

Table 1. Demographic characteristics of participants.

Variable	Frequency	Percentage %
Age (continuous)		
Range: 28–82		
Mean (SD): 52.3 (12.9)		
Sex		
Male	15	11.1
Female	120	88.9
Race/Ethnicity*		
White	114	83.8
Black	6	4.5
Asian	4	3.0
Native American	5	3.7
Pacific Islander	1	.7
Hispanic	9	6.7
Arab	4	3.0
Other	4	3.0
Race/Ethnicity (dichotomous)		
White (only)	105	73.4
Non-White (only)	29	21.6
Religious Affiliation		
Christian	68	50.4
Muslim	2	1.5
Jewish	8	5.6
Buddhist	3	2.2
Hindu	1	.7
Atheist	8	5.9
Agnostic	5	3.7
Other	13	9.6
None	27	20
Religious Affiliation (combined categories)		
Christian	68	55.7
Non-Christian	14	11.5
No religion	40	32.8

*Can select more than one category

Number of Arab clients

All these professional variables are of importance to the identification of the role they may place in levels of mental health provider cultural competence. However, to highlight a notable statistic, over half the sample (56%) indicated they had worked with six or more Arab clients during their career, suggesting that these participants, as a whole, are at least superficially familiar with this population, particularly in a professional capacity.

Overall knowledge of Arabs

To look at overall variability within the sample, this item queried participants about their overall knowledge of Arabs. Specifically, the item asked, "In general, how would you rate your level of overall knowledge of Arab culture, values, and practices?" Results indicated that a majority of this sample (66.7%) self-reported

Table 2. Professional characteristics of participants.

Variable	Frequency	Percentage %
No. of clients in any given week		
Range: 2–60		
Mean (SD):18.5 (10.3)		
No. of Arab clients (during career)		
None	11	7.8
1–5	51	36.2
6–10	33	23.4
10+	46	32.6
Type of Agency		
Private	38	26.8
Non-Profit	13	9.2
Public Agency	10	7.0
Community-Based Mental Health	16	11.3
Agency		
Hospital	1	.7
Private Practice	54	38.0
University Counseling Center	2	1.4
Forensic Setting	2	1.4
Veterans Administration	1	.7
Other	5	3.5
Role		
Case Manager	9	6.3
Administrator	4	2.8
Therapist/Clinician	121	85.2
Other	8	5.6
Client type (unique)		
Children/adolescents only	6	4.2
Adults only	35	24.55
Couples/Families only	2	1.4
Degree		
Master's	96	67.1
Doctorate	42	29.4
Field		
Social Work	43	32.8
Clinical Psychology	34	26.0
Counseling Psychology	21	16.0
Mental Health Counseling	33	26.2

*Can select more than one category

moderate or high previous knowledge of Arabs. Please see Table 3 for a final distribution of level of overall knowledge of Arabs.

Sources of previous knowledge

Participants were questioned about the level to which they gained information from television, internet, and books. The number of individuals receiving substantial knowledge from television and the internet were fairly consistent (15.4% and 14.7%, respectively). This increased with participants receiving a substantial source of knowledge from books (39.2%).

Table 3. Overall knowledge of Arabs.

Overall knowledge of Arabs	Frequency	Percentage
Extremely Low	12	8.7
Somewhat Low	34	24.6
Moderate	77	55.8
Somewhat High	10	7.2
Extremely High	5	3.6
Overall knowledge of Arabs		
Low	46	33.3
Moderate	77	55.8
High	15	10.8

Social closeness variables

Social closeness variables were consisted of items asking participants about the extent to which they know Arabs in their immediate family, extended family, professional community, or neighborhood/community.

Results indicated that no participant indicated a high degree of social closeness to each of the four levels. Approximately 26% of participants reported two or three levels of social closeness. However, 37.8% of the sample indicated no level of social closeness toward Arabs. A large number of these providers residing in a geographic area with a high population of Arabs exhibited little to no previous interactions with Arabs. It has been hypothesized that personal interactions (*cultural encounters*) with a group one is not familiar with may mitigate negative or inaccurate misconceptions about individuals in that group (Campinha-Bacote, 2002).

Readiness for change

Participants were questioned about their readiness to address cultural competence in general. Readiness for change was conceptualized as an independent variable consisting of one construct made up of four stages: pre-contemplation, contemplation, preparation/action, and maintenance.

Factor analyses

To identify whether items in a hypothesized scale measured an underlying latent construct, factor analyses were performed for both the dependent variable measuring level of cultural competence and the predictor variable measuring readiness for change.

Factor analyses — cultural competence
A series of factor analyses were conducted, revealing the best fitting structure to consist of a unidimensional scale.

Factor loadings. Using a factor loading threshold of .3, twelve items were retained, explaining 14.9% of the variance. This lower factor loading is justified due to a goal of inclusivity: previous analyses revealed that a multi-subscale structure was likely not valid. See Table 4 for a summary of items remaining in the scale, the domain from which they originated, factor loadings, and communalities.

Reliability analyses. Alpha for the overall scale was revealed to be .63. The statistical evidence is moderately strong, with 10 of the 12 items reflecting factor loadings above .4, and with adequate evidence of reliability. This unidimensional scale consisting of 12 items was titled *Cultural Competence – Arabs*, or CC-A.

Factor analysis — readiness for change

A series of factor analyses were conducted, revealing the best fitting structure conceptually and statistically to consist of a unidimensional scale, explaining 37% of the variance. Seven out of eight items loaded on the factor at a

Table 4. Items remaining in final scale (factor loadings >.3).

Initial Domain	Item	Highest Factor Loading	Communality
Knowledge	I have had little to no personal or social interactions with Arabs/Arab Americans (*reverse coded*)	.37	.14
Awareness	I respect the religious beliefs and practices that clients may have, even if I feel that they are interfering with the therapeutic relationship.	.42	.18
Awareness	Many people may hold negative attitudes, stereotypes, preconceived notions, and biases toward Arabs/Arab Americans.	.41	.17
Knowledge	I am cognizant of the role physical distance may play with an Arab/Arab American client.	.45	.20
Skills	I am comfortable seeking consultation from a traditional or indigenous faith healer to support my work with an Arab/Arab American client.	.52	.27
Skills	Family should be integrated in many levels of treatment with Arabs/Arab Americans.	.41	.17
Skills	I would be comfortable engaging the services of a third party certified translator to communicate more effectively with an Arab/Arab American client.	.41	.17
Awareness	I am aware of the historical oppression Arabs/Arab Americans have experienced.	.67	.44
Knowledge	All Arabs are Muslim.	.41	.17
Knowledge	I would encourage my Arab/Arab American clients to differentiate their individual identities from that of their families (*reverse coded*)	.47	.22
Skills	I would find it challenging to work with an Arab/Arab American female dressed in clothing where I could not see her facial features or read her body language.	.41	.17
Awareness	I believe that Arabs/Arab Americans can be simultaneously privileged and oppressed.	.37	.14

threshold of .4. Four of the seven items had factor loadings of .6 or above. Table 5 provides information about the remaining seven items.

Alpha for the overall scale was revealed to be .77. A lower score on this measure was indicative of a greater readiness for change. The statistical evidence was moderately strong, with seven of the eight items reflecting factor loadings above .4, and with strong evidence of reliability. This unidimensional scale consisting of seven items was titled *readiness for change*.

Convergent validity

Convergent validity of the CC-A with the Multicultural Counseling Knowledge and Awareness Scale [MCKAS] (Ponterotto et al., 2002) was found with a correlation of .60 (p < .01). The expectation that these two measures reflected similar yet different constructs are suggested in this correlation.

Composite scores

To reduce the impact of missing data, a mean value was utilized for the dependent variable (scores on the CC-A). Lower scores were indicative of higher levels of cultural competence. The potential scores ranged from one to five, with actual scores ranging from 1.33 to four, indicative of high variability.

Please see Table 6 for a summary of the distributions of this measure and the MCKAS.

Table 5. Items remaining in final readiness scale (factor loadings >.4).

Initial Domain	Item	Highest Factor Loading	Communality
Preparation/ Action	I am ready to meet with members of minority groups in order to learn more about their culture.	.67	.45
Preparation/ Action	I am ready to explore and clarify the origins of any biases and/or stereotypes I may hold about individuals from minority groups.	.40	.16
Preparation/ Action	I will seek out continuing education seminars, workshops, and trainings to further refine awareness of the experiences of minority groups.	.83	.69
Preparation/ Action	I will try to have conversations with peers about the importance of cultural competence.	.69	.47
Maintenance	I will endeavor to approach new situations with humility.	.53	.28
Maintenance	I interact with members of minority groups in community and neighborhood settings.	.56	.32
Maintenance	I attend trainings, seminars, and continuing education workshops in order to maintain my familiarity with minority groups.	.76	.58

Table 6. CC-A and MCKAS summary of distributions.

Measure	Mean*	SD	N	Range	Reliability
Cultural Competence	2.22	.46	143	1.3–4.0	.63
MCKAS	2.02	.55	142	1.0–4.0	.83

*lower scores are indicative of higher cultural competence

Bivariate analyses

There was a significant difference in scores along the MCKAS for Whites (M = 1.97, SD = .38) and non-Whites (M = 1.83, SD = .29); t(131) = 1.84, p = .04. Non-Whites appeared to exhibit better levels of cultural competence than Whites along the MCKAS. These findings tentatively support the hypothesis that providers who are members of a racial/ethnic minority themselves should exhibit higher levels of cultural competence.

Social closeness

Associations between social closeness variables (to what extent Arabs are part of one's familial, social, or professional group) and levels of cultural competence were explored (i.e., if one had low vs. substantial interactions with Arabs at a particular level).

Level of social closeness. With regard to levels of social closeness (whether one had zero, one, or two or more levels of closeness to Arabs as evidenced through immediate family, extended family, profession, and community), bivariate results revealed a difference (at p < .1) between the zero level social closeness group (M = 2.31, SD = .49) and the two or more level social closeness group (M = 2.08, SD = .48), along the CC-A, F(2,140) = 2.70, p = .07. Overall, these results support the hypothesis that individuals with a greater degree of closeness to Arabs would exhibit higher levels of cultural competence toward Arabs.

Overall knowledge of Arabs

With regard to self-reports of overall knowledge of Arabs, bivariate results revealed a significant difference between groups along the CC-A, F (2,135) = 12.19, p < .01. Tukey post-hoc tests revealed a significant difference between those providers rating themselves as having low knowledge of Arabs (M = 2.43, SD = .38) and those providers rating themselves as having moderate (M = 2.10, SD = .41), and high (M = 1.99, SD = .43) knowledge of Arabs. As providers self-reported increasing levels of knowledge of Arabs, scores on the CC-A progressively decreased, indicating a higher level of cultural competence.

Sources of previous knowledge — television

Bivariate results revealed a significant difference between the two groups along the CC-A, $t(141) = -.35$, $p = .02$, with those relying on television to a lesser degree exhibiting slightly higher levels of cultural competence ($M = 2.22$, $SD = .49$) compared with those relying on television to a greater degree ($M = 2.25$, $SD = .29$). These results supported the hypothesis that individuals receiving their knowledge from television would exhibit lower levels of cultural competence.

Readiness for change

To further understand the relationship between mental health provider readiness for change and levels of cultural competence toward Arabs, correlations between scores on the readiness scale and the CC-A were calculated. There was a significant relationship between the two constructs, $r = .38$, $p < .01$, in the hypothesized direction. As scores on the CC-A decreased (i.e., higher cultural competence), so did scores on the readiness for change variable (i.e. greater readiness for change). Those who exhibited a greater level of readiness for change appeared to show a higher level of cultural competence.

Multiple regression analysis

The amount of variance in levels of cultural competence, as measured by mean scores on the CC-A, explained by demographic, professional, familiarity, prior experience/knowledge, and readiness for change variables, was determined through the use of multiple regression modeling. The independent variables included in the hierarchical models were consisted of: 1) demographic variables (age, sex, race/ethnicity, religious affiliation); 2) professional variables (field, number of Arab clients); 3) familiarity variables (social closeness); 4) previous knowledge (self-reports of overall knowledge of Arabs, sources of previous knowledge, and prior travel to the Middle East); and 5) readiness for change.

Results of these five models are presented in Table 7.

Regression results

In the final, best-fitting model, mean score on the CC-A was regressed onto the demographic, professional, familiarity variables, previous experience variables, as well as readiness for change. This model yielded an R^2_{adj} of .19, which was statistically significant ($F_{18,107} = 2.63$, $p < .01$). The variables significantly (at the $p < .05$ level) associated with (predictive of) levels of cultural competence toward Arabs included previous knowledge of Arabs and readiness for change. Given that knowledge was hypothesized to only comprise a part of cultural competence, it may have been that knowledge was

Table 7. Regression results.

	Model 1	Model 2	Model 3	Model 4	Model 5
	R^2 adj. = -.30	R^2 adj. = -.03	R^2 adj. = .06	R^2 adj. = .14	R^2 adj. = .19
	$F_{5,122}$ = .26[b], p = .93	$F_{9,113}$ = .62, p = .77	$F_{11,114}$ = 1.70, p = .08*	$F_{17,108}$ = 2.20, p = .01**	$F_{18,107}$ = 2.63 p = .00***
	b^a (std. error) p	b^a (std. error) p	b^a (std. error) p	b^a (std. error) p	b^a (std. error) p
Age	.00 (.00) .96	.00 (.00) .50	.00 (.00) .70	.00 (.00) .74	.00 (.00) .80
Sex (female)	.11 (.12) .36	.08 (.12) .96	.05 (.12) .70	.04 (.12) .73	.07 (.11) .53
Non-White	.00 (.09) .98	.00 (.10) .86	.05 (.09) .56	.14 (.10) .14	.16 (.09) .08
Non-Christian	−.06 (.13) .62	.02 (.13) .63	−.04 (.13) .73	−.08 (.12) .49	−.05 (.12) .68
No religion	.03 (.09) .70	.04 (.09) .98	.02 (.09) .82	.04 (.09) .66	−.01 (.08) .90
Number of Arab clients (6+)		−.07 (.08) .42	−.03 (.08) .69	.07 (.08) .38	.08 (.08) .32
Clinical Psychology		−.10 (.10) .33	−.11 (.10) .25	−.03 (.10) .76	−.02 (.10) .82
Counseling Psychology		.02 (.12) .86	.02 (.11) .89	.06 (.11) .60	.12 (.11) .31
Mental Health Counseling		.11 (.10) .29	.13 (.10) .18	.13 (.09) .16	.15 (.09) .11
One level of Social Closeness			−.06 (.09) .47	.02 (.09) .79	.05 (.09) .60
Two + levels of Social Closeness			−.33 (.10) .00***	−.21 (.10) .04**	−.18 (.10) .08*
Low overall knowledge - Arabs				.21 (.10) .04**	.18 (.09) .05**
High overall knowledge – Arabs				−.10 (.13) .45	−.09 (.12) .47
Knowledge – TV (substantial)				−.03 (.12) .82	−.06 (.12) .59
Knowledge – Net (substantial)				−.13 (.12) .30	−.13 (.18) .28
Knowledge – Bks (substantial)				−.17 (.08) .03**	−.16 (.08) .05*
Travel to Middle East				−.14 (.09) .14	−.11 (.09) .23
Readiness for change					.22 (.08) .00***

***p < .01; **p < .05; *p < .1
[a]value indicating the number of units the DV changes as the IV changes one unit.
[b]F-tests are used to compute the significance of a set of variables to information reflected in R^2

the most superficially identifiable aspect of cultural competence. At the p < .1 level, utilizing books as a source of previous knowledge of Arabs and possessing two or more levels of closeness were significant predictors of levels of cultural competence. These and other bivariate results suggested that self-reports of prior knowledge, usage of books as a source of knowledge,

increased levels of closeness, and readiness for change all played a role in the development of cultural competence toward Arabs.

Discussion

The CC-A was shown to possess good measurement validity and consistency, as evidenced through a factor analysis, Cronbach's alpha estimate, and convergent validity with the MCKAS. Additionally, the CC-A reflected an underlying unidimensional structure, not the anticipated three domains (knowledge, awareness, and skills). Examining the 12 items that loaded on the unidimensional model, while providing only subjective evidence, revealed that these items appeared to measure a complex, nuanced, and overlapping conceptualization of cultural competence, not necessarily one in which knowledge, awareness, and skills were mutually exclusive constructs.

Taking into account the unidimensional structure of the CC-A, in combination with other significant findings from the data specific to level of social closeness and readiness for change, it appeared that these data may have better fit an alternative model of cultural competence (e.g., Campinha-Bacote's (2002) model).

This model consists of five constructs, including cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. The first three precepts of this model are consistent with the MDCC (Sue, 2006). The fourth concept, titled cultural encounters, is defined as "the process that encourages the health care provider to directly engage in cross-cultural interactions with clients from culturally diverse backgrounds" (p. 182). This notion of cultural encounters was one that resonated in these results. Campinha-Bacote (2002) argued that these interactions could influence one's extant beliefs about a particular group, and may moderate the effect of bias or stereotyping. This notion was reflected in these data, particularly around the concept of level of social closeness to Arabs. This research indicates that those with two or more levels of social closeness to Arabs exhibited significantly higher levels of cultural competence toward Arabs, compared to those who had zero levels of social closeness to Arabs.

The final precept referred to cultural desire, which was defined as "the motivation of the health care provider to *want* to, rather than *have* to, engage in the process of being culturally aware, culturally knowledgeable, culturally skillful, and familiar with cultural encounters" (p. 182). This construct appeared to reflect the notion encompassed in readiness for change.

Implications of study

These results provide valuable information on the baseline status of a subset of mental health providers. They also identify variables that relate to and

impact cultural competence. Identification of these variables can propel the field forward by further narrowing and specifying variables of interest related to cultural competence. Additionally, an assessment of readiness or desire for change could influence the use of differential interventions depending on where the provider stands in the transtheoretical stages of change model.

The development and validation of a culture-specific measure of cultural competence fills a noted gap in the research, specifically around the development of emic (culture specific) interventions (Sue, 2001). Several generic, validated, measures of cultural competence exist, but none are intended to measure cultural competence toward a particular group.

As a result of this lack of research on valid and reliable culture-specific measures, as well as on cultural competence toward Arabs in mental health in the provision of mental health services, results of this study could contribute to the development and evaluation of cultural competence interventions and outcomes.

There are potential implications with regard to clinical graduate and training programs. Specifically, adapting or modifying graduate school curriculum could entail a broader inclusion of diverse groups (to reflect an intersectional approach). It could also include additional methods of training and assessing cultural competence among students, trainees, and supervisees.

Limitations of study

Social desirability

Social desirability has been associated with self-report measures of cultural competence (Pope-Davis & Dings, 1995; Sue, 1996). In fact, Constantine and Ladany (2000) argued that self-report multicultural counseling competence scales are likely to be conflated with social desirability. The aim of ensuring that this data be anonymous was to limit the impact of social desirability. Interestingly, the option *neither agree nor disagree* was not particularly over-selected by this group. A social desirability measure was not included, primarily due to the increase in length potentially being prohibitive for participants.

Applied cultural competence

There continue to be concerns around self-report measures of cultural competence, particularly around a lack of connection to applied cultural competence (Constantine & Ladany, 2000; Sehgal et al., 2011). Additionally, counselor's self-assessments of cultural competence have not been shown to relate to clients' assessment of counselor cultural competence (Dillon et al., 2016). Additionally, studies have found no significant relationship between self-report measures of multicultural counseling competence and one's ability to conceptualize cases (i.e., demonstrated cultural

competence) (Constantine & Ladany, 2000; Ladany, Inman, Constantine, Hofheinz, & Hill, 1997).

The limitations presented in these studies point to a potential gap between attitudes and behaviors. However, attitudes comprise only one portion of behavior. The theory of reasoned action, (Fishbein & Ajzen, 2010), posits that behavioral intentions influence actual behaviors, which are in turn predicted by one's attitudes and subjective norms. This suggests that other factors (in addition to self-reported cultural competence) likely play a role in impacting culturally competent behavior.

Response rate

The low response rate may be suggestive of self-selection bias in that participants who elected to complete the survey may have significantly differed from those who did not. Responses might not have been representative in that they may not have captured the variety of diverse beliefs, attitudes, and opinions these providers may have held.

Final measure

The final composite measure consisted of a cultural competence scale with a unidimensional underlying structure. To determine the underlying dimensionality, several factor analyses were run, indicating there were potentially a number of models that could fit these results. To retain the maximum number of items, low factor loadings of .3 were utilized, potentially indicative of a weak relationship between item and factor.

Directions for future research

This study provided information on the current status of a group of mental health providers working in a geographic area with a high Arab population. Results can contribute to an exploration of additional methodologies surrounding the ability to ascertain levels of knowledge, awareness, and skills among mental health providers. In particular, this may involve exploring and utilizing multiple methodologies (both direct and indirect), particularly to address clinical skills and behavior.

In addition to the exploration of multiple methodologies assessing cultural competence (specifically related to clinical behavior), future research can involve further validation of the CC-A or the readiness for change measure, in order to more accurately identify latent constructs found within each measure. Additionally, future research can involve measure adaptation, particularly around utilizing Campinha-Bacote's (2002) model of cultural competence.

Understanding what providers currently know, as well as what current practices toward Arab clients entail, is integral in the future development and

evaluation of interventions (individual, professional, and organizational). Possible outcomes include greater participation in necessary mental health services; greater access to mental health services; receipt of higher quality mental health services, in addition to an observed improvement in client well-being.

And finally, future research can begin to focus on understanding the client perspective, particularly as it relates to accessing and remaining in mental health services. This study queried providers about their own levels of cultural competence; this data can be triangulated with client ratings of provider cultural competence. Additionally, focus groups of potential clients (i.e., Arabs) can be utilized to further understand cultural and religious nuances that may impact one's willingness to seek or remain in mental health services. Focus groups of current clients can also be useful in assessing a more holistic picture of the entry into, and the experience of, mental health treatment. The client perspective can also play a valuable role in the assessment of any cultural competence interventions. For example, the impact of an intervention can be assessed via client ratings of the counselor, or via the number of sessions the clients returned for (similar to Wade & Bernstein, 1991). It is clear that both the provider and client perspectives are of great value and should be triangulated in order to present a more holistic and accurate assessment.

References

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review*, *31*(6), 934–948. doi:10.1016/j.cpr.2011.05.003

Abu-Raiya, H., Pargament, K. I., & Mahoney, A. (2011). Examining coping methods with stressful interpersonal events experienced by Muslims living in the United States following the 9/11 attacks. *Psychology of Religion and Spirituality*, *3*(1), 1–14. doi:10.1037/a0020034

Abu-Ras, W., & Abu-Bader, S. H. (2009). Risk factors for depression and posttraumatic stress disorder (PTSD): The case of Arab and Muslim Americans post-9/11. *Journal of Immigrant and Refugee Studies*, *7*, 393–418. doi:10.1080/15562940903379068

Abu-Ras, W., & Suarez, Z. E. (2009). Muslim men and Women's perception of discrimination, hate crimes, and PTSD symptoms post 9/11. *Traumatology*, *15*(3), 48–63. doi:10.1177/1534765609342281

Alegria, M., Lin, J., Chen, C.-N., Duan, N., Cook, B., & Meng, X.-L. (2012). The impact of insurance coverage in diminishing racial and ethnic disparities in behavioral health services. *Health Services Research*, *47*(3), 1322.

Al-Krenawi, A. (2002). Mental health service utilization among the Arabs in Israel. *Social Work in Health Care*, *35*(1–2), 577–589. doi:10.1300/J010v35n01_12

Al-Krenawi, A. (2005). Mental health practice in Arab countries. *Current Opinion in Psychiatry*, *18*(5), 560–564. doi:10.1097/01.yco.0000179498.46182.8b

Al-Krenawi, A., & Graham, J. R. (2000). Culturally sensitive social work practice with Arab clients in mental health settings. *Health and Social Work*, *25*(1), 9–22. doi:10.1093/hsw/25.1.9

Aloud, N., & Rathur, A. (2009). Factors affecting attitudes toward seeking and using formal mental health and psychological services among Arab Muslim populations. *Journal of Muslim Mental Health*, 4, 79–103. doi:10.1080/15564900802487675

Amer, M., & Hovey, J. (2007). Socio- demographic differences in acculturation and mental health for a sample of 2nd Generation/Early immigrant Arab Americans. *Journal of Immigrant and Minority Health*, 9(4), 335–347. doi:10.1007/s10903-007-9045-y

Amer, M., & Hovey, J. (2011). Anxiety and depression in a post- September 11 sample of Arabs in the USA. *Social Psychiatry and Psychiatric Epidemiology*, 47(3), 409–418. doi:10.1007/s00127-011-0341-4

Anglin, D., Alberti, P., Link, B., & Phelan, J. (2008). Racial differences in beliefs about the effectiveness and necessity of mental health treatment. *American Journal of Community Psychology*, 42(1), 17–24. doi:10.1007/s10464-008-9189-5

Arab American Institute Foundation. (2011). *Virginia*. Retrieved from https://d3n8a8pro7vhmx.cloudfront.net/aai/pages/7706/attachments/original/1431630814/Virginia.pdf?1431630814

Arab American Institute Foundation. (2012). *Demographics*. Retrieved from http://www.aaiusa.org/demographics

Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development*, 24(1), 42–78. doi:10.1002/jmcd.1996.24.issue-1

Awad, G. H. (2010). The impact of acculturation and religious identification on perceived discrimination for Arab/Middle Eastern Americans. *Cultural Diversity and Ethnic Minority Psychology*, 16(1), 59–67. doi:10.1037/a0016675

Bauer, A. M., Chen, C., & Alegría, M. (2012). Associations of physical symptoms with perceived need for and use of mental health services among Latino and Asian Americans. *Social Science & Medicine*, 75(6), 1128–1133. doi:10.1016/j.socscimed.2012.05.004

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of health care services: A model of care. *Journal of Transcultural Nursing*, 13(3), 181–184. doi:10.1177/10459602013003003

Carpenter-Song, E., Whitley, R., Lawson, W., Quimby, E., & Drake, R. E. (2011). Reducing disparities in mental health care: Suggestions from the Dartmouth-Howard collaboration. *Community Mental Health Journal*, 47, 1–13. doi:10.1007/s10597-009-9233-4

Constantine, M. G., & Ladany, N. (2000). Self-Report multicultural counseling competence scales: Their relation to social desirability attitudes and multicultural case conceptualization ability. *Journal of Counseling Psychology*, 47(2), 155–164. doi:10.1037/0022-0167.47.2.155

Dillon, F. R., Odera, L., Fons-Scheyd, A., Sheu, H., Ebersole, R. C., & Spanierman, L. B. (2016). A dyadic study of multicultural counseling competence. *Journal of Counseling Psychology*, 63(1), 57–66. doi:10.1037/cou0000118

Fishbein, M., & Ajzen, I. (2010). *Predicting and changing behavior: The reasoned action approach*. New York, NY: Psychology Press.

Graham, J. R., Bradshaw, C., & Trew, J. L. (2009). Adapting social work in working with Muslim clients. *Social Work Education*, 28(5), 544–561. doi:10.1080/02615470802400729

Hanes, E., & Machin, S. (2014). Hate crime in the wake of terror attacks. *Journal of Contemporary Criminal Justice*, 30(3), 247–267. doi:10.1177/1043986214536665

Ibish, H. (2001). *1998-2000 Report on hate crimes and discrimination against Arab Americans*. Washington, D.C.: American-Arab Anti-Discrimination Committee.

Ibish, H. (2003). *Report on hate crimes and discrimination against Arab Americans: The post 9/11 backlash, 9/11, 2001-October 11, 2002*. Washington, D.C.: American-Arab Anti-Discrimination Committee.

Ibish, H. (2008). *2003-2007 report on hate crimes and discrimination against Arab Americans*. Washington, D.C.: American-Arab Anti-Discrimination Committee.

Imel, Z. E., Baldwin, S., Atkins, D. C., Owen, J., Baardseth, T., & Wampold, B. E. (2011). Racial/ethnic disparities in therapist effectiveness: A conceptualization and initial study of cultural competence. *Journal of Counseling Psychology*, 58(3), 290–298. doi:10.1037/a0023284

Jadalla, A., & Lee, J. (2012). The relationship between acculturation and general health of Arab Americans. *Journal of Transcultural Nursing*, 23(2), 159–165. doi:10.1177/1043659611434058

Khoury, D. & Manuel, J.I. (2016). The development and validation of a measurement of multicultural competence towards Arab Americans. *Best Practices in Mental Health*, 12(1), 43–60.

Kulwicki, A., Miller, J., & Schim, S. (2000). Collaborative partnership for culture care: Enhancinghealth services for the Arab community. *Journal of Transcultural Nursing*, 11(1), 31–39. doi:10.1177/104365960001100106

Ladany, N., Inman, A., Constantine, M., Hofheinz, E., & Hill, C. E. (1997). Supervisee multicultural case conceptualization ability and self-reported multicultural competence as functions of supervisee racial identity and supervisor focus. *Journal of Counseling Psychology*, 44(3), 284–293. doi:10.1037/0022-0167.44.3.284

Lauber, C., & Rössler, W. (2007). Stigma toward people with mental illness in developing countries in Asia. *International Review of Psychiatry*, 19(2), 157–178. doi:10.1080/09540260701278903

Moradi, B., & Hasan, N. T. (2004). Arab American persons' reported experiences of discrimination and mental health: The mediating role of personal control. *Journal of Counseling Psychology*, 51(4), 418–428. doi:10.1037/0022-0167.51.4.418

Naber, N. (2000). Ambiguous insiders: An investigation of Arab American invisibility. *Ethnic and Racial Studies*, 23(1), 37–61. doi:10.1080/014198700329123

Obasi, E. M., & Leong, F. T. L. (2009). Psychological distress, acculturation, and mental health-seeking attitudes among people of African descent in the United States. *Journal of Counseling Psychology*, 56(2), 227–238. doi:10.1037/a0014865

Padela, A. I., Gunter, K., Killawi, A., & Heisler, M. (2011). Religious values and healthcare accommodations: Voices from the American Muslim community. *Journal of General Internal Medicine*, 27(6), 708–715. doi:10.1007/s11606-011-1965-5

Padela, A. I., & Heisler, M. (2010). The association of perceived abuse and discrimination after September 11, 2001, with psychological distress, level of happiness, and health status among Arab Americans. *American Journal of Public Health*, 100(2), 284–291. doi:10.2105/AJPH.2009.164954

Ponterotto, J. G., Gretchen, D., Utsey, S. O., Rieger, B. P., & Austin, R. (2002). A revision of the multicultural counseling awareness scale. *Journal of Multicultural Counseling and Development*, 30(3), 153–180. doi:10.1002/jmcd.2002.30.issue-3

Pope-Davis, D. B., & Dings, J. C. (1995). The assessment of multicultural counseling competencies. In: J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 287–311). Thousand Oaks, CA: Sage.

Savaya, R. (1998). Associations among economic need, self-esteem, and Israeli Arab women's attitudes toward and use of professional services. *Social Work*, 43(5), 445–454. doi:10.1093/sw/43.5.445

Sehgal, R., Saules, K., Young, A., Grey, M., Gillem, A., Nabors, N., & Zárate, M. A. (2011). Practicing what we know: multicultural counseling competence among clinical psychology trainees and experienced multicultural psychologists. *Cultural Diversity and Ethnic Minority Psychology*, 17(1), 1–10. doi:10.1037/a0021667

Soheilian, S. S., & Inman, A. G. (2009). Middle Eastern Americans: The effects of stigma on attitudes toward counseling. *The Journal of Muslim Mental Health*, 4(2), 139–158. doi:10.1080/15564900903245766

Sue, D. W. (1996). Multicultural counseling: Models, methods, and actions. *The Counseling Psychologist, 24*(2), 279–284. doi:10.1177/0011000096242008

Sue, D. W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist, 29*(6), 790–821. doi:10.1177/0011000001296002

Sue, D. W. (2006). *Multicultural social work practice*. Hoboken, NJ: Wiley.

Wade, P., & Bernstein, B. L. (1991). Culture sensitivity training and counselor's race: Effects on black female clients' perceptions and attrition. *Journal of Counseling Psychology, 38*(1), 9–15. doi:10.1037/0022-0167.38.1.9

Wood, J., & Newbold, K. (2012). Provider perspectives on barriers and strategies for achieving culturally sensitive mental health services for immigrants: A Hamilton, Ontario case study. *Journal of International Migration and Integration, 13*(3), 383–397.