Predictors of Self-Perceived Cultural Competence Among Children's Mental Health Providers

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Based on empirical research and predictions from the Multicultural Assessment-Intervention Process model, the racial attitudes, ethnic identity, and acculturation of a national sample of 371 child mental health service providers were assessed as possible predictors of practitioner self-perceived cultural competence. It was hypothesized that ethnic identity and racial attitudes would each directly affect self-perceived cultural competence and that acculturation and racial attitudes would mediate the effect of ethnic identity. The results indicated that ethnic identity exerted a direct effect on self-perceived cultural competence and that this effect was partially mediated by respondents' racial attitudes; however, acculturation had no significant role as a mediator. The results are discussed within the context of the Multicultural Assessment-Intervention Process model and implications for providing culturally competent services to children.

Keywords: children's mental health, culture, Multicultural Assessment-Intervention Process, cultural competence

The present study examines the hypothesis that the self-perceived cultural competence of child mental health practitioners is a function of cultural variables such as ethnic/racial identity, acculturation, and racial attitudes that are identified as salient by the Multicultural Assessment Intervention Process (MAIP) model. The MAIP model serves three overlapping functions: a cultural competence model, a social justice mechanism, and a culturally sensitive service delivery paradigm. The MAIP was selected as a theoretical framework that identifies various constructs associated with fostering and encouraging cultural competence among service providers. The MAIP was designed to encompass cultural variables into culturally competent mental health service delivery by linking diverse behavioral health clients with human and material agency resources (Dana, 1993; Gamst, Liang, & Der-Karabetian, 2011; Gamst, Dana, Meyers, Der-Karabetian, & Guarino, 2009; Gamst, Rogers, Der-Karabetian, & Dana, 2006). The MAIP model has evolved to include at least seven phases of client–practitioner

multicultural parameters that have been shown to affect behavioral health service delivery. These phases are culturally sensitive intake contact, client match preference (cultural, gender, language, etc.), client multicultural status assessment (acculturation, identity, perceived discrimination), provider self-perceived cultural competence assessment, provider multicultural training, ethnic-specific and/or general interventions, and clinical outcome and service satisfaction assessment.

Within the framework of the MAIP model, self-perceptions of cultural competence are said to emerge from a combination of several experiential and attitudinal factors (Gamst & Liang, 2013; Gamst et al., 2009). For example, those child practitioners who are more sensitive to similarities and differences among diverse clients and families, who understand the personal significance of a client's ethnic or racial identity, who appreciate and respect the acculturative journey a client may have traversed, or who acknowledge and are willing to address client perceptions and experiences of racism and discrimination during the course of the therapeutic relationship might believe themselves to have greater cultural competency.

The MAIP model has been examined at both an empirical (Gamst et al., 2011) and theoretical level (e.g., Pieterse & Miller, 2010; Ponterotto, Gretchen, & Chauhan, 2001). To date, the MAIP has been used to describe how multicultural service delivery variables explain the interaction between behavioral health clients and those practitioners who deliver those services. The current study extends this analysis by proposing for the MAIP model a more explicit set of relationships among some of the factors that are said to shape self-perceived cultural competence; specifically, factors pertaining to ethnic identity, acculturation, and racial attitudes are configured in a structural model to predict the level of

self-perceived cultural competence of behavioral health service delivery professionals.

An urgent need exists for culturally competent clinicians to address the current mental health crisis in a growing population of ethnically diverse children and their families (Hernandez, Nesman, Isaacs, Callejas, & Mowery, 2006; Pumariega, Rogers, & Rothe, 2005; Tolan & Dodge, 2005). Members of culturally diverse ethnic groups are vulnerable to service deficiencies such as differential forms of treatment, invalid psychosocial assessments, and early treatment dropout rates (Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Clinicians who are culturally competent, that is, those who are knowledgeable about the cultural world of their clients, and aware of their own personal cultural values, may contribute to increased service utilization of ethnically diverse families across all systems of care in children's mental health.

There is currently a scarcity of research on the impact on cultural competence of the cultural characteristics and personal experiences of the therapists, particularly among providers of mental health services for children (Liu & Clay, 2002; Tummala-Narra, Singer, Li, Esposito, & Ash, 2012). Providing culturally competent mental health services to children requires a unique understanding and skill set. For example, Liu and Clay (2002) have emphasized that effective service delivery to children must be coupled with identifying the salient and relevant cultural facts (e.g., ethnic/racial identity, acculturation, gender) implicit in the child's worldview and cultural value system. The MAIP model provides one possible systematic approach to the integration of cultural factors into treatment of children in the area of behavioral health.

The present study focuses on essential MAIP cultural variables (ethnic/racial identity, acculturation, racial attitudes) affecting provider self-perceived cultural competence, with the goal to provide more knowledge about the various individual and interpersonal variables that are assumed to contribute to child practitioner cultural competence. Such knowledge is crucial because of the genuine paucity of empirical work in this regard, coupled with the fact that children from diverse cultural backgrounds are more vulnerable to misdiagnoses from inaccurate assessments (Dana, 2007). In order to systematically link child provider characteristics with their perceived cultural competence, we briefly review the existing research concerning the effects of the three sets of child provider characteristic constructs (ethnic/racial identity, acculturation, and racial attitudes) on self-perceived cultural competence together with social desirability effects.

Provider Self-Perceived Cultural Competence

Culturally competent mental health and primary health care service delivery practice to clients and patients has been a fairly consistent goal over the past three decades (Gamst & Liang, 2013; Smedley, Stith, & Nelson, 2003; Sue et al., 1982; Sue, Zane, Hall, & Berger, 2009). Efforts to achieve these goals have generated numerous cultural competence models (Mollen, Ridley, & Hill, 2003) and associated instrumentation (Gamst et al., 2011), with unrealized clinical impact on research, practice, and training (Gamst & Liang, 2013).

Early cultural competence conceptualizations focused on practitioner characteristics (e.g., knowledge, skills) or service delivery (e.g., culturally sensitive intakes, cultural diagnostic formulations) practices (e.g., Arredondo et al., 1996; Sue et al., 1982; Sue, Arrendondo, & McDavis, 1992). More recent conceptualizations (Gamst et al., 2011; Hernandez, Nesman, Mowery, Acevedo-Polakovich, & Callejas, 2009) have viewed cultural competence as an interaction between the cultural characteristics, values, and needs of a community on the one hand and the mental health agency policies, procedures, and structures that are situated to provide social justice-oriented mental health services on the other hand.

One set of cultural characteristics, related to practitioner cultural competence and worth noting at this juncture, is the construct of universal-diverse orientation (UDO) of Miville et al. (1999). UDO, and its operationalization, (the Miville-Guzman Universality-Diversity Scale) is designed to measure an individual's awareness and acceptance of similarities and differences in others. Culturally competent practitioners need to be both aware of client similarities and also understand and appreciate client differences (see Constantine et al., 2001; Fuertes & Gelso, 2000; Thompson, Brossart, Carlozzi, & Miville, 2002; Yeh & Arora, 2003).

A number of valid self-report multicultural competence measurement instruments are now available to researchers and practitioners (Gamst et al., 2011). For the most part, these instruments reflect the early concerns about provider cultural beliefs, attitudes, cultural knowledge, and culturally appropriate clinical intervention skills. A comprehensive review of these instruments is beyond the scope of the present study and can be found elsewhere (e.g., Gamst & Liang, 2013).

Provider Ethnic/Racial Identity

The concepts of racial and ethnic identity have had a long and sometimes tumultuous history in the clinical and counseling psychology literature (Ponterotto & Park-Taylor, 2007). An individual's ethnic identity encompasses a sense of affiliation coupled with the degree of emotional significance invested in identifying with his or her ethnic group (Bernal, Knight, Garza, Ocampo, & Cota, 1990; Phinney, 1990, 1992, 2003). Ethnic identity is also related to an integration of one's cultural customs and traditions, history, and spiritual or religious influences with existing societal norms and perceptions (Chae & Larres, 2010; Trimble, 2007). In contrast, racial identity addresses how racial minorities develop their self-image within the context of an often racist society (Cross, 1991, 1995; Helms, 1990, 1995; Ponterotto & Park-Taylor, 2007). Evidence indicates that racial identity development is stimulated by exposure to racism during adolescence (Quintana, 2007).

Ethnic and racial identity are clearly distinct constructs (Helms, 2007), but they do appear to have at least three points of common ground (Gamst et al., 2011; Ponterotto & Park-Taylor, 2007). First, both constructs emphasize "belongingness" to a social group based on perceived characteristics. Second, both constructs address possible positive and negative attitudes developing toward both one's social group and other groups. Third, these constructs tend to vary in importance across time and context (Helms & Talleyrand, 1997; Phinney & Ong, 2007).

The relationship of provider racial/ethnic identity and provider self-perceived cultural competence has received little attention in the literature. For example, Ladany, Inman, Constantine, and Hofheinz, 1997 found that the racial identity of counseling supervisors

(both White American and persons of color) was significantly positively related to self-reported multicultural competence.

Provider Acculturation

Acculturation can be viewed as a process of individual changes within behavioral, cognitive, and affective domains that people experience due to cross-cultural contact (Gamst et al., 2011; Rivera, 2008). Individuals acculturate from their culture of origin to their new culture within a social–economic context. Gamst et al. (2011) suggested that these contextual factors include volitional intent (e.g., study abroad), fluidity (e.g., colonization), perpetuity (e.g., duration of stay), pecuniary aspects (e.g., availability of financial aid), oppression (e.g., racism and discrimination), sociodemographics (e.g., occupation), and similarities between the two cultures (e.g., linguistic similarities).

Within this acculturative context, lifestyle interacts with psychological factors for both the new culture and the culture of origin (Gamst et al., 2011; Lam, 1995). Facets of the lifestyle dimensions include language, daily habits, living arrangement, ethnic norms/heritage, social relationships, political affiliations, and religious affiliation. Lam (1995) has argued that these lifestyles facets interact with the three psychological dimensions of acculturative change of attitudes or values, knowledge or cognition, and behavior or personal practice.

Findings regarding the relationship between client (or provider) acculturation and perceptions of provider cultural competence have been limited and mixed; some studies have reported little or no effects of acculturation (Atkinson, Casas, & Abreu, 1992; Gim, Atkinson, & Kim, 1991), whereas others (Dettlaff & Rycraft, 2006) have emphasized the importance of this construct in affecting clinical practice with children.

Provider Racial Attitudes

Racial attitudes of providers encompass a broad spectrum of generalized positive and negative beliefs and attitudes, as well as stereotypes (prejudice) and its manifestations such as racism in social practice (Allport, 1954; Gamst et al., 2011). The development of racial attitude inquiry can be characterized in terms of three successive waves of empirical research (Dovidio, 2001). In the first wave (prior to 1950), investigators viewed negative racial attitudes (e.g., prejudice) as a form of individual psychopathology due to pathological personality development or overuse of certain defense mechanisms (e.g., displacement). The 1950s ushered in the second wave of racial attitude research where prejudice was considered to be a normative process. Instead of an individual-level of focus, macrolevel influences were examined, leading to investigations of aversive racism (i.e., unintentional acts of discrimination, Gaertner & Dovidio, 1986), modern racism (i.e., overt racial stereotyping, McConahay, 1986), and symbolic racism (i.e., attributing an entire race with negative attributes, McConahay & Hough, 1976; Sears & Henry, 2005). The third wave of empirical research emerged in the 1990s in which racial attitudes were considered with respect to both the holder and the target of racial prejudicial messages. One example of this research attempted to identify the cognitive processes (psychological and physiological) involved in stereotype formation and the responses to perceived racism (e.g., Utsey, Ponterotto, Reynolds, & Cancelli, 2000).

This progression of racial attitude research has been guided by complimentary theoretical frameworks. Research that focused on individual-level differences initially embraced psychodynamic perspectives (e.g., Adorno, Frenkel-Brunswik, Levinson, & Sanford, 1950). Gordon Allport's (1954) seminal monograph helped provide the transitional content for developing social–cognitive (Hamilton, 1981) and social–identity (Tajfel & Turner, 1986) perspectives on racial attitudes. More recent theoretical frameworks have linked racial attitudes and physical and psychological health through biopsychosocial perspectives (Brondolo, Gallo, & Myers, 2009) and transactional stress (Harrell, 2000).

Recent empirical work has demonstrated a link between racial attitudes and self-perceived cultural competence of mental health providers. For example, Loya (2011) found that White American practitioners having higher levels of color-blind attitudes (Neville, Lilly, Duran, Lee, & Browne, 2000) were less likely to be aware of racial privilege and blatant racial issues. Further, practitioners receiving cultural diversity training were statistically significantly more aware of racial privilege and blatant racial issues by the end of the course.

Provider Social Desirability Effects

Social desirability bias, where respondents answer items with socially desirable answers that may not reflect their true attitudes, can threaten the validity of self-report measures (Gamst, Meyers, Burke, & Guarino, in press). Such contamination may result in spurious or suppressed covariance and biased response distributions (Ganster, Hennessey, & Luthans, 1983; Presser & Stinson, 1998). Group differences in racial attitude self-reports have often been attributed to social desirability bias (Stocǩ, 2007).

Several theoretical approaches have been proposed to explain social desirability effects. Rational choice theory suggests that respondents use impression-management strategies to gain social approval from others (Tourangeau, Rips, & Rasinski, 2000). Alternatively, unconscious respondent motivations to generate a positive self-image may also drive social desirability effects (Paulhus, 2003). Whether driven by impression management or self-deception, it is important to control for social desirability contamination when measuring provider self-reported cultural competence (Gamst & Liang, 2013).

The Present Study

The MAIP model identifies the racial attitudes of child mental health service providers, ethnic identity, and acculturation, as contributors to self-perceived cultural competence. The purpose of the present study was to evaluate a model of hypothesized relationships between these variables that was based on the MAIP formulation.

The hypothesized model is presented in Figure 1. We presumed from the MAIP model that Ethnic Identity and Racial Attitudes each would directly affect Self-Perceived Cultural Competence. Specifically, it was proposed that those who had a stronger ethnic identity and those who were less blind to racial bias and discrimination issues would perceive themselves as having greater levels of cultural competence.

Ethnic Identity was also hypothesized to exert indirect effects on Self-Perceived Cultural Competence in two ways. First, it was
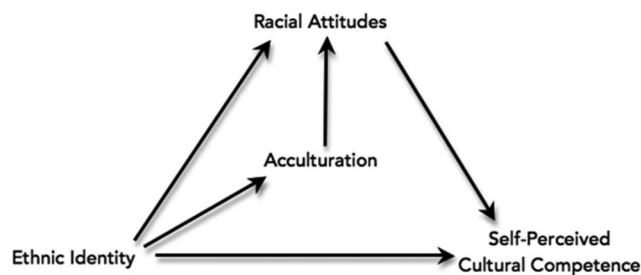
Figure 1. The hypothesized model based on the MAIP framework.

proposed that it would act through Racial Attitudes; specifically, those who reported a stronger Ethnic Identity were expected to exhibit lower levels of color blindness to racial bias and discrimination issues, which in turn would result in higher levels of Self-Perceived Cultural Competence. Second, it was proposed to act through Acculturation to partially drive Racial Attitudes that would, in turn, partially drive Self-Perceived Cultural Competence.

Method

Sample and Participant Selection

The present study was based on data from a national sample of children's mental health providers consisted of 371 participants, with 59 men and 312 women. Participant age ranges were as follows: 24 years and under (67%), 25–34 years (48.8%), 35–44 years (19.1%), 45–54 years (12.4%), 55–64 (12.7%), and 65 years and over (0.3%). The sample consisted of mostly White American (71.3%), with other ethnicities distributed as follows: Latino/a American (10.0%), African American (4.6%), Asian American (7.1%), Pacific Islander (0.8%), Native American Indian (0.3%), other (5.6%), and unknown (0.3%). Participants' education included doctoral degree (29.1%), master's degree (60.9%), bachelor's degree (8.6%), high school diploma (0.6%), and other degree (0.8%). In terms of linguistic ability, 75.7% of the participants spoke English only, 21.3% were bilingual, and 3.0% indicated they were multilingual. Roughly half (53.8%) of the participants were trained in "multicultural coursework." Two thirds of the participants (66.4%) had "attended multicultural workshops." Almost two thirds of the participants (60.7%) had 7 years or less of mental health experience, and about half (52.5%) had 7 years or less working with multicultural children or working with multicultural clients (55.0%).

Participants were recruited through the listservs for the Society of Clinical Child and Adolescent Psychology, Division 53 of the American Psychological Association (APA); Society of Counseling Psychology, Division 17 of the APA; the Asian American Psychological Association; National Latina/o Psychological Association; the Society for the Psychological Study of Culture, Ethnicity, and Race, Division 45 of the APA; and DIVERSEGRADS, a public listserv for psychology graduate students who are dedicated to working with culturally diverse populations. These listservs were specifically targeted for the present study because of their diverse psychologist practitioner clientele.

Prospective participants were invited to complete an online questionnaire designed to gain a better understanding of the cultural characteristics of children's mental health service providers. Participants were informed that their participation was voluntary and that their responses would be anonymous. As an incentive, all participants received a $5.00 electronic gift card (e-card) to Amazon.com within 24 hr of completing the survey.

Measures

The online questionnaire contained 121 items comprising a demographic sheet, three questions regarding experience in the mental health field, and six scales.

Demographic sheet. The demographic sheet contained items regarding the participant's gender, age, ethnicity, education, preferred language, multicultural training, multicultural course work, multicultural counseling workshops, and years of mental health experience working with multicultural clients and with children.

Ethnic identity. Provider ethnic identity was measured with the Multigroup Ethnic Identity Measure-Revised (MEIM-R) scale (Phinney & Ong, 2007). The MEIM-R was designed to measure ethnic identity across diverse racial and ethnic groups. The six-item scale is comprised of two evenly divided subscales measuring commitment and exploration. Participants responded to the six statements using a 5-point summative response scale that ranged from 1 (*strongly disagree*) to 5 (*strongly agree*). The Ethnic Identity Commitment subscale (MEIMEIC) reflects the participants' sense of belonging and attachment to their ethnic group; an example statement is, "I have a strong sense of belonging to my own ethnic group." The Ethnic Identity Exploration subscale (MEIMIE) reflects the level to which participants engage in activities that lead to obtaining information and experiences about their ethnicity; an example statement is, "I have spent time trying to find out more about my ethnic group."

Scores were averaged on each subscale such that higher values indicated greater levels of commitment and exploration. Prior research has documented consistent reliability and validity of MEIM-R subscale scores (e.g., Lee & Yoo, 2004; Yancey, Aneshensel, & Driscoll, 2001), but occasional exceptions have been noted (Worrell, Conyers, Mpofu, & Vandiver, 2006). In the present study, the scores of the Exploration and Commitment subscales yielded Cronbach's alpha values of .89 and .90, respectively.

Acculturation. Provider acculturation was measured with the Stephenson Multigroup Acculturation Scale (SMAS; Stephenson, 2000), which assesses the level of immersion into the dominant and ethnic culture across diverse groups. Participants responded to 32 statements assessing individual attitudes and behaviors involving language, food, social interaction, and media. The 32 items break down into a 17-item Ethnic Society Immersion (ESI) subscale and a 15-item Dominant Society Immersion (DSI) subscale. The ESI subscale measures participants' identification with their culture of origin; an example statement is, "I know how to speak my native language." The DSI subscale measures the participants' identification with the dominant culture; an example item is, "I speak English with my spouse or partner." The SMAS is scored on a 4-point summative response scale (1 = *false*, 2 = *partly false*, 3 = *partly true*, and 4 = *true*). Means were calculated for each subscale, with lower values reflecting greater acculturation.

Recent research has documented high reliability of diverse responses to the scale (Harvey, Fischer, Weieneth, Hurwitz, & Sayer, 2013; Schwartz et al., 2013). For this investigation, the Cronbach's alpha reliability coefficients were .94 for the ESI subscale and .59 for the scores of the DSI subscale. Because of the relatively low reliability, the DSI subscale was eliminated from all subsequent analyses in the present study.

Racial attitudes. The Color-Blind Racial Attitudes Scale (CoBRAS; Neville et al., 2000) served as the measure of provider racial attitudes. The CoBRAS assesses attitudes and beliefs about the salience of race and perceived racism as well as the level to which individuals deny the social ramifications of race. The CoBRAS consists of 20 items representing three subscales. The Unawareness of Racial Privilege subscale (CoBRASUP) measures the amount of awareness of individual racial privilege (e.g., "White people in the United States have certain advantages because of the color of their skin"). The Institutional Discrimination subscale (CoBRASID) assesses attitudes regarding social policies or racist and discriminatory actions (e.g., "English should be the only official language in the United States."). The Blatant Racial Issues subscale (CoBRASBRI) measures the saliency of the racism construct to the individual (e.g., "Talking about racial issues causes unnecessary tension"). Participants were asked to rate their agreement of each racial attitude statement using a 6-point summative response scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*).

Validity for the CoBRAS has been established through positive correlations with other measures of racism, discrimination, and racial injustice (Neville et al., 2000) with a 2-week test–retest reliability for the CoBRAS total scale score of .68 (Neville et al., 2000). The present data yielded alpha coefficients of .73, .77, and .82 for the CoBRASUP, CoBRASID, and CoBRASBRI subscales, respectively.

Cultural competence. Provider self-reported cultural competence was measured with the California Brief Multicultural Competence Scale (CBMCS; Gamst et al., 2004). The 21-item CBMCS was selected because of its brevity, its evaluation as one of the more consistently reliable and valid cultural competence measures available in the literature (Gamst & Liang, 2013; Ponterotto, Utsey & Pedersen, 2006), and its unique inclusion of the Sociocultural Diversities subscale, which explores confidence in working with other cultural dimensions such as gender, socioeconomic status, sexual orientation, age, and ability.

The CBMCS was designed to measure the self-perceived cultural competency of mental health providers. Participants responded to 21 items that examined their self-reported cultural competence utilizing a 4-point summative response scale that ranged from 1 (*strongly disagree*) to 4 (*strongly agree).* Four subscales comprise the CBMCS, each representing a conceptually and theoretically salient component of cultural competence.

The Sociocultural Diversities subscale (CBMCSSD) consists of seven items that measure the providers' level of confidence working with other dimensions of culture such as gender, socioeconomic status, sexual orientation, age, and ability; an example item is, "I have an excellent ability to assess accurately the mental health needs of gay men." The Awareness of Cultural Barriers (CBMCSACB) subscale consists of six items that measure the providers' awareness of White privilege, the influence of personal cultural values, and beliefs about minority status; an example item

for this subscale is, "I am aware that counselors frequently impose their own cultural values on minority clients." The five items of the Multicultural Knowledge subscale (CBMCSMK) measures how conversant the provider is regarding multicultural research, the awareness of the impact of culture on psychological assessment tools, and the ability to discuss cultural issues; an example item from this subscale is, "I have an excellent ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons with different cultural/racial/ethnic backgrounds." The Sensitivity and Responsiveness to Consumers (CBMCSSRC) subscale is composed of three items that assess the providers' response to the client or consumer; an example item from this subscale is, "I am aware that my values might affect the client."

Prior research with the CBMCS (Gamst et al., 2004, 2009) has shown high reliability and evidence of validity of responses to the subscale scores. For this data set, the Cronbach's alpha reliability coefficients for the CBMCSSD, CBMCSACB, CBMCSMK, and CBMCSSRC subscales were .84, .82, .80, and .53. Because of the relatively low reliability, the CBMCSSRC subscale was eliminated from all subsequent analyses in the present study.

Social desirability. Provider social desirability bias was measured with the Marlowe-Crowe Social Desirability Scale-Short form (MCSDS-SF; Reynolds, 1982). The MCSDS-SF measures the tendency to submit a response that is socially acceptable, indicating a need for approval. Participants responded to 13 true–false statements such as, "I sometimes try to get even rather than forgive and forget." Scores were totaled, with higher scores indicating a social desirability response tendency. Numerous studies have reported consistently high levels of reliability with this measure (e.g., Li & Sipps, 1985). For the present study, internal consistency as measured by Cronbach's alpha was .76.

Analysis Plan

In the present study, IBM SPSS 20.0 was used to examine the data for missing values, to analyze data distribution and skewness patterns, and to conduct correlation analyses for preliminary comparisons. The Shapiro–Wilk and Kolmogorov–Smirnov tests indicated that all of the study's variables had approximately normal distributions (ps > .05). Assessments for linearity, independence of observations, and homoscedasticity indicated no statistical assumption violations. Social desirability contamination appeared to be minimal in the present data set.

Following some exploratory factor analyses, Amos 20.0 was used to evaluate the fit of the data to the hypothesized structural model. Several fit indices were used to assess whether the model was a good fit for the data: chi square, root mean-square error of approximation (RMSEA), goodness-of-fit index (GFI), normed fit index (NFI), and the comparative fit index (CFI). We relied on values of at least .95 for the CFI, NFI, and GFI and .08 or below for the RMSEA as indicators of the model being a good fit to the data (Meyers, Gamst, & Guarino, 2013). Although a nonsignificant chi square is preferred, this test is too powerful for most studies and was not weighted very heavily for the judgment of model fit (Byrne, 1989).

Results

Table 1 presents the means, standard deviations, and correlations of all key variables in the present study. The subscales within the MEIM-R were moderately correlated, those within the CoBRAS were somewhat strongly correlated, and those within the CBMCS tended to be moderately correlated. The four CBMCS subscales did not correlate appreciably with the practitioner experience variables of having received training in a multicultural counseling training program, having participated in a multicultural workshop, and the number of years of mental health experience, with the rs ranging from $-.02$ to $-.15$.

Preparing the Structural Model

In preparing to configure a structural model to predict self-perceived cultural competence, an evaluation was made of the relationships among the nine scales achieving an acceptable level of reliability (two MEIM-R subscales, three CoBRAS subscales, three CBMCS subscales, and one SMAS subscale). Of particular interest was the Awareness of Cultural Barriers subscale of the CBMCS. Although one aspect of the construct of Self-Perceived Cultural Competence is the recognition of cultural barriers faced by minority individuals (Gamst et al., 2004), the item content of that subscale (e.g., "being born White affords certain advantages," "minorities face challenges that Whites do not face") appeared to overlap considerably with the domains assessed by the color-blind racial attitudes items of the CoBRAS subscales (e.g., "race is important in determining success," "racial and ethnic minorities have fewer opportunities than Whites in this country") as both inventories tap into the issue of being aware of obstacles faced by minorities.

To determine with which latent variable in the structural model the Awareness of Cultural Barriers subscale might be most appropriately associated, the nine subscales were subjected to a principal components analysis with a promax rotation. Because we were hypothesizing that there were three latent constructs assessed by the main inventories (ethnic identity measured by the MEIM-R scales, racial attitudes as measured by the CoBRAS subscales, and

self-perceived cultural competence as measured by the CBMCS subscales), a three-component solution was specified. All three components yielded eigenvalues in excess of 1.00 and cumulatively accounted for almost 69% of the total variance. As expected, each rotated principal component was associated with subscales from a different inventory with the exception of the Awareness of Cultural Barriers subscale of the CBMCS; this subscale correlated most strongly (-.757) with the rotated component associated with the CoBRAS subscales, whereas its correlation with the component capturing the CBMCS subscales was substantially less (.563). Based on this finding, and acknowledging its "cross-loading," it was decided that it could be best represented in the model by linking it to the latent variable representing racial attitudes. The SMASESI did not substantially correlate with any of the rotated components and so was placed as a stand-alone measured variable in the model.

Configuring the Structural Model

The configured structural model is presented in Figure 2. The two subscales of the MEIM-R (MEIMEIC and MEIMIE) were specified as indicators of Ethnic Identity; the three CoBRAS subscales (CoBRASUP, CoBRASID, and CoBRASBRI) together with the CBMCSACB subscale of the CBMCS were specified as indicators of Racial Attitudes; and the CBMCSSD and the CB-MCSMK subscales of the CBMCS were specified as indicators of Self-Perceived Cultural Competence.

Evaluating the Structural Model

The initial analysis, performed with IBM SPSS Amos version 20.0, suggested that the model as configured was not a good fit, chi square (23, $N = 370$) = 128.549, $p < .001$, GFI = .932, NFI = .894, CFI = .910, RMSEA = .112. However, the error terms for the indicator variables in the initial model were all treated as being uncorrelated, a presumption that often is not realistic (e.g., Brown & Moore, 2012; Kline, 2011). Because it is frequently difficult to determine in advance which correlations between errors are ap-

Table 1
Correlation Coefficients Among Variables Used to Predict Self-Perceived Cultural Competence Among Children's Mental Health Providers (N = 371)

Variable	1	2	3	4	5	6	7	8	9	10	M	SD
1. Sociocultural	—	.35**	.55**	−.05	−.05	−.13*	.18**	.28**	.13*	.18**	2.79	.49
2. Awareness		—	.50**	−.57**	−.44**	−.55	.22**	.29**	.02	−.05	3.32	.40
3. Knowledge			—	−.21**	−.23**	−.27**	.26**	.39**	.12*	.09	2.79	.49
4. Unawareness				—	−.55*	.65**	−.05	−.16**	.04	.20**	19.87	5.94
5. Institutional					—	.63**	−.08	−.27**	.05	.03	19.32	5.65
6. Blatant						—	−.13*	−.05	−.00	.10	11.87	3.48
7. Commitment							—	.72	.12	.12*	3.58	.90
8. Exploration								—	.05	.11*	3.63	.88
9. Acculturation									—	.14**	2.99	.87
10. Desirability										—		

Note. Sociocultural = CBMCS Sociocultural Diversities; Awareness = CBMCS Awareness of Cultural Barriers; Knowledge = CBMCS Multicultural Knowledge; Unawareness = CoBRAS Unawareness of Racial Privilege; Institutional = CoBRAS Institutional Discrimination; Blatant = CoBRAS Blatant Racial Issues; Commitment = MEIM-R Ethnic Identity Commitment; Exploration = MEIM-R Ethnic Identity Exploration; Acculturation = SMAS Ethnic Immersion; Desirability = social desirability.
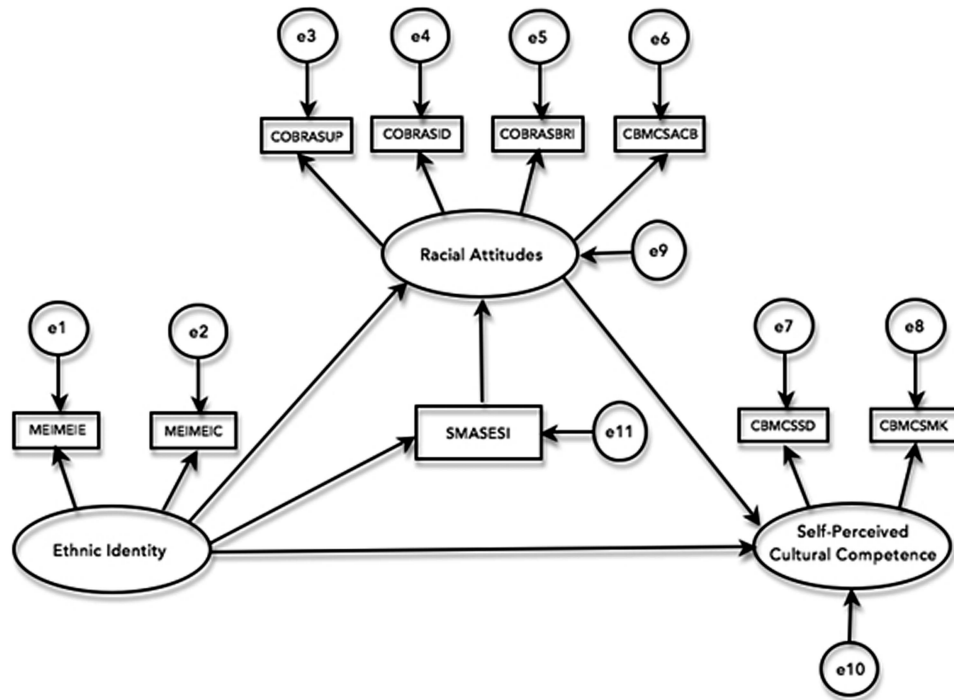* $p < .05$. ** $p < .01$.

Figure 2. The hypothesized structural model as it was configured with the measured variables.

propriate to specify in an initial model configuration, the modification indexes provided by the software were used as guides to identify correlations between error terms that were potentially appropriate to be added to the model to improve model fit; we limited such correlations to error terms of indicator variables that were within the same hypothesized latent variable.

Evaluating the Modified Structural Model

The respecified model, together with the path coefficients and squared multiple correlations, is shown in Figure 3. Model fit was improved by specifying correlations between four pairs of errors associated with the indicators of Racial Attitudes, and the statistically significant correlations are shown in the figure. Including these correlations still yielded a statistically significant chi square (19, $N = 370$) $= 56.136$, $p < .001$), but because the chi square statistical test is quite sensitive to sample size, other indexes were also used to assess the quality of model fit (Bentler, 1990; Jöreskog & Sörbom, 1996). The values of the GFI, NFI, CFI, and RMSEA were .968, .954, .968, and .073, respectively; these values all would be interpreted as suggesting that the model was a good fit to the data (Schreiber, Nora, Stage, Barlow, & King, 2006; West, Taylor, & Wu, 2012).

Although a good level of fit was obtained only after some modifications were made to the initial model, thus adding an exploratory element to the model-testing process, three sets of results are worth noting. First, as can be seen in Figure 3, the standardized path coefficients associated with the SMASESI subscale assessing acculturation were essentially zero, as Ethnic Identity did not predict acculturation and acculturation did not predict Racial Attitudes. Second, Ethnic Identity directly predicted both

Racial Attitudes (standard path coefficient $= -.24$, unstandardized regression coefficient $= -.826$, $SE = .234$) and Self-Perceived Cultural Competence (standard path coefficient $= .34$, unstandardized regression coefficient $= .117$, $SE = .025$). Third, Racial Attitudes also directly predicted Self-Perceived Cultural Competence (standardized path coefficient $= -.44$, unstandardized regression coefficient $= -.044$, $SE = .007$). The magnitudes of all of these path coefficients were judged to be practically significant, and the squared multiple correlations obtained for Racial Attitudes and Self-Perceived Cultural Competence were .06 and .38, respectively.

The standardized value of the indirect effect of Ethnic Identity through Racial Attitudes on Self-Perceived Cultural Competence was .106. One common way to test the statistical significance of the indirect effect is to use the Aroian (1947) test, one of the variants of the Sobel (e.g., Sobel, 1982, 1986) test family. The Aorian test yielded a z value of 3.049, $p = .002$, indicating that the indirect effect was statistically significant. If the assumption is made that the model is reasonably fully specified, then it is possible to meaningfully ascertain the extent to which Racial Attitudes mediated the influence of Ethnic Identity on Self-Perceived Cultural Competence. Such an evaluation rests on the presumption that Ethnic Identity predicts Self-Perceived Cultural Competence in isolation (i.e., in an unmediated model), and the results from an analysis of the unmediated model did yield a statistically significant path coefficient (standardized path coefficient $= .42$, $p < .001$).

With a path coefficient of Ethnic Identity to Self-Perceived Cultural Competence in the unmediated model of .42 (unstandardized regression coefficient $= .138$, $SE = .032$) and a path coeffi-
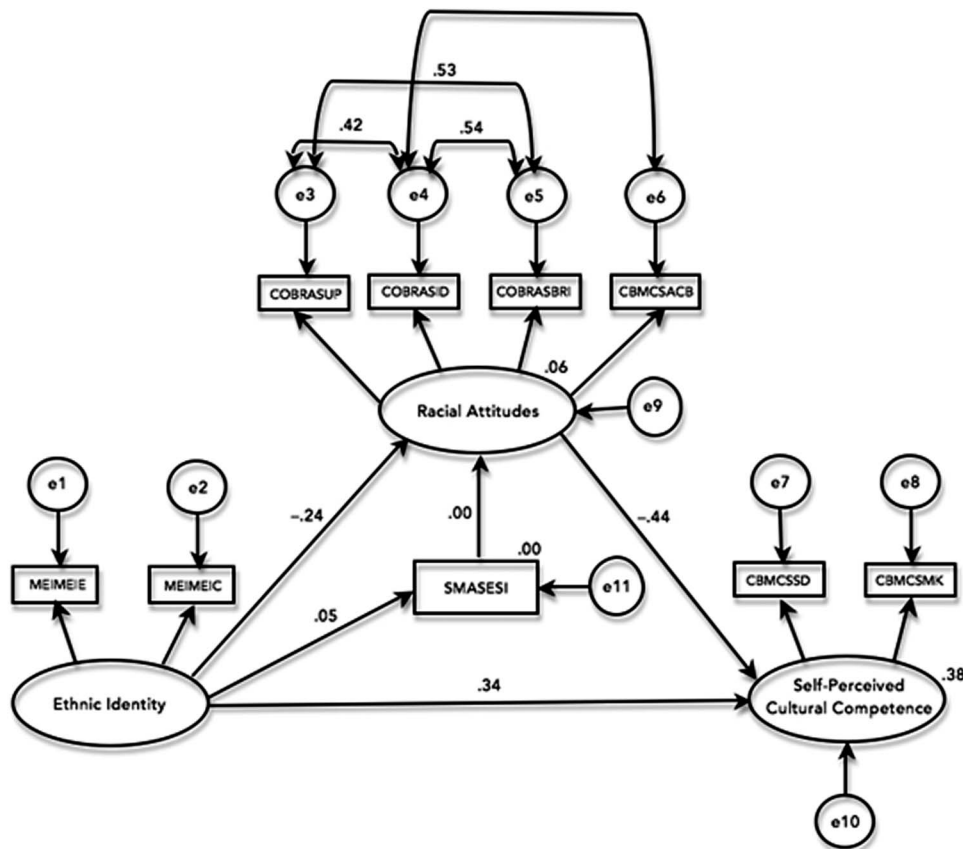
Figure 3. The results of the structural model after correlating some error terms associated with the indicators of Racial Attitudes.

cient in the mediated model of .34 (unstandardized regression coefficient = .117, *SE* = .025), it appears that partial mediation might have occurred. That possibility was tested using the Freedman and Schatzkin (1992) procedure to compare the strengths of the two coefficients. The results of the Freedman-Schatzkin test indicated that the path coefficient from Ethnic Identity to Self-Perceived Cultural Competence in the mediated model was significantly lower than the corresponding coefficient in the unmediated model, $t(368) = 5.70$, $p < .001$, signifying that a partial mediation effect was observed. Based on the ratio of the strength of the indirect effect (.106) to the strength of the direct effect (.42), it is estimated that approximately 25% of the effect of the Ethnic Identity on Self-Perceived Cultural Competence is mediated through Racial Attitudes.

In summary, it appears that Ethnic Identity assessed with the MEIM-R exerted a direct effect on Self-Perceived Cultural Competence as measured with the CBMCS. That effect was partially mediated by taking into consideration the Racial Attitudes of the respondents as measured by the CoBRAS. Acculturation appears to have had virtually no impact in this structure, at least as assessed in the present sample.

Discussion

The present study provides support for a mediation model of the effects of cultural characteristics on child mental health providers'

self-perceived cultural competence. The structural model, informed by the MAIP framework, supported the predicted direct relationships between Ethnic Identity and Racial Attitudes and Self-Perceived Cultural Competence, a finding consistent with previous research (e.g., Ladany et al., 1997; Loya, 2011). Child mental health providers who had higher levels of ethnic identity and who were less "blind" to the racial oppression of others were more likely to see themselves as having greater levels of cultural competence.

We also found that Ethnic Identity (as measured by the MEIM-R subscales) directly affected Self-Perceived Cultural Competence (as measured by the CBMCS subscales); however, this effect was partially mediated by the practitioners' Racial Attitudes (as measured by the CoBRAS subscales). In practice, this finding suggests that understanding the role of White privilege and societal racism in combination with a willingness to scrutinize and allocate cognitive resources regarding one's ethnic background enhances the amount of claimed cultural competence variance explained. Specifically, it appears that higher levels of ethnic identity coupled with a greater understanding of the effects of White privilege and racism are related to higher levels of practitioner self-perceived cultural competence.

Our findings underscore the important relationship between color-blind racial attitudes and self-perceived cultural competence (e.g., Loya, 2011). By implication, these results suggest that more

effective work with culturally diverse children occurs when the provider is aware of White privilege and other cultural barriers and acknowledges the ramifications of pervasive and blatant racism in our society. Furthermore, our findings extend the research of Neville et al. (2000), who found greater levels of color-blind racial attitudes to be related to lower self-reported levels of multicultural counseling knowledge and awareness as well as a reduced ability to competently conceptualize the cases of culturally diverse clients.

The general predictive utility of the MAIP model is evidenced with the present results. The MAIP postulates the synchronization of provider (and/or client) multicultural elements assumed to affect the therapeutic relationship. The present structural model explicates the role of essential child provider cultural characteristics (e.g., ethnic identity, racial attitudes) and its relationship to self-perceived cultural competence.

The SMAS Ethnic Immersion subscale, our measure of provider acculturation in the present study, did not correlate substantially with the indicators of the three latent variables. The lack of any consistent acculturation effect may be more a function of the predominantly White American sample (71%) than an inconsistency in the model specification. This lack of effect, possibly attributable to the composition of sample itself, suggests that future iterations of the MAIP model should perhaps be empirically fine-tuned for each ethnic/racial group.

The present results also indicate that one of the CBMCS facets of self-perceived cultural competence (Awareness of Cultural Barriers) is more strongly correlated with the Racial Attitudes latent construct. The three CoBRAS subscales (Unawareness of Racial Privilege, Institutional Discrimination, and Blatant Racial Issues) clearly share commonality with the (CBMCS) Awareness of Cultural Barriers subscale. This outcome, while unexpected, is not entirely surprising, because practitioner racial attitudes and awareness have been noted as crucial constituents in the development of cultural competencies and sensitivity (Sue et al., 2009; Mollen, Ridley, & Hill, 2003). It is also congruent with and extends the research of Neville et al. (2000), who found greater levels of color-blind racial attitudes to be related to lower self-reported levels of multicultural counseling knowledge and awareness as well as a reduced ability to competently conceptualize the cases of culturally diverse clients. Further confirmation of these results comes from Iwamasa (1996); Komarraju and Cokley (2008); Mahalik, Worthington, and Crump (1999), and Manoleas, Organista, Negron-Velasquez, and McCormick (2000), who found that client conceptualization and interaction with clients is enhanced by the racial attitudes and world views of the mental health provider. These findings suggest that those children's mental health providers who endorse equality, selflessness, and a commitment to the greater good tend to be more cognizant of the challenges that face culturally diverse children and their families.

Finally, our findings have implications for the training of child mental health practitioners. The results of this study suggest that exploration and assessment of provider racial attitudes, ethnic identity, and acculturation strategies are appropriate as part of the training process, increasing the understanding of the complex intersection of cultural competence and provider personal characteristics. Of particular importance are the results from this study that address the relationship between color-blind racial attitudes and self-perceived cultural competence. The implications here are

as expected: that more effective work with culturally diverse children occurs when the provider acknowledges the ramifications of pervasive racism in our society. Multicultural training programs (e.g., Dana, Gamst, & Der-Karabetian, 2008) as well as clinical supervisors have an obligation to assess and increase awareness of the limitations of denying or minimizing the impact of culture by assuming a color-blind stance. Children's mental health providers also have an ongoing responsibility to engage in self-awareness strategies in order to combat these attitudes.

An increase in culturally competent mental health providers is said to be one response to children's mental health disparity and increased service utilization (Chang, Ritter, & Hays, 2005; Huang et al., 2005; Tolan & Dodge, 2005). Cultural competence implies a critical understanding of how culture affects the mental health of children in addition to the ability to provide culturally sensitive and responsive treatment. Limited understanding of cultural factors on the part of mental health providers contributes to the psychological misdiagnosis of children of color. Because of this country's growing population of ethnic minority children and their families, there is an increased need for culturally responsive children's mental health care. The present findings emphasize some of the relevant individual and interpersonal factors of the children's mental health provider that serve as predictors to self-perceived cultural competence.

Limitations and Future Directions

Although a national convenience sample of child mental health providers was obtained, no attempt was made to sample with respect to a stratification strategy. Thus, our findings may have limited generalizability to all child practitioners. Because the variety of participant occupation was not determined in the present study, the range of services provided and participant general experience is unknown and may have impacted participant overall self-evaluations of cultural competency. Further, by using a self-report measure of the cultural competence construct (e.g., Constantine, 2001; Worthington, Mobley, Franks, & Tan, 2000), it is possible that respondents may still have exhibited a tendency to select or offer a more politically or socially appropriate response beyond the bias presumably screened for by our social desirability measure.

Overall, the results of this study provide some direction for further work with child mental health practitioners based on the MAIP model. Future research might examine specifically how MAIP model factors such as ethnic identity, acculturation, and racial attitudes predict self-perceived cultural competence for various racial/ethnic groups (e.g., African American, Latino/a American, Asian American). The present study may also provide the foundation for future research involving the predictors of cultural competence (Gamst & Liang, 2013) embedded in a social justice framework, specifically among children's mental health providers.

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