INTERNATIONAL JOURNAL OF PSYCHOLOGY AND PSYCHOLOGICAL THERAPY 2011, 11, 2, pp. 201-218

Racial Identity Development and Multicultural Counseling Competencies of White Mental Health Practitioners

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ABSTRACT

The underlying premise of this study is the belief that racial identity development is essential to the framework of multicultural counseling competency. Structural equation modeling was used to test the merit of this hypothesis among White mental health practitioners (professional counselors, counseling psychologists and clinical psychologists). There was a positive significant association between the Pseudo-Independence status of White Racial Identity and Multicultural Counseling Competencies. Women practitioners perceived themselves to be more culturally competent than men. Results are reported with respect to individual practitioner groups. Implications for multicultural counseling training, practice, and research are discussed.

Key words: white racial identity, multicultural counseling competency, mental health practitioners.

RESUMEN

La premisa subyacente en este estudio es la creencia de que el desarollo de identidad racial es imprescindible en el marco de la competencia orientativa psicológica multicultural. El modelo de ecuación estructural se usó para analizar el mérito de esta hipótesis en los profesionales de salud mental de raza blanca (orientadores profesionales, psicólogos asesores y psicólogos clínicos). Se observó una asociación positiva y significativa entre el estatus de Pseudo-Independencia de la Identidad Racial Blanca y las Compentencias en Orientación Multiculturales. Las mujeres profesionales se percibieron a sí mismas como más competentes culturalmente que los hombres. Los resultados se informan con respecto a grupos de profesionales. Se discuten las implicaciones para la orientación y la práctica e investigación multiculturales.

Palabras clave: identidad racial blanca, competencia de asesoramiento multicultural, profesionales de salud mental.

Racial identity is an important dimension that mediates the counseling relationship (Karl Kwan, 2001). The literature provides evidence that personal aspects of the individual influence the multicultural counseling competency of mental health practitioners. Gender (Carter, 1990; Pope-Davis & Ottavi, 1994), educational level (Ottavi *et al*., 1994;

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Sabnani *et al*., 1991), and age (Holcomb-McCoy & Myers, 1999; Pope-Davis & Ottavi, 1994) are shown to be related to racial identity development (RID) and multicultural counseling competency (MCC). Carter (1990) and Pope-Davis and Ottavi (1994) found that women reported greater comfort with racial interactions and issues than did men. In a study of white racial identity development of counseling graduate students, White racial identity development, educational level, and clinical experiences demonstrated moderate correlations with multicultural counseling competencies (Ottavi, Pope-Davis, & Dings, 1994). Among a sample of clinical psychologists, gender was also found to be an indicator of self-reported multicultural counseling competency; women reported greater levels of multicultural competency when compared to men in a earlier study conducted by Middleton *et al*. (2005). The current study is embedded within part of a larger program of study (Middleton et al., 2005) and provides advanced analysis of the data in order to further examine the relationships between racial identity development and multicultural competencies of white mental health practitioners.

Multicultural counseling consists of practice between or among individuals from different backgrounds based on race, ethnicity, ability, sexual orientation, religion, national origin and culture (Sue, 2001). Sue, Bernier, Durran, Feinberg, and Pedersen, (1982) portray multicultural counseling competency across three domains. The first, Attitudes/Beliefs, speaks to the ability to examine personal biases and stereotypes and an awareness of how counselors' preconceptions may negatively impair effective service delivery. The second, Knowledge, references counselors' understanding of their own worldview, the historical and current sociopolitical influences that may impact their clientele, and specific knowledge of the cultural groups they serve. The third factor, Skills, relates to interventions and strategies helpful in working with specific groups. A fourth aspect examined by Sodowsky, Taffe, Gutkin, and Wise (1994), not studied as often, is Relationship -the counselor's interaction process with minority clients (e.g., comfort level, worldview, and counselor's trustworthiness). Racial identity development is an important element in developing multicultural counseling competencies.

Racial identity theory (RIT) helps us to understand how people interpret messages received about race. RIT also allows us to gain insight into how people view themselves as racial beings and how people view persons from other racial groups different than their own. The development of one's racial identity has a bearing on the ability of the individual to modify and interpret messages received about race in light of one's experiences. White racial identity development (WRID) models (Hardiman, 1982; Helms, 1990; Ponterotto, 1988; Sabnani, Ponterotto, & Borodovsky, 1991) provide a means for understanding and representing how White individuals develop a nonracist White identity.

There is a range of empirical literature grounding the study of racial identity development -RID and its importance to multicultural counseling competency- MCC (Helms, 1984, 1995; Ottavi, Pope-Davis, & Dings, 1994; Sabnani *et al*., 1991; Tokar & Swanson, 1991; Vinson & Neimeyer, 2000, 2003). The vast majority of empirical research examining the relationship between RID and MCC focuses on counselors and psychologists in training (D'Andrea, Daniels, & Heck, 1991). Research exploring how WRID emerges among professional counselors and psychologists practicing in the field is nearly non-existent. It is important to examine the RID and MCC of White mental

health professionals, as they continue to represent a significant majority of those working in the field (APA, 2002).

The framework upon which this study is based is grounded in Helms' (1990) racial identity theory. Thus, this study explores how personal aspects of the individual, in combination with racial identity, contribute to the counselors' and psychologists' multicultural counseling competency. The underlying premise of this research is the belief that one's personal attributes and identity are not mutually exclusive from one's professional perspective or identity as a mental health practitioner. Consequently, racial identity development is believed to be an essential component of MCC. The racial identity of the individual is not mutually exclusive from one becoming a culturally competent mental health practitioner. The transtheoretical framework upon which this study is based is described below and presented in Figure 1.

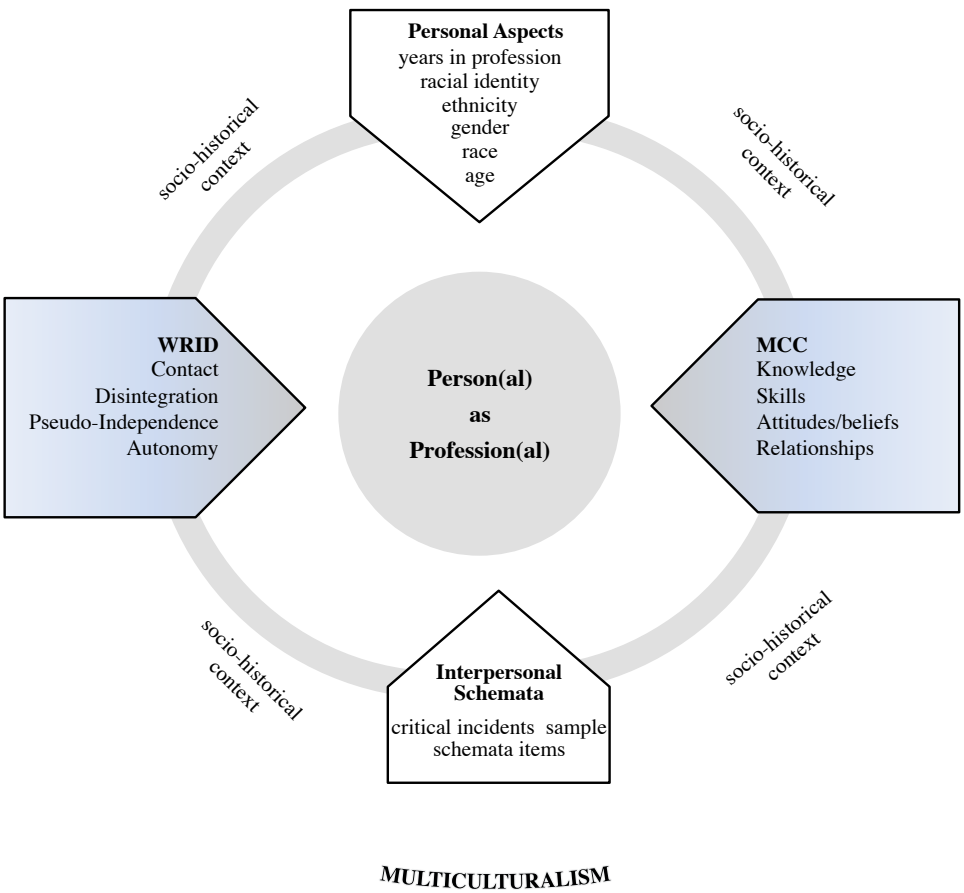

Figure 1. The Person(al)-As-Profession(al) (P-A-P) Transtheoretical Framework. WRID= White Racial Identity Development, MCC= Multicultural Counseling Competencies (Del Signore *et al*., 2010).

In an effort to identify factors that contribute to MCC, including RID, the authors utilized a transtheoretical framework identified as the Person(al)-As-Profession(al) or P-A-P model (DelSignore *et al*., 2010). The term transtheoretical is used to convey the multiple approaches used to conceptualize human interactions i.e., biological, environmental, cognitive, and psychosocial. As illustrated in Figure 1, the core components of the framework in this study are shaded and identified as WRID and MCC. Person(al) aspects of the individual intersect and together shape various aspects of the professionals' MCC (knowledge, skills, attitudes/belief, relationships) and ultimately their proficiency in contributing to an environment that supports multiculturalism.

As Figure 1 illustrates, the model we describe has four dimensions -Personal Aspects, RID (WRID), MCC, and Interpersonal Schemas- that contribute to an understanding of the Person as a mental health professional, who influences the mental health profession. The interpersonal schemata dimension of the P-A-P transtheoretical framework describes how one uses cognitive and psychodynamic processes to conceptualize racial aspects of interpersonal interactions. Schemas of "the other" result from interpersonal interactions and focuses on the individual's development of the view of others as racial beings. This differs from the WRID dimension, where the focus is on self as a racial being. Another element of the P-A-P transtheoretical framework is the socio-historical context which focuses on the historically situated context of the person and professional. The lived experiences of the individual's development as a person and professional are embedded in the sociohistorical context, which includes, but is not limited to, forces such as values and upbringing of family of origin; exposure to cultural diversity in the work, social, educational, and living environment; experiences of discrimination and victimization; access to societal resources (jobs, housing, education, medical care, etc.); social movements in a particular historical era; political climate; and religious affiliation. Multiculturalism frames the entire model as attaining multiculturalism is the ultimate goal. For our purposes, we define multiculturalism in the clinical setting as the existence of a prevailing and vitalizing environment originating from effective intra- and intercultural exchanges (Middleton, Flower, & Zawaiza, 1996).

Helms' theory on White Racial Identity Development (WRID) describes the developmental process of racial identity across six ego statuses. Racism is central to each of the six statuses, with an emphasis on the moral dilemmas an individual faces in clinical and social interactions (Helms, 1990). Helms and Carter (1990) indicate that the abandonment of racism ends with the status of Reintegration and that defining a positive White identity begins with the status of Pseudo-Independence (P-I). The statuses develop sequentially, reflecting increasing levels of complexity and sophistication both within the individual and with regard to understanding racial issues.

The Contact status is exemplified by satisfaction with the racial status quo and obliviousness to racism and one's participation in it. Disintegration status represents disorientation and anxiety provoked by irresolvable racial moral dilemmas that force one to choose between own-group loyalty and humanism. Reintegration status includes reversal or regression of the idealization of one's socioracial group and the denigration and intolerance of other groups. Here racial factors may strongly influence life decisions. The status of Pseudo-Independence manifests itself by an intellectualized commitment

to the White socioracial group and deceptive tolerance of other groups. The Immersion/ Emersion status is marked by a search for an understanding of the personal meaning of racism and the ways in which one benefits from White privilege. From this status, a redefinition of Whiteness occurs and life choices may incorporate racial activism. The last status, Autonomy, is described as an informed positive socioracial group commitment, use of internal standards for self-definition, and a capacity to relinquish the privileges of racism. At this status, the individual avoids life options that require participation in racial oppression.

The purpose of this study is to explore the extent to which personal variables; age, gender, educational level, practitioner group, and racial identity influences Multicultural Counseling Competency (knowledge, skills, attitudes/beliefs, relationship). This study uses empirical data to assess the potential differences among three mental health practitioner groups (professional counselors, counseling psychologists, and clinical psychologists). Structural equation modeling (SEM) is the statistic of choice that enables us to engage in the simultaneous analysis of the entire system of variables, while obtaining explicit estimates of the error variance parameters. However, SEM is not used to infer causation. This method allows us to draw a clearer conceptualization of WRID and MCC.

The current study is the first to examine the WRID among practicing clinical and counseling psychologists. The current article provides additional analysis of the data obtained in Middleton *et al*. (2005), using SEM, to answer the following model fit question: Do the data fit the model of specified demographic variables and White Racial Identity Development (WRID) effects on Multicultural Counseling Competency (MCC) for individual professional practitioner groups (professional counselors, counseling psychologists, and clinical psychologists) and the combined group of mental health practitioners?

Method

Participants

As a second analysis of data presented in Middleton *et al*. (2005), the sample demographics in the current investigation are identical. The population of study in Middleton *et al*. was White American mental health practitioners working in the field. Participants also met the following criteria for inclusion in this study: a) master's and/ or doctoral degrees, b) clinical and counseling subfields only, c) certified practitioners only, d) self-identified as White Americans, and e) all geographic regions of the U.S. Subjects surveyed in this study were obtained from the membership rosters of the American Counseling Association (ACA, *N*= 61,905) and American Psychological Association (APA, *N*= 55,218). Each organization released a pool of 3,000 geographically distributed and randomly selected names and addresses. Potential respondents consisted of approximately 300 practitioners from each of the 10 geographic regions in the U.S. for both ACA and APA. It is quite possible that participants held memberships with both the ACA and APA; however, what was more important for data analysis and interpretation purposes was the professional group identity of the participant. A total of 5,603 surveys

were mailed (3,000 to ACA members and 2,603 to APA members). There was a total response rate of 11%, however, the researchers excluded surveys from individuals who did not self identify as white, resulting in 412 surveys. On a demographic questionnaire, participants self-identified as a member of one of the following professional groups: professional counselors (*n*= 163 or 40%), counseling psychologists (*n*= 70 or 17%), and clinical psychologists (*n*= 179 or 43%). Of those responding, 49% (*n*= 201) were members of ACA and 51% (*n*= 211) were members of APA. At the time of this study, the American Counseling Association did not provide workforce data on the ethnicity or race of counselors, therefore self-identification was used as a criteria. Participants ranged in age from 23 to 81 years of age, with a mean age of 47.99 years (*SD*= 10.59). Of the 412 participants, 265 were female (64%) and 146 were male (35%); one participant did not report gender. Participation in the study was anonymous and voluntary.

The regional breakdown of the pool of 3,000 was New England, 8%; Middle Atlantic, 12%; East/West North Central, 22%; South Atlantic, 23%; East/West South Central, 15%; Mountain, 10%; and Pacific, 9%. It was not possible to chart the geographical area of the responding participants, so only the initial geographic breakdown is known. ACA's membership is 71% female and 29% male. In our sample of ACA respondents (*n*= 201), 74% were female and 26% were male, and 83% reported having the master's degree as their highest terminal degree; approximately 17% reported having a doctoral degree. Employment characteristics for ACA members in this study were as follows: private counseling centers, 31%; school setting, 21%; university setting, 17%; and community agency, 16%. The remaining 15% worked in government agencies, rehabilitation agencies, colleges or business settings. Average time in the profession was 10 years (*SD*= 8.78). In this study, 92% of the counselors responding reported having a master's as their terminal degree.

Potential respondents identified by APA consisted of 3,000 members, of whom 2,603 (87%) were White Americans. Surveys were mailed to all regional locations: New England (11%), Middle Atlantic (19%), East/West North Central (22%), South Atlantic (15%), East/West South Central (10%), Mountain (6%), and Pacific (17%). Again, it was not possible to chart the geographical area of the responding participants; only the initial geographic breakdown is known. Employment characteristics for APA members were independent practice, 55%; hospital, 13%; clinic, 6%; university settings, 6%; and other human services, 20%. Our sample of APA respondents (*n*= 211) was 44% male and 54% female with an average of 20 years in the profession (*SD*= 8.43). This is an inversion of the gender breakdown of the original 2,603 APA members surveyed, with 54% male members and 46% female members. More specifically, among counseling psychologists, 53% were male, 47% were female, and 88% of them reported having doctoral degrees. Among clinical psychologists, 39% of respondents were male, 62% were female, and 98% of them reported having doctorates as their terminal degree.

Procedure

Mailing labels were obtained in response to telephone and written communication to ACA and APA explaining the purpose of the study. Once the mailing labels were

obtained, a cover letter outlining the purpose and intent of the study was mailed to members on the mailing list. Along with the cover letter of information, the WRIAS, MCI, and the Demographic Questionnaire were mailed to each listed individual with a request to answer anonymously and voluntarily. Three months after the initial mailing, a reminder postcard was sent to each person on the initial mailing list. Participants were asked to contact by e-mail, telephone, or fax if they required an additional survey package. Only those self-identifying as White were included in the study.

Instruments

White Racial Identity Attitude Scale (WRIAS). The 50 self-report items of the WRIAS (Helms & Carter, 1990) designed to assess the 5 racial identity attitude statuses proposed by Helms (1984) include the following: (a) Contact, (b) Disintegration, (c) Reintegration, (d) Pseudo-Independence (P-I), and (e) Autonomy. Participants used a 5-point Likert scale, ranging from strongly disagree (1) to strongly agree (5), to describe themselves. Each of the 5 subscales consists of 10 items; thus total subscale scores may range from 10 to 50. Scores are calculated by adding the point values of the responses for each of the subscales. To maintain the scale metric, each subscale sum was divided by 10. However, to keep results consistent with Helms (1990) and other researchers reporting mean scores obtained in their use of the instruments (Ottavi *et al*., 1994; Burkhard *et al*., 1999; Tokar & Swanson, 1991), we did not divide our scores by 10. Internal consistency reliability coefficients in an initial investigation of the WRIAS by Helms and Carter (1990) achieved Cronbach alphas of .55, .77, .80, .71, and .67 for the WRIAS Contact, Disintegration, Reintegration, P-I, and Autonomy scales, respectively. In our current study, coefficient alpha reliabilities calculated for test scores of the 5 WRIAS scales were as follows: .60, .77, .74, .83, and .79 for the WRIAS Contact, Disintegration, Reintegration, P-I, and Autonomy scales, respectively.

Multicultural Counseling Inventory (MCI). This 40-item self-report inventory (Sodowsky *et al*., 1994) assesses behaviors and attitudes related to 4 multicultural competencies on a 4-point Likert scale from very inaccurate (1) to very accurate (4). Scale scores are obtained by adding the items specific to each subscale. Higher subscale scores indicate greater multicultural competence in the respective subscale areas. The four areas of multicultural competency are as follows: Awareness, 10 items measuring multicultural sensitivity, interactions and advocacy in general life experiences, and professional activities; Knowledge, 11 items measuring treatment planning, case conceptualization, and multicultural counseling research; Skills, 11 items measuring general counseling and specific multicultural counseling skills; and Relationship, 8 items measuring the counselor's interaction process with minority clients (e.g., comfort level, worldview, and counselor's trustworthiness). Internal consistency reliabilities (Cronbach's alphas) reported by Sodowsky *et al*. (1994) were .80 for Multicultural Awareness, .80 for Multicultural Counseling Knowledge, .81 for Multicultural Counseling Skills, and .67 for Multicultural Counseling Relationship, and .86 for the full scale. Coefficient alpha reliabilities for the 4 subscales in our study were .79 for Multicultural Awareness, .76 for Multicultural Counseling Knowledge, .73 for Multicultural Counseling Skills, .52 for Multicultural Counseling Relationship, and .79 for the full scale. These reliability coefficients closely approximate the reliabilities reported by Sodowsky *et al*. (1994).

Demographic questionnaire. The demographic questionnaire elicited participants' age, gender, highest degree earned, year highest degree earned, professional identity, and

racial-ethnic origin. In this study, only the data generated from participants who self-identified as White European Americans was analyzed.

RESULTS

Before any analyses began, the Mahalanobis distance method was used to check for any multivariate outliers. This test for multivariate normality compares the difference between the empirical distribution of the squared robust distances and the distribution function of the chi-square. Overall, results suggested that there are no cases with extreme values and independent variables were normally distributed. Correlations among the variables studied are presented in Table 1 for the combined group of practitioners. The MCI subscales significantly correlated with all 4 WRIAS subscales included in the structural equation model (SEM) except for the Contact subscale, therefore it was excluded from the model.

Data were analyzed using a structural equation modeling (SEM) software package, Analysis of Moment Structures (Amos 4.0, Arbuckle & Wothke, 1999). In developing the model for the path analysis, we made certain assumptions about which variables would affect others and the directionalities of these effects. We replaced missing data with the mean score for the specified variable. The analysis tested the structural relations hypothesized in Figure 2. Of primary interest is the extent to which our hypothesized model fits or describes the sample data. Assessment of model fit takes into account multiple considerations, including statistical and practical factors. It is important to use multiple criteria to assess model fit because of the influence of sample size on various fit indices. Convergence of several criteria of fit increases confidence in the viability of the hypothesized model. In this study, model fit was assessed by using the chi-square likelihood ratio statistic (χ^2), the comparative fit index (CFI), the normed fit index (NFI), the chi-square minimal degrees of freedom (CMIN/DF), and the root mean square error of approximation (RMSEA).

Theoretically, the statuses in Helms' (1995, 1997) model of White Racial Identity Development (WRID) must be examined as a whole, not separately or in isolation. Therefore, it was necessary for our model to account for the interrelationships among

Table 1. Intercorrelations of Demographic Variables, WRAIS Subscale, and MCI Subscales for All Groups Combined (Middleton *et al*., 2010).

	Age	Gender	Years in Profession	Contact	Dis-integration	Re-integration	Pseudo-independence	Autonomy
Age								
Gender	-.19**							
Years in Profession	.65**	-.26**						
Contact	.06	.05	-.05					
Disintegration	-.10*	-.04	-.09	.15**				
Reintegration	-.04	-.01	-.04	.05	.65**			
Pseudoindependence	-.01	.06	-.09	.14**	-.48**	-.35**		
Autonomy	.06	-.09	.09	.10*	-.53**	-.40**	.59**	
MCI Total	-.06	.15**	-.09	.10	-.19**	-.18**	.35**	.26**

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

**Correlation is significant at the 0.01 level (2-tailed).

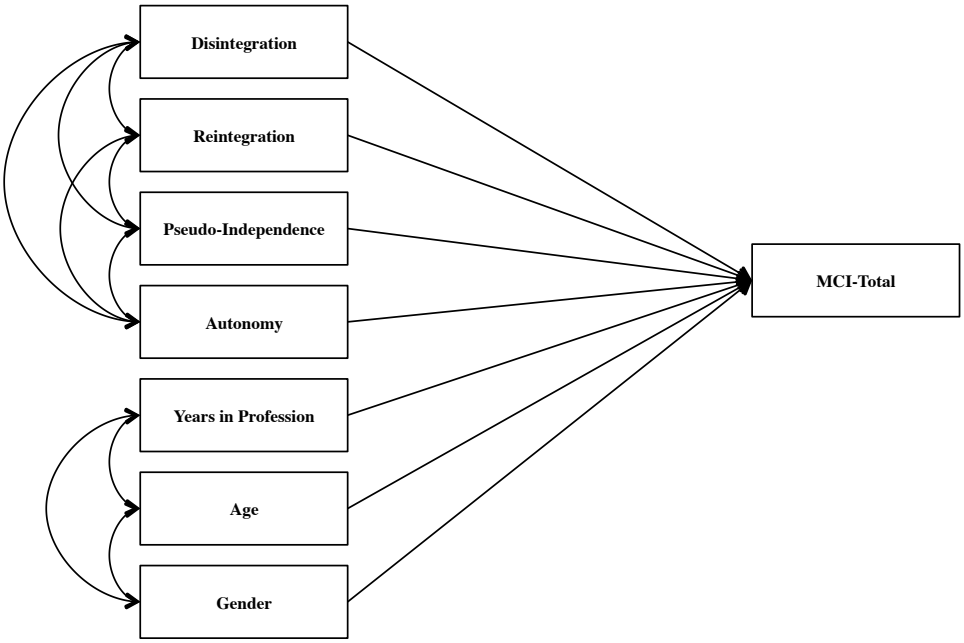

Figure 2. Structural equation model (Del Signore *et al*., 2010).

the WRID scales. Because it is not possible to co-vary endogenous variables, the errors were co-varied and WRID was placed as an endogenous variable. The initial model contained 3 exogenous variables (age, gender, and years in the profession). Exogenous variables are those variables not explained by a casual model whose variance is accounted for by other variables outside of the model, referred to as an independent variable in multivariate analysis (Mertler & Vanatta, 2002). There are two endogenous variables (WRID and the MCI) in the model. To keep the model simple, we placed MCI as a latent variable. As such, the relevant MCI subscales (relationship, awareness, skills, and knowledge) were linked to the total score of the MCI, thereby making their measurement possible.

As seen in Figure 2, there were eight parameters in our model: years in the profession (PRO-YEAR); age; gender; four of the WRAIS statuses, including Disintegration (DIS), Reintegration (REIN), Pseudo-Independence (PSEU), Autonomy (AUTO); and the multicultural counseling inventory (MCI). Relationship (RELA), Skills, Awareness (AWAR), and Knowledge (KNOW) are placed as latent indicators of MCC as measured by the MCI. Our model emphasized paths leading from the demographic characteristics (age, gender, and years in profession) to statuses of WRID and MCI and from WRID to MCI.

Table 2 provides a summary of the results of the fit statistics associated with the modified model. The chi-square statistic is a measure of the overall fit of the specified model to the data (Jöreskog & Sörbom, 1996). Typically, the chi-square value should be small and non-significant so that it fails to reject the null hypothesis, indicating a

Table 2. Fit Statistics Associated with the Modified Model (*N*= 412) (Middleton *et al*., 2010).

	χ^2	*df*	*p*	CFI	NFI	CMIN/DF	RMSEA
			Full Population				
Initial Model	14.45	11	0.209	0.998	0.997	2.96	0.171
			Professional Group Fit				
Group 1. Counseling Psychologist	27.22	11	0.004	1.00	0.994	0.983	0.07
Group 2. Clinical Psychologist	4.77	11	0.94	1.00	0.997	1.15	0.029
Group 3. Counselors	14.44	11	0.20	0.998	0.996	1.77	0.069

good fit. However, the chi-square statistic is not always a good indicator of model fit, especially with larger samples. It tends to take on larger values and therefore may result in a misleading interpretation of the data. In this instance, the original model generated (See Figure 3) produced a significant chi-square value, χ^2 (12, *N*= 412)= 35.459, *p*= .000, *CFI*= .998, suggesting that the model did not fit the data. The CFI is a normal fit index, ranging from 0 to 1.0; values of .90 or greater indicate that a model shows substantial improvement over the null model. Simulations presented by Bentler and Bonett (1980) indicated that the CFI provides an accurate portrayal of relative model fit, particularly in the context of small sample sizes. The NFI is another fit measure with an analogous rationale. The value of the NFI also indicates the proportion in the improvement of the overall fit of the model relative to a null model; however, it is sensitive to the choice of the baseline model used with specified multiple models. The CMIN/DF, or the chi-square divided by the degrees of freedom, should be relied on more than the chi-square when samples are large. Research experts (Arbuckle & Wothke, 1999; Marsh & Hocevar, 1985; Wheaton, Muthén, Alwin, & Summers, 1977) indicate that generally ratios in the range of 2 to 1 or 3 to 1 are indicative of an acceptable fit between the hypothetical model and the sample data. Arbuckle and Wothke (1999) generally suggest that a value of about .08 or less for the RMSEA would indicate a reasonable error of approximation as a general rule of thumb in determining model fit. According to Arbuckle and Wothke (1999), accepting a RMSEA at a value equal to or less than .05 is based on subjective judgment and cannot be regarded as infallible or correct. With respect to the current study, the RMSEA of .171 also suggests a poorly fitting model.

Based on these findings of poor model-fit indices, an alternative, modified model was developed; age and years in the profession were excluded from the SEM as they were not found to be significant in contributing to model fit. Gender remained an exogenous variable. Once again, the MCI remained a latent variable in the measurement model such that Skills, Awareness, and Knowledge were unobserved variables as indicators of the MCC. The relationship subscale of the MCI has poor reliability; therefore, it was dropped to produce a better fit for the model. A covariance path between Skills and Knowledge was included. This path assumed no sequence or causal direction between these two variables. Paths from gender to WRID and MCC formed the SEM. The new

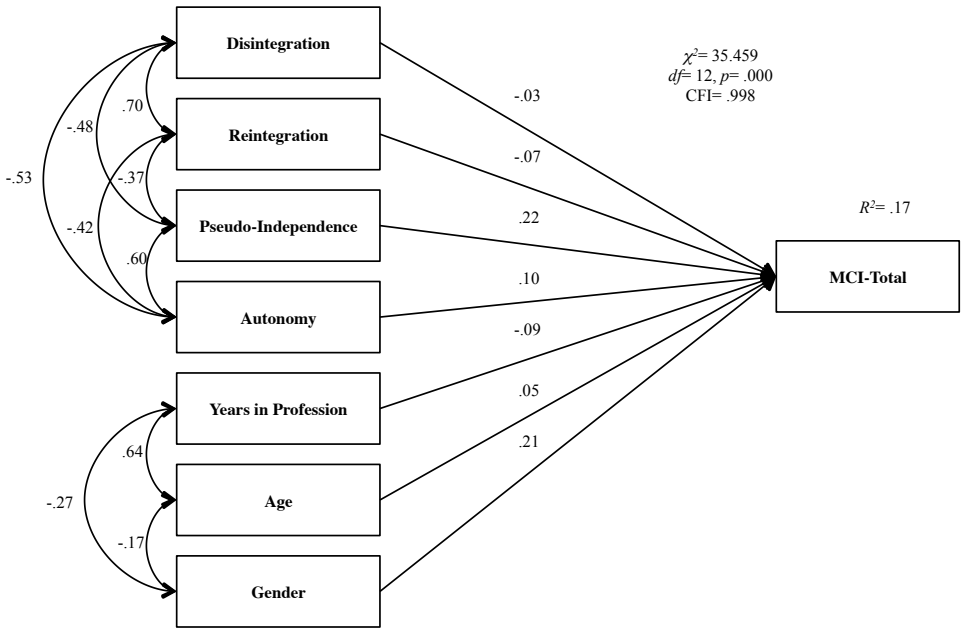

Figure 3. Structural equation model with covariances and standardized regression weights.

analysis tested the structural relations hypothesized in Figure 3.

Comparing the initial and modified models, the modified model produced a more improved fit. Specifically, the chi-square for the modified model was not significant, χ^2 (11, *N*= 412)= 14.45, *p*= .209. The chi-square and CMIN/DF is less than 3 and both the CFI and NFI had values greater than .90. Each of these indices, including the RMSEA, indicated a good fit for the data. This model produced an effect size (R^2) of .42. Effect size was indicative of the magnitude of the phenomena under study, in this instance, MCC. Thus, the exogenous variables accounted for 42% of the variance with respect to MCC as measured by the MCI.

In summary, data in Table 2 suggested a good model fit for the full population. All measures of fit (χ^2, RMSEA, CMIN/DF, NFI, and CFI) were reasonable in relation to baselines of acceptable fit. Thus, we determined that the model had merit for the combined population of practitioners under study. Our sample comprised 3 distinct professional groups; therefore, it was important to assess the extent to which the data fit the modified model for each of the 3 independent groups.

For Individual Practitioner Group Analysis (Counseling Psychologists, Clinical Psychologist and Licensed Professional Counselors) Table 2 presents fit statistics associated with the modified model applied independently to each of the three professional groups under study. Group 1 refers to Counseling Psychologists (*n*= 70); Group 2 refers to Clinical Psychologists (*n*= 179); Group 3 refers to Professional Counselors (*n*= 163). In Table 3, we report the significant path coefficients with respect to the standard error

(SE) and the critical ratio (CR). A significance level of .05 was utilized; therefore, any ratio that exceeded 1.96 in absolute value was identified as significant beyond the .05 level. The sign of the CR, whether positive or negative, indicates the direction of the association.

The data for counseling psychologists was derived from a smaller sample size than desirable (n= 70). However, we proceeded with the analysis. As Table 2 indicates, the modified model produced a significant chi-square value, χ^2 (11, n= 70)= 27.22, p= .004. Additionally, the RMSEA is greater than .05 and the CMIN/DF ratio is greater than 3 to 1. Together, these data indicate that the model is a poor fit for this population.

Among clinical psychologists, Table 2 indicates that the χ^2 was not significant [(11, n= 179)= 4.77, p= .94]. Additionally, all other goodness-of-fit indices indicated that the data in the model demonstrated a good fit for this population. Thus, consistent with our hypothesis, this unique set of values accounts for the variance in MCC as measured by the MCI. Utilizing standardized regression estimates and standard errors (SE) for clinical psychologists, we found significant associations between gender and MCC (SE= 0.028, CR= 3.144, p< .005) and the racial identity status of P-I and MCC (SE= 0.004, CR= 4.861, p< .01). These findings indicate that practitioners who were able to access the pseudo-independence status reported being more culturally competent, as indicated by higher MCI scores, than those operating at lower statuses. Further, females perceived themselves as being significantly more culturally competent than males. The effect size, as measured by R-Square (R^2), for clinical psychologists is .56. Thus, these variables account for 56% of the variance in the MCI score. The directionality of each of the variables is also important. Although not significant, the directionality of other racial identity statuses were consistent with what we would expect to find. The negative direction in perceived MCC are associated with Disintegration (CR= -0.239) and Reintegration (CR= -1.470), the less complex statuses of RID.

There was a good statistical model fit for professional counselors. Table 2 indicates that the chi-square was not significant [χ^2 (11, n= 163)= 14.44, p= .20]. Additionally, all other goodness-of-fit indices indicated that the data in the model demonstrated a good fit for this population. Thus, MCC can be inferred by this unique set of values in the model. Utilizing standardized regression estimates and SE for counselors found a significant association between the racial identity status of pseudo-independence and MCC (SE= 0.586, CR= 2.11, p< .035). These findings indicate that practitioners who were able to access the pseudo-independence status contributed significantly to variance

Table 3. Standardized Regression Coefficients (SRC), Standard Errors, Critical Ratios, and p-Values for Specified Practitioner Groups in Relation to Multicultural Competency (Middleton *et al*., 2010).

	Counseling Psychologists (n= 70)				Clinical Psychologists (n= 179)				Counselors (n= 163)			
Variables	SRC	*SE*	CR	*p*	SRC	*SE*	CR	*p*	SRC	*SE*	CR	*p*
Gender	0.313	0.052	3.072	0.002**	0.202	0.028	3.144	0.002**	0.139	0.042	1.795	0.073
Age	0.138	0.004	0.885	0.376	0.061	0.002	0.685	0.494	0.056	0.002	0.629	0.529
Years in Profession	-0.296	0.005	-1.865	0.062	-0.079	0.002	-0.876	0.381	-0.062	0.002	-0.684	0.494
Disintegration	-0.027	0.009	-0.194	0.846	-0.026	0.005	-0.239	0.811	0.005	0.006	0.043	0.966
Reintegration	-0.176	0.009	-1.384	0.166	-0.136	0.005	-1.470	0.142	0.031	0.005	0.290	0.772
Pseudo-independence	0.012	0.009	0.080	0.937	0.391	0.004	4.861	0.000***	0.103	0.586	2.11	0.035
Autonomy	0.248	0.011	1.611	0.107	0.035	0.005	0.424	0.672	0.144	0.006	1.406	0.160

* p < .05; ** p < .01; *** p < .001

in the MCI scores than those operating at less complex statuses. Gender differences were not observed in this sample population. The effect size, as measured by R^2 for professional counselors is .29. Thus, this variable accounts for 29% of the variance in the MCI scores.

Discussion

Our sample comprised three distinct professional groups. Within-group comparison produced similar results with respect to WRID among counselors and clinical psychologists. However, among counseling psychologists, we believe the lack of model fit was due in large part to sample size (n= 70). The results of our study are based upon a theory that is asymptotic, meaning that the theory can be made to apply with any desired degree of accuracy, but only by using a sufficiently large sample (Arbuckle & Wothke, 1999). Sample size affects the standard of error in Table 3, which in turn affects the critical ratio (CR) that was used to test the significant effect of our personal variables on MCC. Therefore, there is reason to continue to consider the potential influence of racial identity status on MCC among counseling psychologists. It is not clear if one could expect similar results among counseling psychologists as those found for clinical psychologists.

Among both clinical psychologists and professional counselors, racial identity contributed significantly to Multicultural counseling competencies. Racial Identity Development status of Pseudo-Independence was a significant contributor for White professional counselors and clinical psychologists. Among clinical psychologists, the variables of gender and racial identity status emerged as significant. Specifically, in our modified model, White female clinical psychologists perceived themselves to be more multiculturally competent than did White male clinical psychologists. Our findings with respect to gender in relation to multicultural counseling competency are somewhat disconcerting, considering that 54% of the APA membership is male. Our findings may call into question the privileges and/or personal barriers experienced by some White male clinical psychologists that may contribute to their perception of being less multiculturally competent than White female clinical psychologists. There is a need to continue to examine the role of power and gendered privileges present in our society and profession that serve to keep these differential experiences intact.

In Helms' theory of White Racial Identity Development, the last status in developing a positive White identity is Autonomy. This status is a process of lifelong discovery and recommitment to defining oneself in positive terms as a White person. It is interesting to note that in this current study, there was a lack of significant association between the advanced status of Autonomy and multicultural counseling competencies. The lack of significant contribution to the model fit may be because there were not enough respondents able to access or operate within the status of Autonomy. Overall, the results suggest that racial identity and gender contribute to White mental health practitioners' perceptions of their multicultural counseling competence.

Consistent with the work of Holcomb-McCoy and Myers (1999), educational level, age, and years in the profession were not found to be related to multicultural

competence or racial identity development. This is the first study to include length of time in the profession as a variable. Pope-Davis and Ottavi (1994) earlier found that older students experienced greater discomfort with racial interactions and issues than did younger students. It is possible that individuals practicing longer in the field would have greater experience in dealing with racial issues, reporting greater competence. Although the psychologists had significantly more years in working in the field than counselors, there was no evidence in our model that this was the case. Consequently, our next step was to generate a model based on those personal factors found to be significant.

Our modified model (see Figure 3) demonstrated good model fit for the combined practitioner sample. Gender and racial identity status emerged as important scaffolds contributing to multicultural competence. Specifically, in our modified model, White females contributed to the model fit as perceiving themselves to be more multiculturally competent than did White males. In terms of racial identity development, in previous studies among graduate counseling students (Carter, 1990; Pope-Davis & Ottavi, 1994), women indicated greater comfort with racial interactions and issues than men. Carter (1990) found that men had higher levels of Disintegration attitudes. White women in his sample had higher levels of Pseudo-Independence and Autonomy attitudes. Pope-Davis and Ottavi (1994) achieved similar findings. The data in our study did not yield similar results among practitioners.

With respect to our findings regarding racial identity, we note that Helms (1990) posits that the status of Pseudo-Independence begins the White person's process for constructing a positive White identity. Our research validates this theory that none of the early-developing statuses (Contact, Disintegration, and Reintegration) were found to contribute to multicultural competence. Only the status of Pseudo-Independence was found to be a statistically significant variable in relation to multicultural counseling competency. At this status, there is a purposeful and conscious decision to interact with racially diverse populations. However, the racial redefining process described by Helms (1990) usually takes the form of intellectual acceptance and curiosity about racially diverse populations. Generally, they have worked through many of the major dilemmas in abandoning racism, though some dilemmas may remain unrecognized in the subconscious system of personality. White individuals accessing this status are often more liberal or socially conscious.

The Person(al)-As-Profession(al) or [P-A-P] transtheoretical framework is used to conceptualize our theoretical supposition. (See Figure 1). Based on our research, there remains an ongoing need for mental health practitioners to consider how the development of their racial identity (personal) has the potential to affect the counseling dyad (professional). From a training perspective, person(al) variables such as racial identity development should be viewed as critical to culturally appropriate developmental experiences. The person(al) variables that underlie the MCC of the practitioner are important, especially if multiculturalism is to be achieved and maintained. For more information on the Person(al)-As-Profession(al) model, readers can refer to DelSignore *et al* (2010).

In terms of practice, it is important for the practitioner to understand how his or her attributes (personal) are critical to contextualizing culturally appropriate counseling

practice (professional). Additionally, understanding how the racial identity development of psychologists and counselors has the potential to affect the therapeutic relationship and client welfare. To this end, mental health practitioners seeking to be multiculturally competent will increase their MCC and be willing to apply racial identity theory in practice. Self-exploration, taught at the graduate level, is one method of encouraging future practitioners to examine their own racial identity development prior to entering the field as clinicians (Green, McCollum, & Hays, 2008). Arredondo *et al* (1996) provides a thorough list of activities individuals can engage in to increase MCC, while DelSignore *et al* (2010) provides specific descriptions of what practitioners did to increase their own MCC and RID.

The vast majority of multicultural counseling, racial identity, and training research have examined students in training. Replication of this study would be encouraged to include a larger sample of counseling psychologists. Research is needed to replicate the extent to which personal variables (gender, age, racial identity, etc.) contribute to multicultural competence among professional counselors and psychologists. Further investigation is also needed to determine if specified differences in clinical training and experiences produce differences in racial identity development and multicultural counseling competence. There is a need to investigate if one's multicultural counseling competence will increase with time if one is open and intentionally engaged in obtaining multicultural experiences. Future research should determine how to best assess the usefulness and effectiveness of structured experiential exercises and clinical experiences. Presently, coefficient alphas, inter-subscale correlations, factor analysis, and structural equation modeling are not entirely effective in assessing the validity and usefulness of racial identity measures and theories. Strategies for addressing complex patterns formed by interactive convergent and divergent forces in dynamic systems must be developed for the improvement of our inquiry. Methods such as cluster analysis or those associated with chaos theory may be more effective in assessing the validity and usefulness of racial identity measures and theories. We have measured the perceived multicultural competence of White professional counselors and psychologists. Further research is needed to assess the demonstrated competence.

Interpretation of the results of this study must be viewed in light of two general issues of concern. First, limitations inherent in self-report measures such as the MCI and the WRIAS must be considered. A common challenge is that participants may be selecting socially desirable responses. Second, it bears stating that conducting research of this magnitude is difficult, given the known respondent reactivity to issues of race and racial identity (Carter, 1997). The low response rate overall, and among counseling psychologists in particular, presented a challenge. After an initial mailing, a follow-up postcard reminder yielded few additional surveys. Due to financial restraints, we were unable to conduct a third mailing. Still, it is not clear why, among counseling psychologists in particular, we were unable to significantly increase the response rate. One possible reason may be due to the strident criticism and opposition to the WRIAS in the counseling psychology literature (Behrens, 1997; Behrens & Rowe, 1997; Tokar & Swanson, 1991). Helms (2005) contends that these criticism are partly due to mis-application of reliability theory as they pertain to the WRIAS. Further, Helms (2005)

states that perhaps the vociferous need to impute psychometric properties to the WRIAS instead of to scores on it is perhaps due to denial (Contact schema in White racial identity theory) about the role of Black people in the psyche of White people in the United States. Thus, we attribute the low return rate of 11% to at least 3 factors: (a) the length of the survey materials, (b) possible participant discomfort with research on race, and (c) limited follow-up procedures due to financial constraints. Notwithstanding, our sample is representative of the population information of both ACA and APA based on gender, employment setting, and geographic location.

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Received, 10 January, 2011
Final Acceptance, 21 March, 2011