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The Evolving Definition of Cultural Competency: A Mixed Methods Study

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Abstract

This research established a definition of cultural competency from the perspective of the psychologists using mixed methodology. In Study 1 (*N*= 9) participants were interviewed and asked how they conceptualize cultural competency; three emergent themes were identified: awareness, knowledge, and skills. Based on the results from Study 1, a survey was created for Study 2 and completed by psychologists (*N*= 142). Results from a confirmatory factor analysis did not support cultural competency as a 3-dimensional construct. A post-hoc exploratory factor analysis suggested that cultural competency is best conceptualized as a 2-dimensional construct consisting of knowledge/awareness and skills. Results suggest that the knowledge needed to work with diverse populations is more than simply knowing about the major cultural groups in the United States; a more sophisticated level of knowledge is needed as there are many cultures and sub-cultures.

Key words: cultural competency, diversity, cultural considerations.

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Novelty and Significance

What is already known about the topic?

- Cultural competency is the belief that people should not only appreciate and recognize other cultural groups, but also be able to effectively work with them.
- While several definitions have been proposed, they have been criticized.
- A consensus in the field has not been reached regarding how to define cultural competency despite that experts have emphasized the need to establish a clear definition of this term.

What this paper adds?

- Cultural competency is best conceptualized as a 2-dimensional construct consisting of knowledge/awareness and skills.
- The knowledge needed to work with diverse populations is more than simply knowing about major cultural groups; a more sophisticated level of knowledge is needed as there are many cultures and sub-cultures.

S. Sue has been a pioneer in the arena of cultural competency; he defined cultural competency as the belief that people should not only appreciate and recognize other cultural groups, but also be able to effectively work with them (Sue, 1998) and postulated that cultural competency is multidimensional and includes a 3 (Awareness, Knowledge, and Skills) X 4 (Individual, Professional, Organizational, and Societal) X 5 (African American, Asian American, Latino/Hispanic American, Native American, and European American) factorial combination (Sue, 2001a). Despite these advances in conceptualizing cultural competency, Sue has been criticized because he equates cultural competency and multicultural counseling competency, his definition is circular, he uses synonyms within the definition as substitutions for the word "competency", his model is descriptive, and he does not illustrate how the dimensions he presents interact or operate as an aggregate construct (Ridley, Baker, & Hill, 2001). In addition to the above, critics

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have noted that cultural sensitivity and cultural competency are used interchangeably (Cardemil, 2008; Rice & O'Donohue, 2002; Ridley, Baker, & Hill, 2001; Whaley, 2008) which is problematic as cultural sensitivity, while semantically connected to cultural competency, is a believed to be a distinct construct (Whaley, 2008).

One mechanism through which the construct of cultural competency has been studied is via measures intended to assess cultural competency. Both the Multicultural Counseling Inventory (MCI: Sodowski, Taffe, Gutkin, & Wise, 1994) and the Multicultural Awareness-Knowledge-and Skills Survey (MAKSS: D'Andrea, Daniels, & Heck, 1991) were developed based on Sue, Arrendondo, and McDavis's (1992) theoretical model of cultural competency. The generalizability of these measures to psychologists is unknown as the MCI was normed on counselors and the MAKSS was normed on graduate students. Since the creation of the MAKSS and the MCI, several researchers have attempted to take a bottom-up approach to developing definitions of cultural competency using qualitative methodology.

Constantine, Melincoff, Barakett, Troino, and Warren (2004) examined how minority counselors who work in academic training programs defined multicultural competency. A qualitative analysis from the Constantine *et alii* (2004) study revealed that being a multiculturally competent counselor includes being open-minded and flexible, being committed to the field, engaging in active listening, having knowledge and awareness of cultural issues, being skillful in making cultural interventions, being committed to social justice issues, and having exposure to broad and diverse life experiences. This study was limited as it focused on academicians and thus its generalizability to practicing psychologists is questionable. Additionally, multicultural competency has been argued to be a distinct construct from cultural competency (Whaley, 2008). More recently, Taylor, Gambourg, Rivera, and Laureana (2006) interviewed therapists who work with Latino clients and asked them how they constructed the idea of cultural competency in the counseling room. The interviews were analyzed and six themes emerged: the use of language in therapy; the impact of social class, gender, and power on the therapeutic relationship; immigration and culture clash; definitions of family; and the unique construction of cultural competency.

In addition to the above qualitative studies, Bassey and Melluish (2013) reviewed the literature to create a narrative representation of what cultural competency means to the clinical practice of individuals delivering psychotherapeutic interventions. Findings from the Bassey and Melluish review indicated that a culturally competent practitioner is one who: 1) is aware of his or her own personal and professional values and biases and how these may influence their perceptions of an "other", their problem, and the therapeutic relationship; 2) has acquired or knows how to acquire cultural knowledge relevant to the client; and 3) has the skill to intervene to alleviate distress of the client in a culturally response manner. Bassey and Melluish noted that the research has shifted its focus from the categorical approach (knowledge of and tailored intervention for a particular group) to a focus on socio-cultural factors that affect the individual and indicated that this shift occurred in response to concern over the capacity of categorical approaches to stereotype.

As illustrated above, a consensus in the field has not been reached regarding how to define cultural competency and much has been written about the need to establish a clear definition of this term (O'Donohue & Benuto, 2010; Whaley, 2008). While theoretical models have been proposed (Sue, Bernier, Durran, Feinberg, Pedersen, Smith, & Vasquez-Nuttall, 1982; Sue, Arrendondo, & McDavis, 1992; Sue, 2001),

empirical research on these constructs is limited. Several researchers have highlighted the importance of deriving a definition of these constructs from individuals who are knowledgeable in this domain (Constantine *et alii*, 2004; Taylor *et alii*, 2006; Zayas, Torres, Malcolm, & DesRosiers, 1996) however, the research that has taken this approach is flawed due to issues of generalizability and limited sample sizes. Also, no study to our knowledge has addressed this issue with a mixed method design. Finally, while Sue (2001) provided a definition of cultural competency his model is descriptive (and not empirically based) and does not illustrate how the dimensions he presents interact or operate as an aggregate construct (Ridley, Baker, & Hill, 2001). Thus, the purpose of this study was to empirically derive a definition of cultural competency by replicating the work of Constantine *et alii* (2004) and Taylor *et alii* (2006) using a mixed method design with psychologists as participants.

Study 1

Method

Participants

The majority of participants were female (n= 6) and over half the sample were ethnic minorities (n= 5) including one Asian/Pacific Islander and four Latinas. Participants ranged in age from 32 to 47 (M= 39.89; SD= 5.12). All participants were either clinical (n= 7) or counseling (n= 2) psychologists who worked in a community clinic (n= 2), in private practice (n= 4), or at an academic medical center or clinic (n= 3). All participants reported that they had attended an APA-accredited program. Participants reported spending between 2 and 29 hours per week working with cultural minority clients (M= 11.38 hours/week; SD= 9.29 hours/week) including working with Latinos, African Americans, Pacific Islanders, Indians, and Lesbian, Gay, Bisexual, Transgendered, and Questioning (LGBT-Q) populations.

Materials

The qualitative data reported in this manuscript involves a subset of data that was collected as part of a larger study. The data analyzed for the current study were responses from participants to the open-ended question: *From your perspective, what is cultural competency?* Congruent with qualitative research procedures, the interview was semi-structured in that the question above was asked of all of the participants, but follow-up questions were asked as needed for further elaboration and clarification from participants.

Procedure

The recruitment for participants was open from April 2015 to October 2015. After Institutional Review Board (IRB) approval was obtained, a list of 30 potential participants who were personal contacts of the leader researcher was created based on the inclusion criteria of the study. The inclusion criteria were that the participant 1) be a (doctoral-level) psychologist and 2) have experience working with diverse clients. From the list, an individual was randomly selected to be invited and act as the first participant. The participant was sent an E-mail invitation to participate in the study including the

informed consent document (during the interview the informed consent document was reviewed with the participant and the participant was given the opportunity to provide consent and ask questions). Originally snowball sampling was used to recruit additional participants; at the conclusion of each interview participants were asked to suggest additional individuals who may wish to participate in the research study. However, this sampling method did not yield a sufficient sample, thus additional participants were randomly selected from the list of 30 potential participants that was originally created and sent an invitation to participate. A total of 20 participants were invited to participate in the study and out of those 20, nine agreed to participate.

Data Analysis

As described above, all interviews were audio-recorded and transcribed. Initial coding was conducted on each of the interview transcripts as part of the first cycle coding process. This process involved reviewing the transcript and making notes and then cross-reviewing the notes to identify consistency across the transcripts (Strauss & Corbin, 1998). Tentative labels (short phrases) were applied to the codes (Saldana, 2013). Next, basic categorization was used to examine how the various codes were similar and how they were different (Gibson & Brown, 2009) and were then listed according to commonality (Saldana, 2013). Finally, axial coding was employed to determine which codes were the dominant codes, establish which codes were the less important ones, and identify (and remove) redundant codes so that ultimately the best representative codes were selected (Boeije, 2010). Codes from this last level of data coding were organized into larger emergent themes or core categories.

RESULTS

Participants were asked open-ended questions regarding defining cultural competency. Three large emergent themes were identified in the data (see Figure 1 for a depiction of the emergent themes and sub-themes). The first emergent theme with cultural competency was best construed as awareness of how cultural factors might influence diagnosis, treatment, and the clinical/therapeutic relationship (see Table 1 for a list of what participants considered to be cultural factors). As part of *awareness*, clinicians emphasized that part of cultural competency is an understanding and awareness of their own personal biases, limitations as a clinician, and worldview (including how this worldview might diverge or converge with that of the client's).

The second emergent theme was *knowledge*, specifically having *knowledge* about the individual's culture and *knowledge* about one's specific area of practice. With regard to having knowledge about the individual's culture, Participant 9 stated: "knowledge of the population you're working with, but knowledge to include not just the demographic characteristics, but the cultural world view of the clients." This was saliently described by Participant 3 who shared how in her work context, marijuana use is considered a cultural norm; thus, pathologizing marijuana use could easily alienate the client. With regard to having culturally relevant knowledge specific to one's area of practice, Participant 1 (who conducted forensic evaluations of competency in private practice) highlighted how understanding the legal system for his client's country of origin is necessary for him to conduct culturally competent forensic evaluations. Specifically, the participant stated: "For a number of the Spanish-speaking clients there legal systems provides a Napoleonic system where there's a presumption of guilt instead of innocence and so

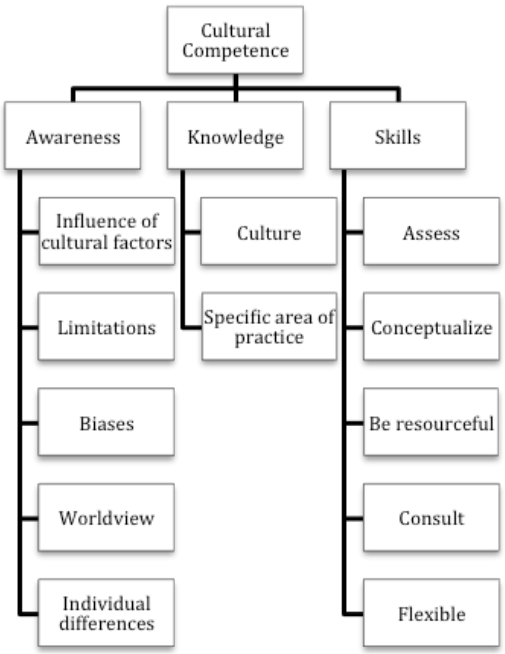

Figure 1. Cultural Competence.

Table 1. What are cultural factors?

Cultural Factor	Participants from Qualitative Study (*N*= 9)	Participants from Quantitative Study (*N*= 142)
Everything	3	-
Country of origin	3	140
Immigration Status	3	137
Language	3	135
Sexual orientation	3	133
Economic Status	2	133
Ethnicity	2	139
Gender	2	127
Acculturation	1	136
Education	1	125
Family of origin	1	125
Health	1	104

their foundation of legal process knowledge is based on that premise and so having to teach them that in the United States and the legal system that they're being evaluated in the presumption is innocence before guilt". Other participants indicated that they were knowledgeable about normative data in the context of assessment for various cultural groups (Participants 1, 4, 5, and 8).

The third emergent theme was focused on *skills*. This included the having the ability and to assess the client's needs, consider the client's unique and individual circumstances as part of the case conceptualization, knowing when to consult, knowing how to be resourceful and seek more information when needed, and being flexible. Approaching the

client from an individual perspective and considering the client's unique and individual circumstances was a theme that resonated across interviews. Participant 2 stated: "...it is unrealistic … it seems almost like a unicorn because there are so many cultures and sub-cultures, and when I was in graduate school I used to think of cultural competence as something you need to be competent to work with this particular culture. You need to understand the ins and outs of that culture before you start working with them, analyze, and now I just think when you do … when you take on a new client." Participant 3 highlighted how the unique factors of each client need to be taken into consideration: "We look at first helping the individual within their system and how we can get more preventative or psychological change within the system." Participant 4 described how "because there are so many cultural factor, you have to look at all of those factors when you are working with a client." This was echoed by Participant 6 who stated: "...you can't possibly know all of the different situations that culturally may arise."

Flexibility (as a skill) was manifested by Participant 7 who stated: "Knowing that when we work with diverse or underserved population we cannot apply what is taught in the books or in the mainstream psychology. We realize that people have different world views, different from yourself and you have to say to yourself, okay, they come from a different background, they have a different world view but I am going to give them the service and apply my knowledge to their needs, not to my needs or the needs of the system per se." With regard to being resourceful, Participant 1 stated: "Cultural competence would be… that you are aware of where those resources are [literature, referrals, normative data] and be able to impart those resources for diagnosing and treatment." While not a direct component of cultural competency per se, several participants noted that cultural competency was not attainable and instead rests on a continuum that is constantly evolving.

STUDY 2

After the qualitative data was analyzed a questionnaire was created to assess the extent to which the qualitative results generalized to a larger sample. Ten items were created whereby one item mapped to each of the subordinate themes identified in the qualitative results. After the initial version of the questionnaire was drafted, two psychologists reviewed the qualitative results and the questionnaire, providing feedback and recommendations for improvement. Because the goal of this study was to obtain a better understanding of the construct cultural competency, a Confirmatory Factor Analysis (CFA) using *laavan* package in R was used to examine the fit of the proposed interrelationship of the themes that arose in the qualitative results, and to determine whether the items in the survey loaded onto the dimensions of the construct of cultural competency in the way expected. In addition, this model was compared to a model in which all items loaded onto a single factor.

METHOD

Participants

A total of 275 participants accessed the survey; the final sample consisted of 142 participants. The data from eight participants were omitted as they indicated in the survey

that they were not psychologists; 27 participants were not included as while they did access the survey, they did not answer any of the survey questions; finally, an additional 98 participants were excluded as they omitted more than 5% of the survey items. Of the remaining 142 participants, the majority (79%) of participants were female (n= 112) and participants ranged in age from 26 to 71 (M= 40.53; SD= 10.57). With regard to ethnicity, participants self-identified as Asian/Pacific Islander (n= 7), African American (n= 7), Latina/o (n= 13), non-Hispanic White (n= 112), and Other (n= 3). The majority of participants were clinical psychologists (71 participants indicated that they were Ph.D. clinical psychologists whereas 52 reported that they were Psy.D. clinical psychologists) with a minority of participants indicating that they were a counseling psychologist (n= 15) and an additional four participants not endorsing what type of psychologist they were (although they did indicate that they were licensed psychologists). Across the entire sample, participants reported spending between 0 (n= 13) and 47 (n= 1) hours per week working with diverse clients (M= 9 hours/week; SD= 6.73 hours/week) including working with Latinos, African Americans, Pacific Islanders, Indians, and Lesbian, Gay, Bisexual, Transgendered, and Questioning (LGBT-Q) populations. Fourteen percent of the participants reported that they offered services in languages other than English.

Materials

Demographic information was collected including ethnicity, sex, age, degree specialization, year doctoral degree was granted and number of years licensed. Information regarding types of services provided to minority clients and frequency of services provided were collected.

Procedure

The recruitment for participants was open from March 2016 to January 2017. Participants were recruited following ways. First, all professional contacts of the lead researcher who met the inclusion criteria for the study (which was the participant be a psychologist) were forwarded an email invitation to the study and asked to forward the invitation to any professional contact who met the inclusion criteria. Second, all psychological associations and state boards were contacted through email and asked to forward the study invitation to psychologists who were licensed in the state or who were members of the state psychological association. Finally, the Association of Psychology Postdoctoral Internship Centers directory was used to gather the email addresses for all training sites housed within the directory. The director of each internship site was asked to forward to Email invitation with the study details to all past interns of the internship site. The email invitation contained a link the study materials including an informed consent which participants were asked to review and indicate whether or not the consented to participating in the study.

Data Analysis

Preliminary data screening revealed that there was no evidence of ill-scaling of the covariance matrix, suggesting the data would converge for SEM-type analyses. All variables included in the analysis were univariate and multivariate non-normal, however these issues of multicollinearity and normality are somewhat typical problems when using only data with Likert-type scales with a limited range.

RESULTS

A Confirmatory Factor Analysis (CFA) was used to evaluate the interrelationship of the themes that arose in the qualitative results, and to determine whether the items in the survey loaded onto the dimensions of the construct of cultural competency in the way expected. The hypothesized themes of cultural competency were labeled: awareness, knowledge and skills (see Table 2) and as described under methodology, 10 questions were created based on the conceptual themes that emerged in the qualitative data that mapped to each of the subordinate themes.

Structural Equation Modeling was used to determine whether or not the 10 items that were created and that mapped to the subordinate themes from the qualitative data were linked to the latent variables: awareness, knowledge and skills. All correlations between the latent variables were freed and all covariance between error terms were constrained to 0. This was done in order to make sure there was no covariance between

Table 2. Cultural Competence-Factors from Qualitative Analysis

Factor 1: Awareness/ understanding of:	Factor 2: Knowledge	Factor 3: Skills
-How CF influence diagnosis.	-Specialized knowledge in the clinician's area of practice.	-Ability to assess the client's needs.
-How CF influence treatment.		-Ability to look at the client as Individual.
-How CF influence the clinical relationship.	- Factual Knowledge about the cultural group that the clinician is working with.	-Seeking more information when needed.
-Personal biases.		-Knowing when to Consult.
-Your own abilities and limitations.		-Being Flexible.
-Worldview (both the client's, the clinician, and any discrepancies therein).		
-Individual differences across clients.		

Note: *CF= Cultural Factors.

the latent variables that would affect the model. To determine the overall fit of the model defined in Study 1, we examined a number of fit indices. Fit indices included the standardized root mean squared residual (SRMR), root mean square error of approximation (RMSEA), the χ^2 statistic; and the χ^2 ratio (the CFI was not computed as the RMSEA of the null model was less than 0.158 [Kenny, 2015]). It is important to examine multiple fit indices as different indices provide different information and are sensitive to different aspects of model fit. For example, SRMR is more sensitive to the specified factor covariance structure, and RMSEA is more sensitive to the specified factor loadings (Hu & Bentler 1999). Furthermore, while a significant χ^2 may indicate lack of satisfactory model fit (as significance indicates that the given model's covariance structure is significantly different from the observed covariance matrix) this fit index is conservative (prone to Type II error) and may be discounted if other model fit measures support the model (Garson, 2015).

The TLI (.827) and SRMR (.114) did not support that the model was a good fit whereas the RMSEA (.078) indicated that it was a reasonable approximate fit. Given that only one of the fit indices suggested that the model was a reasonable approximate fit, we opted to be conservative and conduct a post-hoc exploratory factor analysis (EFA) to evaluate how the ten observed variables, factored. Table 3 shows the post-hoc EFA which suggested that cultural competency is a 2-dimensional construct (consisting of skills and awareness/knowledge).

Table 3. Post-Hoc EFA Model (Cultural Competence).

	Component 1	Component 2
- Awareness/ understanding of how CF influence diagnosis	.724	
- Awareness/ understanding of how CF influence treatment	.743	
- Awareness/ understanding of how CF influence the clinical relationship	.654	
- Awareness/ understanding of personal biases	.774	
- Awareness/ understanding of your own abilities and limitations	.683	
- Awareness/ understanding of worldview (both the client's, the clinician, and any discrepancies therein)	.531	
- Awareness/ understanding of individual differences across clients	.700	
-Knowing When to Consult	.631	
-Having specialized knowledge in the clinician's area of practice	.587	
-Having factual Knowledge about the cultural group that the clinician is working with	.539	
- Seeking more information when needed		.733
- Ability to look at the client as an individual		.426
-Being flexible and		.466
-Ability to assess Clinical needs		.409

Note: *CF= Cultural Factors.

Discussion

The purpose of this study was to empirically derive a definition of cultural competency by replicating the work Constantine et alii (2004) and Taylor et alii (2006), while implementing a protocol that took into account these studies' flaws. Specifically, we designed our study so that the results would be generalizable to psychologists who are practitioners -Constantine et alii (2004) used academicians as participants- and we did not restrict participants to any single cultural group -Taylor *et alii* (2006) only interviewed therapists who worked with Latino clients; Sodowski *et alii* (1994) used only counselors as participants; D'Andrea, Daniels, & Heck (1991) used graduate students as participants. We also extended existing research by utilizing mixed methodology, including both qualitative and quantitative elements, the latter of which allowed us to examine how the different dimensions of cultural competency relate to each other. This study represents one small -albeit important- step towards further understanding an important and elusive construct.

Per the qualitative results, cultural competency was conceptualized as a three-dimensional construct consisting of awareness, knowledge, and skills. This converges with the theoretical (non-empirical) literature on cultural competency (e.g., Alizadeh, 2016; Bassey & Melluish, 2013; Hansen, Pepitone-Arreola-Rockwell, & Greene, 2000; Sue *et alii*, 1982) and this convergence is not surprising. Knowledge, awareness, and skills were first highlighted as necessities for cultural competency nearly 50 years ago (Sue et alii, 1982). A recent systematic review of the literature (Benuto, Casas, & O'Donohue, 2018) revealed that the goals of cultural competency trainings are typically to increase or improve awareness, knowledge, and skills which may explain why participants in our study conceptualized cultural competency this way.

Because current models of cultural competency have been criticized for not examining how the theorized dimensions of cultural competency interact or operate as an aggregate construct (Ridley, Baker, & Hill, 2001) we used structural equation modeling to examine the construct of cultural competency as it was derived in the qualitative results. Interestingly, a CFA did not support cultural competency as a three-dimensional construct. A post-hoc EFA suggested that cultural competency is best conceptualized as a two-dimensional construct whereby the dimensions of knowledge and awareness are a

single dimension (whereas in the qualitative analysis we conceptualized these as separate dimensions). While it has been noted that across definitions of cultural competency having skills and knowledge relevant to the client's cultural background is necessary (Chu, Leino, Pflum, & Sue, 2016) the notion that awareness and knowledge are one and the same, diverges from the existing literature on the measurement of cultural competency which suggests that cultural competency is either a 3-factor or 4-factor construct (i.e., research on the MCI and the MAKSS).

Earlier studies using exploratory and confirmatory factor analysis revealed that the MCI (Sodowski et alii, 1994) is best conceptualized as consisting of four factors: multicultural counseling skills, awareness, relationship (defined as reflecting the interpersonal process of multicultural counseling including openness and warmth), and knowledge. Similarly, the MAKSS -a 60-item self-report assessment used to determine counseling practitioners' and trainees' multicultural competency (D'Andrea, Daniels, & Heck, 1991)- is also based on Sue *et alii*'s (1992) model. More recently the measure has been revised to include 33 items (Kim, Cartwright, Asay, & D'Andrea, 2003) and both the original and revised version house the subscales of awareness, knowledge and skills. While these studies suggest that awareness and knowledge are distinct subscales (and therefore dimensions), it is important to note that the MCI was developed with counselors and the MAKSS was developed with a sample of graduate students. This brings to light issues of generalizability. Moreover, these measures were created over 20 years ago (even the revised version of the MAKSS is nearly 15 years old) and it is possible that perspectives on cultural competency have shifted over time. The authors of both the MCI and MAKSS utilized a top-down approach whereby they tested existing theoretical models (and their findings did mostly converge with theoretical frameworks for cultural competency).

This study is the first to find that knowledge and awareness may be a single dimension of cultural competency. This may be in part due to the fact that awareness in this study involved being aware of how cultural factors interplayed with psychological manifestations (i.e., symptom expression, diagnosis etc.) and being aware of one's own culture and limitations; other conceptualizations do not include the former element of awareness in their definition (Sue *et alii*, 1982). In this study part of awareness was more conceptually similar to knowledge; if one considers as a parallel, awareness vs. knowledge of depression, awareness of depression allows a clinician to have a general sense that depression exists (which would be helpful when working with a client who presented with depressed mood) whereas knowledge about depression might be more concrete and profound (i.e., this might include knowing about the etiology, epidemiology, specific diagnostic features, assessment measures for depression, treatment options for depression etc.). On closer note, attempting to find a clear distinction between awareness and knowledge is challenging as they both require knowing. The same may be true for awareness and knowledge as they relate to cultural competency.

Awareness and knowledge have long since been touted as dimensions of cultural competency (Sue *et alii*, 1982) and have been conceptualized as distinct dimensions of cultural competency. While the qualitative results from this study led us to conceptualize (i.e., hypothesize) that awareness and knowledge were separate dimensions of cultural competency, the quantitative results suggest that these are indeed part of the same dimension which diverges from other quantitative research on cultural competency (see above for a discussion of this).

In this study, cultural competency was conceptualized as having knowledge about the individual's culture and having knowledge about one's specific area of practice and awareness of their own personal biases, limitations as a clinician, and worldview (including how this worldview might diverge or converge with that of the client's). This is congruent with Sue's (1998) model of cultural competency where he noted that a psychologist must have a good knowledge and understanding of their own worldviews, and specific knowledge of the cultural groups with which they work. This semi-consistent with the components of cultural competency that were developed in the Division 17 Education and Training Committee's (Sue *et alii*, 1982) position paper on cultural competency. Congruent with our findings, results from the Constantine et alii (2004) study revealed that the aspects of being a [multi]culturally competent counselor included knowledge and awareness of cultural issues and Taylor *et alii* (2006) found that therapists constructed cultural competency as including understanding the impact of social class, gender, and power on the therapeutic relationship (which would fit under awareness) and immigration and culture clash; definitions of family.

Our results indicated that the dimension skills consisted of being resourceful and flexible, integrating cultural factors into psychological services, assessing the client's needs, and conceptualizing the client as an individual. Various theoretical models of cultural competency have been proposed with several elements of these models overlapping with our findings. For example, La Roche and Maxie (2003) discussed how the patient's level of distress and presenting problem will determine when and if cultural differences are discussed in psychotherapy (which fits with our findings that emphasize the importance of assessing the client's needs). Additionally, our findings are congruent with the research on the MCI (Sodowski *et alii*, 1994) and MAKSS (D'Andrea, Daniels, & Heck, 1991) both of which indicate that skills are a dimension of cultural competency.

Sue (1998) indicated that dynamic sizing was a necessary component of cultural competency. In dynamic sizing the therapist is able to place the client in a proper context -whether that client has characteristics typical of, or idiosyncratic to, the client's cultural group; the therapist must know when to generalize and be inclusive and when to individualize and be exclusive. This allows the therapist to avoid the stereotypes that result when one conceptualizes an individual as a member of a group while still appreciating the importance of culture; this also allows the therapist to place the client in a proper context. This fits with our findings that therapists should be resourceful, assess the client's needs, and conceptualize the client as an individual.

Sue (1998) also referenced the notion of "flex" (proposed by Ramírez, 1991) whereby in flex individuals can learn how to switch cognitive styles to more accurately deal with the environment. Sue noted that flexibility and the ability to consider the unique characteristics of each individual client were paramount to being culturally competent. This supports our findings that the psychologist must be flexible and conceptualize the client as an individual and also fits with the findings of the Constantine *et alii* (2004) study that revealed that one aspect of being multiculturally competent is flexibility.

Finally, Sue (1998) indicated that as part of being culturally competent psychologists must be scientifically minded meaning that they form hypotheses rather than make premature conclusions about the status of culturally different clients and they must develop creative ways to test hypotheses and act on the basis of acquired data. Our model was somewhat congruent with this philosophy as under the emergent theme "skills" we found that cultural competency included having the ability and skills to assess the client's needs and consider the client's unique and individual circumstances.

These findings also fit with Constantine *et alii*'s (2004) findings that multiculturally competent counselors should be open-minded.

A primary limitation of this study was its reliance on self-report. Interviews and questionnaires were used to gather data to establish how clinicians define cultural competency. This creates the potential for social desirability response bias; participant's may have provided definitions of cultural competency that they felt others would agree with (Schlenker & Weigold, 1989; Sedgwick, 2014; Goffman, 1959). Sample bias (as participants self-selected to be in the study) also represents limitations to the current study (Fournier, 2016). Participants volunteered to be in the current study, which may have decreased the study' validity. It is possible that our study attracted certain individuals such as those who personally felt that they had knowledge and experience with cultural competency. Such a scenario could influence the findings from our study and influence the definition of cultural competency. A third limitation of this study is that the majority of our sample from Study 2 was non-Hispanic White participants calling into question the generalizability of these results to minority psychologists. Moreover, two separate (and distinct) samples were used. The findings from this study should be interpreted in light of the fact that samples varied with regard to demographic characteristics. In Study 1 the majority of participates were ethnic minorities and were diverse with regard to sex (almost half of the sample was male) whereas in Study 2, the majority of participants were non-Hispanic White females. Additionally, in Study 2 there were 13 participants who indicated that they did not currently work with cultural minority clients. Because of the potential of these participates to have confounded our results, we re-ran (post-hoc) the CFA with these 13 participants omitted and no differences were noted in the results.

Finally, the results from this study do not demonstrate or illustrate how these concepts are related to client outcomes despite that these have been touted as important (Chu et alii, 2016). General inferences are being made over the impact of an individual's level of cultural competency and their impact on the therapist-client relationship and client outcomes, however this was not empirically tested in this study. This study also did not examine the extent to which clinicians practice the skills that they described as a dimension of cultural competency and it has been noted that clinicians do not tend to engage in culturally competent practices despite that they cite them as important (Hansen, Randazzo, Schwartz *et alii*, 2006). Thus, despite that participants defined cultural competency as a combination of awareness/knowledge and skills, the evidence indicates that they may not engage in practices that are congruent with the information that they endorsed.

Future research should take these limitations into account to increase validity. A larger random and more diverse sample should be used to further explore what it means to be culturally competent in order to reduce sample bias. Future researchers should examine other similar but possibly distinct constructs (i.e., cultural competency and cultural sensitivity are often used interchangeably yet have been noted to be distinct concepts) to determine whether these constructs are the same or distinct from cultural competency. Because the progression of science rests on operational definitions (we all need to ensure that we are studying the same concepts), it is necessary that as a field agreed-upon definitions be established. This study represents a first step towards examining the construct of cultural competency while addressing existing criticisms of how this concept has been defined in the past. The findings from the study current study have established a foundation that will allow future researchers to continue to universally define cultural competency.

The results from this study challenge the existing paradigms for cultural competency and suggest that being aware and having knowledge are one and the same. Additionally, results from suggest that the knowledge needed to work with diverse populations is more than simply knowing about the major cultural groups in the United States; a more sophisticated level of knowledge is needed as there are many cultures and subcultures. Findings from this study highlight that the expectation that a psychologist be well-versed in all potential cultures that a client might be part of, is unrealistic. The leading textbook Counseling the Culturally Diverse: Theory and Practice (Sue & Sue, 2015) houses chapters on major cultural groups and while the book acknowledges the existence of intersectionality, the emphasis is more on group differences than on understanding the idiosyncrasies of clients. The results from this study contradict this model and instead emphasize the need to evaluate and consider the individual cultural factors of each individual client and then call for the psychologist to be flexible and adapt to the unique presentation of the individuals with whom they work -the latter of which fit with the concepts of dynamic sizing and flex (Sue, 1998). Indeed, the extant literature has highlighted how even within a single cultural group (i.e., Latinos) there are many other factors that make up with cultural cloth of the client i.e., immigration status, English language proficiency etc.: (Benuto & Leary, 2018; Benuto & Bennett, 2015). Knowledge with regard to one's area of practice was also highlighted as important by the participants in this study. This suggests that post-doctoral training and professional development may be the best way to acquire this knowledge and supports the notion that cultural competency is an ongoing and dynamic process as opposed to a static, dichotomy (i.e., either you are culturally competent or you are not).

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