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**THE RELATIONSHIP BETWEEN COUNSELORS' MULTICULTURAL
COUNSELING COMPETENCE AND POVERTY BELIEFS**

by

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Old Dominion University in Partial Fulfillment of the
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DOCTOR OF PHILOSOPHY

COUNSELOR EDUCATION AND SUPERVISION

OLD DOMINION UNIVERSITY

MAY 2016

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ABSTRACT**THE RELATIONSHIP BETWEEN COUNSELORS' MULTICULTURAL COUNSELING
COMPETENCE AND POVERTY BELIEFS**

Madeline E. Clark
Old Dominion University, 2016
Chair: Dr. Jeffrey Moe

The relationship between increased levels of poverty and decreased levels of psychological wellbeing and overall wellness is well documented. Although poverty clearly impacts mental health and wellness, little research in counseling has been conducted exploring the poverty attitudes of counselors. This study explored the relationship between professional counselors' multicultural counseling competence (MCC), poverty beliefs, and select demographic factors (i.e. counseling specialty, gender, age, ethnocultural identity, poverty counseling experience, and personal poverty experience). Data were collected using survey-based methods from professional counselors of all specialties. Results of a hierarchical linear regression indicate that increased MCC, adjusted for select demographic factors, is predictive of increased counselor structural poverty beliefs and decreased counselor individualistic poverty beliefs. Further, select counselor demographic factors were found to not be significantly linked to individualistic and structural poverty beliefs. Analyses of these results were insignificant. Implications for counseling practice, education, and supervision, along with future research, directions are included.

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This dissertation is dedicated to my grandfathers, Robert and John.

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CHAPTER 1

STATEMENT OF THE PROBLEM

Chapter 1 provides an introduction to this study, reviewing the background of the problem and limitations of past research. This chapter will also review the purpose of this study, research questions, and study significance. Chapter 1 will conclude with definitions of study-specific terms.

Introduction

In accordance with the American Counseling Association (ACA) *Code of Ethics* (2014), counselors should be willing and able to provide effective services to persons of all social classes (Standard A.2.c). In addition to this ethical mandate, professional counselors are expected to be multiculturally competent, implying counselors must cultivate the attitude, beliefs, knowledge, skills, awareness, and action to work with any diverse population including persons experiencing poverty (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016). Despite these professional standards, mental health theory, practice, and education often reinforce classist beliefs and practices, further marginalizing persons experiencing poverty (Liu, Pickett, & Ivey, 2007; Lott, 2002, 2012; Smith, 2005). Classism in counseling creates barriers for persons in poverty and often does not consider the therapeutic needs of this cultural group (Liu et al., 2007; Smith, 2005). Although, conceptually, the link between multicultural counseling competence (MCC) and awareness of tacit or explicit biases related to poverty seems clear, little empirical research in professional counseling literature exists assessing the relationship between these two concepts.

Classism in mental health treatment is not only unethical but also marginalizing; persons in poverty are vulnerable to psychological disorders, yet the creation or implementation of

treatment modalities are frequently focused on White, middle class, male experiences (Liu et al., 2007; Smith, 2005; Weissman, Pratt, Miller, & Parker, 2015). Poverty and financial barriers impact 45.3 million Americans and approximately one-fifth of American children (U.S. Census Bureau, 2014). High incidences of poverty coupled with the increased likelihood that persons in poverty will experience mental illness, it is clear that counselors need to be adequately prepared to work with this population (U.S. Census Bureau, 2014; Weissman et al., 2015). In this study the researcher seek to explore the relationship between counselor MCC and poverty beliefs in professional counselors. To evaluate the relationship between counselor MCC and poverty beliefs, identity factors were analyzed using hierarchical linear regression and a factorial MANOVA. This study sought to expand literature related to counselors' poverty beliefs and implications from the data for counselors working with individuals experiencing poverty.

Poverty, Mental Health, and Counselor Preparation

In 2013, 14.5% of Americans lived in poverty, with an individual yearly income below \$11,770 (U.S. Census Bureau, 2014). While 14.5% represents the poverty rate of all Americans, poverty is an intersectional issue: children, women, people of color, lesbian, gay, bisexual, and transgender persons, and immigrant groups all experience higher rates of poverty than persons occupying non-marginalized statuses (U.S. Census Bureau, 2014). Coupled with stress associated with financial barriers, many persons in poverty also experience racism, sexism, homophobia, and transphobia, leading to multiple minority stressors and possible negative physical and mental health outcomes (Bockting, Miner, Swinburne-Romine, Hamilton, & Coleman, 2013; Meyer, 2003; Wong et al., 2014).

Persons in poverty experience higher rates of mortality, chronic physical illness, developmental delays, violence, incarceration, barriers to health care, and barriers to housing

(Kaminski et al., 2013; Krieger, Chen, Waterman, Rehkopf, & Subramanian, 2005). In addition, persons experiencing poverty are more likely to experience mental health concerns and psychological disorders (Weissman et al., 2015; World Health Organization [WHO], 2007). Poverty increases the risk for schizophrenia (WHO, 2007). The increased rates of mental illness expressed in persons experiencing poverty, coupled with the barriers to health insurance and to quality, affordable mental health treatment, further marginalizes persons in poverty (Weissman et al., 2015; WHO, 2007; 2010). Without mental health care, persons in poverty presenting with mental illness have difficulty finding stable employment, further limiting their earning power and ability to financially support themselves and their families (Weissman et al., 2015; WHO, 2010).

Poverty and mental health are positively correlated, but little research in counseling and mental health is done to further support this vulnerable population (Liu et al., 2007; Smith, 2005; Weissman et al., 2015). Class biases are unethical in professional counseling, yet counseling theory, practice, and preparation marginalizes people of lower social classes through exclusion (Liu et al., 2007; Smith, 2005; Smith et al., 2011). Many persons have negative poverty beliefs, and counselors are no exception (Cozzarelli, Wilkinson, & Tagler; 2001; Neynaber, 1992; Shapiro, 2004; Smith et al., 2011). Counselors' class biases toward individuals experiencing poverty are evident throughout the literature and continue to perpetuate classism in mental health treatment (Neynaber, 1992; Shapiro, 2004; Smith et al., 2011). For example, counselors are less likely to want to provide services to persons in poverty (Smith et al., 2011).

MCC is a cornerstone of ethical professional counseling practice (ACA, 2014; Ratts et al., 2016). Counselors should be prepared to counsel without bias (ACA, 2014; Ratts et al., 2016). Despite this ethical mandate, counselor preparation programs devote little energy to

preparing students to effectively counsel persons outside of their own social class and often perpetuate practices that further marginalize clients living in poverty (Liu et al., 2007; Smith, 2005).

A lack of preparation to work with persons experiencing poverty is noted when counselor poverty beliefs and therapeutic impressions of clients in poverty are measured (Bray & Schommer-Aikins, 2015; Shapiro, 2004; Smith, Mao, Perkins, & Ampuero, 2011; Toporek & Pope-Davis, 2005). Counselors show the most bias toward clients occupying a lower social class (Shapiro, 2004), are less willing to work with clients from a lower social class (Smith et al., 2011; Shapiro, 2004), and counseling sessions with clients of a lower social class were likely to be less smooth and result in more severe diagnosis (Smith et al., 2011). Further, counselor trainees had the most significant biases towards two distinct groups, clients from a lower social classes and clients with disabilities (Neynaber, 1992). These biases in service delivery and general reluctance to work with this population are especially concerning considering persons experiencing poverty are more likely to present with mental illness; persons in poverty are eight times as likely to present with schizophrenia (Weissman et al., 2015; WHO, 2007). The cyclical relationship between negative mental health outcomes and increased poverty experiences highlights the importance of effective and accessible mental health services for persons experiencing poverty; possessing a healthy mental status can be a factor in breaking the cycle of poverty for some (Weissman et al., 2015; WHO, 2007, 2010). To promote positive mental health outcomes for all persons, regardless of social class, counselors must be prepared to work with persons experiencing poverty.

Limitations of Past Research

Little empirical research exists exploring how poverty impacts the counselor-client relationship, service delivery, or counseling efficacy (Smith, 2005; Toporek, 2013). Most literature regarding social class in counseling is conceptual, offering models for working with this population without evidence to support those models' efficacy (Baggerly, 2006; Foss, Generali, & Kress, 2011; Liu, 2001a, 2001b). Some research exists that explores how counselors understand social class and poverty (Bray & Schommer-Aikins, 2005; Neynaber, 1992; Shapiro, 2004; Toporek & Pope-Davis, 2005). For example, Bray and Schommer-Aikins (2015) found increased multicultural training was linked to positive poverty beliefs in a sample of 513 school counselors; however the study only included one counseling specialty and MCC measured through self-reported levels of multicultural counseling training rather than a validated instrument. In the only study measuring the relationship between multicultural counseling training and poverty beliefs (Toporek & Pope-Davis, 2005), only counseling graduate students were sampled. Further, researchers failed to control for previous multicultural training, a confounding variable identified in subsequent literature (Bray & Schommer-Aikins, 2015). It is clear that current research exploring how MCC relates to poverty beliefs including of counselors of all specialties using validated instruments is needed.

Purpose of the Study

The purpose of this study was to investigate the relationship between counselors' MCC and poverty beliefs to gain understanding of how counselors perceive poverty. This research sampled across counseling specialties, something unexplored in previous related studies exploring MCC and poverty beliefs in counselors (Bray & Schommer-Aikins, 2015; Toporek & Pope-Davis, 2005). This study explored the relationship between counselor MCC and poverty beliefs, including counselor demographics such as age, gender, ethnocultural identity, counseling

specialty, counseling experiences with persons experiencing poverty, and personal poverty experiences. These identity factors have not been controlled for in previous studies of counselor poverty beliefs (Bray & Schommer-Aikins, 2015; Toporek & Pope-Davis, 2005). The exploration and identification of the strength of the relationship between MCC and poverty beliefs will establish a connection between these constructs.

Research Question and Hypotheses

Research Question One

What is the relationship between MCC and individualistic and structural poverty beliefs in a sample of professional counselors and counselor trainees, adjusting for demographic variables (i.e., age, gender, ethnocultural identity, personal poverty experiences, and professional counseling poverty experiences)?

Null Hypothesis One

There will be no significant relationship ($p \leq .05$) between MCC and counselor and counselor trainee individualistic and structural poverty beliefs, after adjusting for knowledge and awareness, age, gender, ethnocultural identity, counselor personal poverty experiences, and professional counseling poverty experiences.

Research Hypothesis One

Counselor and counselor trainees' MCC will predict ($p \leq .05$) structural and individualistic poverty beliefs, adjusting for gender, ethnocultural identity, age, personal and professional poverty experiences.

Research Question Two

What is the relationship between counselor and counselor trainees' poverty beliefs and select demographic variables (i.e., gender, counseling specialty, ethnocultural identity, personal and professional exposure to poverty)?

Null Hypothesis Two

There will be no significant ($p \leq .05$) difference in individualistic and structural poverty beliefs for professional counselors and counselor trainees based on select demographic variables (i.e., gender, counseling specialty, ethnocultural identity, counselor personal poverty experiences, and professional poverty counseling experience).

Research Hypothesis Two

There will be a significant ($p \leq .05$) difference in poverty beliefs for professional counselors based on select demographic variables (i.e., gender, counseling specialty, ethnocultural identity, personal and professional exposure to poverty).

Study Specific Definitions of Terms

Classism

Classism or social class prejudice is the unfair treatment of an individual or group because of their social or economic class background (Toporek, 2013). Classism can be upward (toward upper classes), lateral (within social class), or downward (toward lower classes) (Liu, 2013). Classism can manifest in outward behaviors (discrimination) or internal negative beliefs or biases (prejudice) based on their social class.

Counseling Specialty

Counseling specialty indicates the specific training and practice area in which a particular professional counselor practices. For the purposes of this study, the included counseling specialties were based on the specialties outlined by the Council for Accreditation of Counseling

and Related Educational Programs (CACREP) (2016). These specialties are addictions, career, college, community, gerontological, marriage and family, mental health, rehabilitation, and school counseling.

Ethnocultural Identity

Ethnocultural identity refers to the racial or cultural group(s) with which an individual identifies; for the purposes of this study categories were based on the U.S. Census (2013) categories: African American, American Indian/Alaska Native, Asian, Hispanic/Latin(o/a), multiple heritage, Native Hawaiian/Pacific Islander, White, or Other.

Financial Barriers

Financial barriers are related to an individual or family's ability to meet their basic needs of living including food, shelter, transportation, healthcare, and discretionary expenses in the case of an emergency. Financial barriers are similar and related to relative poverty definitions (United Nations Educational, Scientific, and Cultural Organization [UNESCO], 2015).

Gender

Gender is considered the conceptualization, expression, attitude, or experiences based on their gender identity (American Psychological Association [APA], 2016). For the purposes of the present study participants indicated their gender as female, male, transgender*, other (with the option to write in their gender identity) or a combination of the identities listed.

Multicultural Counseling Competence (MCC)

Multicultural counseling competence (MCC) and multicultural and social justice counseling competence (MSJCC) is an individual counselor's attitudes and beliefs, knowledge, skills, and actions taken when counseling diverse populations (Ratts et al., 2016; Sue et al., 1992). MSJCC includes counselors' understanding of their own and clients' experiences of

privilege and/or marginalization in relation to the counselor's self-awareness, client worldview, the counseling relationship, and counseling and advocacy interventions (Ratts et al., 2016). MCC is a component of ethical counseling practice (ACA, 2014).

Personal Poverty Experience

Personal experiences of poverty include barriers to food, shelter, education, transportation, and/or healthcare, representing the relational definition of poverty. Personal poverty experiences are also understood as an individual's experience in comparison to other persons/groups who have greater access to resources such as food, shelter, education, transportation, and/or healthcare (UNESCO, 2015).

Poverty

Poverty is defined in three ways: absolute, income-based, or relational (UNESCO, 2015; U.S. Census Bureau, 2015). Absolute poverty is ability to meet basic needs such as food, clothing, and shelter (UNESCO, 2015). Income-based poverty is typically used by governmental agencies to provide an income or dollar-amount level that indicates if someone does or does not qualify for governmental assistance (UNESCO, 2015). Relational poverty is a more commonly understood definition of poverty and describes how persons with financial barriers will have limited access to resources (e.g., food, shelter, transportation, healthcare, education) in relation to other people with greater financial means (UNESCO, 2015).

Poverty Beliefs

Poverty beliefs are an individual's understanding of the causes of poverty; these causes may be structural/economic, fatalistic, or individual/motivational (Smith & Stone, 1989). More structural/economic beliefs about poverty include understanding that poverty is caused by structural or economic forces such as oppression, racism, and sexism (Smith & Stone, 1989;

Toporek & Pope-Davis, 2005). Fatalistic beliefs about poverty indicate that a person believes that persons in poverty are fated to have that experience (Smith & Stone, 1989). Concerns about an individual in poverty and their motivation or individual capabilities is reflected in individual/motivational beliefs about poverty (Smith & Stone, 1989).

Poverty Counseling Experience

Professional counseling experiences with at least one person in relative poverty in settings such as community mental health centers, non-profit counseling agencies, pro-bono counseling work, and Title I schools. This is defined by working in any of the previous agencies/school settings for any amount of time.

Social Class

Social class combines the components of socioeconomic status (SES) such as income, educational level, social standing, career, and social prestige with power, privilege, oppression, and access to social resources (Gilbert & Kahl, 1993; Lott, 2012). Persons in lower social classes have less access to social resources, less power and privilege, and are more often oppressed and victims of classism (Liu, 2013).

Socioeconomic Status

Socioeconomic status (SES) is commonly used in research or statistics to measure the combination of an individual's income, social standing, educational attainment, career, and social prestige (APA, 2015). SES is stratified with higher and lower classes based on the combination of those factors.

CHAPTER 2

LITERATURE REVIEW

This literature review will define and explain key concepts related to poverty, classism, cultural competence, and counseling. This chapter will explore literature regarding counselors' views on social class and poverty and how these views impact service delivery to clients experiencing poverty. This literature review includes definitions of poverty and how poverty is measured in the United States, including prevalence and demographics of those experiencing poverty.

Introduction

The concepts of social class and socioeconomic status (SES) are closely connected with poverty and the way individuals understand poverty; these topics will be defined and explored as they relate to mental health services and counselor preparation. It is important to note that classism most impacts persons of lower socioeconomic standing (Liu, 2013; Lott, 2005). Barriers associated with poverty and acts of classism can lead to negative health and mental health outcomes for persons in poverty (WHO, 2007). These outcomes are outlined below in detail, including the cycle of poverty and negative mental health outcomes (WHO, 2007). The cycle of poverty and its impact on mental health highlights the importance that quality and accessible mental health care is to socioeconomic mobility, as improved mental health increases career and financial options for many persons (WHO, 2007, 2010).

To limit negative mental health outcomes associated with poverty experiences, counselors must be prepared and competent to work with this population (ACA, 2014). This concept is reinforced through the *ACA Code of Ethics* (ACA, 2014) and the Association of Multicultural Counseling and Development's (AMCD) *Multicultural Counseling and Social*

Justice Counseling Competencies (MSJCC) (Ratts et al., 2016). Despite the prevalence of poverty in the United States, poverty and social class issues are not addressed in counselor preparation programs, and counseling ethical standards do not specifically address social class competence (ACA, 2014; Liu, 2013; Liu et al., 2007; Smith, 2005). Many counseling graduate students and professionals still believe the causes for poverty are due to a person's own deficits, not social or structural factors, indicating a more negative view of persons experiencing poverty (Toporek & Pope-Davis, 2005; Bray & Schommer-Aikins, 2015). Further, literature exploring poverty and social class competence, models for working with persons in poverty, and counselor preparation for working with this defined social group are all limited (Liu et al., 2007; Smith, 2005). The absence of study in this area indicates a missing piece in counselor competence and professional ability to successfully treat a population with intersecting oppressions.

Poverty Definitions

There are different terms used to define and explain poverty: absolute poverty, relative poverty, income poverty, chronic/long term poverty, and episodic poverty (UNESCO, 2015; U.S. Census Bureau, 2015). Absolute poverty “measures poverty in relation to the amount of money necessary to meet basic needs such as food, clothing, and shelter” (UNESCO, 2015, p. 1). The absolute poverty definition is limited to basic needs and resources without taking into context social and cultural implications of limited income, such as access to transportation, healthcare, education, and career opportunities. Because of these limits, relative poverty is a more commonly used definition of impoverished experiences.

Relative poverty defines poverty in relation to the economic status of other members of the society: people are poor if they fall below prevailing standards of living in a given societal context (UNESCO, 2015, p.1).

Relative poverty is a more appropriate definition for measuring the social and economic impacts of poverty in developed countries such as the United States; persons experience poverty based on their ability to access resources as compared to those with greater access to those resources.

Income poverty is a measure used by governmental organizations to determine poverty levels for access to social assistance (UNESCO, 2015). This assistance includes food benefits, childcare benefits, housing assistance, and cash benefits (UNESCO, 2015). In the United States, federal poverty levels (FPLs) are based on the income poverty definition. The U.S. federal government implements two measures, poverty thresholds and poverty guidelines (U.S. Department of Health & Human Services [USDHHS], 2014). Poverty thresholds are updated yearly and are used to measure population poverty rates and percentages (USDHHS, 2014). Represented poverty statistics, as outlined below, are measured using poverty thresholds. Poverty guidelines are issued yearly, and the guidelines are the measure which establishes eligibility for federal social programs such as Temporary Assistance for Needy Families (TANF), Special Supplemental Nutrition Program for Women Infants and Children (WIC), housing, and childcare assistance (USDHHS, 2014).

Federal poverty guidelines are represented by the Federal Poverty Level (FPL). In 2015, federal poverty guidelines set the FPL at a yearly income of \$11,770 for an individual, adding \$4,160 for each additional household member (USDHHS, 2015). This guideline is followed in the 48 contiguous states and the District of Columbia; in Alaska the 2015 poverty level is

\$14,720 (adding \$4,160 for each additional household member) and in Hawaii it is \$13,550 (adding \$4,780 for each additional household member) (USDHHS, 2015).

Although these poverty guidelines are of note, they ascribe to the income definition of poverty, which does not account for the social and contextual experiences of relative poverty; that is, an individual or family in the United States may not be defined as impoverished using the income poverty definitions (FPL), but still struggle to meet basic needs for living (relational poverty). The concept of relational poverty is important to counselors; relational poverty, not the FPL, determines the lived experiences of an individual (UNESCO, 2015). A person may not meet federal minimum income levels if they earn just slightly more than the income guideline, but it is likely they will experience significant financial hardship distress due to lack of income (UNESCO, 2015). This could manifest in various ways including being: (a) housing poor (inadequate housing or experiencing barriers to housing), (b) health poor (lacking access to healthcare or having poor health overall due to lack of access to resources), or (c) time poor (working significant hours to support themselves financially with limited time for any other activities outside of working hours) (UNESCO, 2015). Often persons who are impoverished experience a combination of housing, health, and time poverty, or all three, at the same time (UNESCO, 2015). Traditionally, when persons conceptualize poverty, they do so in terms of relative poverty (UNESCO, 2015); when counselors' poverty beliefs are measured it is likely they will conceptualize poverty as such. Regardless of definition, poverty experiences are defined as either episodic (two consecutive months or less) or chronic (in poverty for four years or longer) (U.S. Census Bureau, 2015).

Poverty Statistics and Demographics

In 2013, 14.5% of people in the United States, or roughly 45 million, lived in poverty, with income at or below approximately \$11,770 per year (U.S. Census Bureau, 2014). By comparison, in 2013 the median household income in the United States was \$51,939 and the lowest quintile of earners had an income of \$20,900 – above the federal poverty definition (DeNavas-Walt & Proctor, 2014). This juxtaposition illustrates that federal measures of poverty do not fully contextualize poverty in the United States; using a relational poverty lens many more persons are experiencing financial difficulties impairing their ability to successfully access resources than presented by FPL definitions and statistics. Persons living in relative poverty do not meet federal poverty levels and do not qualify for any federal income or health care assistance (UNESCO, 2015). This group experiences specific challenges that would not exist if they qualified for federal assistance such as Medicaid or Temporary Assistance for Needy Families (TANF). Many Americans fall into a gap existing between qualifying for Medicaid and being able to afford health insurance of their own; even under the Affordable Care Act, 9.2% of Americans do not have health insurance (Cohen & Martinez, 2015). Further, 25% of low-income persons in the United States have transportation difficulties getting to and from medical appointments, an issue that is largely ameliorated by Medicaid's transportation services (Syed, Gerber, & Sharp, 2013).

Poverty experiences are not equal across cultural groups; marginalized populations have higher poverty incidences. Nearly one-fifth (19.9%) of children in the United States experienced poverty in 2013 (U.S. Census Bureau, 2014). As previously mentioned, 14.5% of the United States population experienced poverty in 2013, yet the incidences of poverty among people of color were much higher than those of Whites. Specifically, 12.3% of Whites as compared to

27.2% of Black Americans, 10.5% of Asian Americans, and 23.5% Hispanic Americans experienced poverty in that same year (U.S. Census Bureau, 2014).

Gender is also a factor when considering poverty experiences. In 2013, 13.1% of men compared to 15.8% of women, experienced poverty; of households headed by a single adult, households headed by women experienced poverty at double the rate of households headed by men (30.9% vs. 16.4%) (DeNavas-Walt & Proctor, 2014; U.S. Census Bureau, 2014). No federal data have been gathered detailing the poverty levels of cisgender or transgender Americans, although a recent survey conducted by the National Center for Transgender Equality found that 15% of their transgender sample lived on less than \$10,000 per year (National Center for Transgender Equality, 2009).

Many intersecting identities impact poverty experiences, including sexual identity; 20% of LGBT Americans have an income of \$12,000 or less per year, in comparison to 17% of heterosexual Americans (Center for American Progress, 2014). In terms of ability status, persons without disabilities experienced poverty at a rate of 12.3% while persons with a disability experienced poverty at over double that percentage, at a rate of 28.8% (U.S. Census Bureau, 2014). Disability, including mental health related disabilities, appears to increase the likelihood of poverty experiences, and is explored later in this literature review.

Poverty rates are also impacted by citizenship and naturalization status: U.S. citizens who were born in the U.S. experience poverty at lower rates (13.9%) than U.S. citizens who were foreign-born and obtained citizenship later in life (16.1%) (U.S. Census Bureau, 2014). Poverty rates of persons who did not legally immigrate into the United States are not included in federal poverty statistics. In addition to immigration status, poverty levels are unevenly distributed across regions; in 2013 persons in urban areas experienced poverty at a rate of 14.2% while

individuals in rural areas experienced poverty at 16.1%, challenging the idea that poverty typically an urban phenomenon (U.S. Census Bureau, 2014). Poverty rates are lowest in suburban areas (U.S. Census Bureau, 2014). Poverty rates vary by geographical location: 12.7% of persons in Northeast, 12.9% in the Midwest, 16.1% of persons in the South, and 14.7% of persons in the West experienced poverty in 2013 (U.S. Census Bureau, 2013).

It is clear that poverty is an intersectional issue; persons who occupy multiple minority statuses are more likely to have poverty experiences than those who occupy social positions with more power (U.S. Census Bureau, 2013). In addition to experiences of classism and distress associated with poverty (e.g. educational, health care, food, housing and other barriers), a person may experience racism, sexism, homophobia, transphobia, or a combination of oppressive and detrimental social forces. These intersecting oppressions can lead to minority stress (Bockting et al., 2013; Meyer, 2003), which is characterized by chronic high stress levels associated with experiences of oppression, prejudice, discrimination, and even violence. Chronic stress due to and coupled with experiences of oppression leads to negative mental health outcomes, further highlighting the need for quality, effective, and accessible mental health services for persons in poverty (Bockting et al., 2013, Meyer, 2003).

Socioeconomic Status

Income, social standing, educational level/attainment, and social class privilege (the absence of experiencing classism) are concepts related to poverty, social class, and SES (APA, 2015; Lott, 2012; Thompson & Dvorscek, 2013). SES “...is commonly conceptualized as the social standing or class of an individual or group. It is often measured as a combination of education, income, and occupation” (APA, 2015). SES is commonly used in statistics and research as it provides a concrete measure through income; however, SES alone does not fully

explore the impact that education, income, and occupation can have on an individual or group's development (Bullock & Limbert, 2009; Thompson & Dvorscek, 2013). SES does not address concepts related to power, privilege, and access that accompany social class, a more difficult status to measure statistically (Bullock & Limbert, 2009; Thompson & Dvorscek, 2013).

Social Class

In juxtaposition to SES, which is typically an income based measure in research and statistics, social class provides a deeper understanding of how income, education, and occupation influence power, privilege, access, and social location within a culture (Lott, 2012). Social class membership can predict how one can benefit from social resources and related to life experiences (Lott, 2012). Additionally, social class standing and membership will influence how an individual learns, behaves, and opportunities they may or may not seek (Lott, 2012). Social class membership or changes in social class will influence a person's daily living across their lifespan (Lott, 2012).

Social class is stratified and related to power, privilege, and access to social resources (Gilbert & Kahl, 1993; Liu, 2013; Lott, 2012). Individuals in upper classes with increased access to resources, power, and therefore social class privilege (Gilbert & Kahl, 1993; Liu, 2013; Lott, 2012). In the United States, social class is typically organized into six categories: the underclass, the working poor, working class, lower middle class, upper middle class, and the capitalist class (Gilbert & Kahl, 1993).

The underclass, or what some may call the chronically impoverished, typically do not have a high school education and live below federal poverty levels (FPLs), possibly receiving some type of government assistance (Gilbert & Kahl, 1993; Liu, 2013). People socially

positioned into the underclass are often unemployed or underemployed (Gilbert & Kahl, 1993). Members of the underclass experience isolation – not simply due to a lack of material goods and resources, but also from cultural practices and values (Gilbert & Kahl, 1993; Liu, 2013; Lott, 2002). The working poor typically work full time or greater than full time, but do not meet federal poverty guidelines to receive any type of government assistance based on income levels; this group often falls into a gap of not receiving services and despite full time employment, has difficulties meeting basic living needs (Gilbert & Kahl, 1993; Liu, 2013).

The underclass and working poor make up about a quarter of the U.S. population and is what is typically conceptualized as “poor,” especially when conceptualizing poverty relatively (Gilbert & Kahl, 1993; Liu, 2013). Because what society in the United States deems “poor” is ascribed onto nearly one quarter of the population, effective and competent helping practices with persons in relative poverty are needed (Smith, 2005). This need is exacerbated by the reality that mental health fields have been created by middle and upper class individuals either excluding lower class persons from services or minimizing the needs of this group by proposing middle-class solutions or values (Lott, 2002; Smith, 2005). The majority of counseling professionals occupy middle or upper middle class statuses; clients recognize these differences through mannerisms, dress, language, and values which can be further isolating to an already marginalized group (Appio et al., 2012).

The working class straddles the boundary between “poor” and middle class, making up about one-third of the United States population (Gilbert & Kahn, 1993; Liu, 2013). Working class persons typically have high school and/or vocational educations and work hourly skilled positions (Gilbert & Kahn, 2013). Individuals in the working class group often struggle economically, lacking benefits such as insurance and retirement plans while having an income

too high for federal poverty assistance (Liu, 2013). Sometimes working class experiences are described as living paycheck to paycheck, limiting the ability to save money for emergencies or for long-term plans such as higher education and retirement (Liu, 2013)

In the United States the typified middle class is composed of the lower middle class and the upper middle class (Gilbert & Kahn, 1993; Liu, 2013). Lower middle class persons typically have vocational training, an associate's degree, or a bachelor's degree (Gilbert & Kahl, 1993; Liu, 2013). Upper middle class persons often have post-graduate or professional degrees (Gilbert & Kahl, 1993). The lower and upper middle class have distinct differences in experience, but are often grouped into one middle class category (Liu, 2013). Middle class values and understanding are typified as the American norm and often implemented across social classes (Liu, 2013; Lott, 2012). The uppermost social class, the capitalist class, has the most power, privilege, and access to resources (Gilbert & Kahl, 1993; Liu, 2013; Lott, 2012). This social class occupies the top 1% of American society, owning the majority of resources and assets; often, ownership of these assets means traditional work for pay is optional for this group (Gilbert & Kahl, 1993; Liu, 2013; Lott, 2012; Smith, 2005).

Classism

Classism in action is the process by which marginalization, ostracism, and oppression occur (Liu, 2013). Classism is structural and individual; that is, it can occur person-to-person (individual) and at a systemic level with relation to power, privilege, and access to resources (structural) (Liu, 2013; Lott, 2012). Classism can be categorized as upward, downward, lateral, and internalized (Liu, 2001, 2013). Upward classism consists of negative perceptions, prejudices, and discrimination against higher social class groups (Liu, 2013). Upward classism exists on the individual level, but arguably does not impact power, privilege, and access to resources of those

who occupy higher social classes (Liu, 2013; Lott, 2012). Downward classism is associated with the isolation, oppression, and marginalization of individuals who occupy lower-class statuses and/or identities (Liu, 2001, 2013; Lott, 2012; Toporek, 2013). Downward classism is directly linked with economic privilege and access to resources, reinforcing marginalization and limiting access to resources for those who occupy lower classes (Liu, 2001; 2013). Downward classism is often perpetuated by the capitalist and middle classes, reinforcing middle class values and narratives, even in mental health treatment (Liu, 2001, 2013; Lott, 2012; Toporek, 2013).

Downward classism is a conscious or unconscious distancing from the poor, by those in higher social classes (Liu, 2001; Lott, 2002). This distancing is enacted through separation, segregation, and physical exclusion of poorer social class groups, while experiences of lower social class groups are devalued, discounted, and othered in cultural narratives (Lott, 2002). Classism is also experienced through outright class discrimination and classist microaggressions (Liu, 2013; Lott, 2002, 2012; Smith & Redington, 2010).

Lateral and internalized classism is experienced within a social class (Liu, 2001). Lateral classism is experienced by persons who have negative ideas, impressions, or opinions of persons of the same social class as themselves (Liu, 2001). This is due to the prevalence of middle class narrative such as the “American Dream” and ideas that success is based on merit (Liu, 2001; Lott, 2002; Smith, 2005). Separation from “mainstream” culture through classism, and social isolation through employment, education, and housing also increases lateral classism in lower social classes (Liu, 2001; Lott, 2002; Smith, 2005). Similar to lateral classism, social class biases can be turned inward on oneself, as internalized classism (Liu, 2001). This may lead to faulty beliefs about themselves, negative self-talk, or increased distancing from mainstream culture due to perceived personal economic failures (Liu, 2001; Lott, 2002). Because of the relationship of

social class to power, privilege, and resources, individuals occupying lower-social classes experience the greatest amount of classism and are harmed the most by classism (Liu, 2013; Lott, 2002, 2012; Smith & Redington, 2010; Toporek, 2013).

Poverty Outcomes

Intersecting experiences of poverty and classism impact outcomes across individuals' lives; individuals across cultural groups who experience poverty have increased negative outcomes across the domains of health, development, and mental health and mental illness (Kaminski et al., 2013; Krieger, Chen, Waterman, Rehkopf, & Subramanian, 2005; Raphael, 2011; Weissman, Pratt, Miller, & Parker, 2015; WHO, 2007). Poverty itself is not a direct cause of increased health and mental health issues, but rather the impact that limited economic resources has on an individual's daily lived experiences (Kaminski et al., 2013).

There are a variety of physical, social, and environmental experiences associated with poverty that will impact a person's health, mental health, and wellness (Cozzarelli, Wilkinson, & Tagler, 2001; Goodman, Pugach, Skolnik, & Smith, 2012; Logan, Walker, Cole, Ratliff, & Leukefeld, 2003; Myers & Gill, 2004). Environmentally, individuals in poverty are more likely to live in overcrowded and poor quality housing (Anakwenze & Zuberi, 2013; Goodman et al., 2012). People in poverty are more likely to be exposed to neighborhood, domestic, interpersonal violence, and abuse (Anakwenze & Zuberi, 2013; Goodman et al.; Logan et al., 2003). Environmental toxins, irritants, and pollutants are more prevalent in impoverished communities and dwellings due to substandard housing, leading to chronic and acute health and developmental concerns (Goodman et al., 2012; Kaminski et al., 2013). In addition to environmental factors, persons in poverty experience chronic and acute stressors related to food insecurity, relationship instability, significantly higher than average rates of incarceration,

unemployment and underemployment, and lower educational achievement (Goodman et al., 2012; Myers & Gill, 2004; WHO, 2007). Barriers to resources and health care are also a concern, as persons in poverty are less likely to have health insurance, transportation, and access to health and mental health clinics (Goodman et al., 2012, Myers & Gill, 2004; WHO, 2007). Finally, the long-term impact of stereotyping, discrimination, classism, and social ostracization impacts social connection and creates chronic stress for individuals who are experiencing poverty (Cozzarelli et al., 2003; Goodman et al., 2012; Liu, 2013; Lott, 2002, 2012; Toporek, 2013; Myers & Gill, 2004; WHO, 2007). Chronic and acute stressors to include social, physical, and environmental barriers increase health and mental health risk and limit access to health and mental health care, making persons experiencing poverty more vulnerable to physical and mental health maladies.

Health

Experiences of poverty negatively impact health in a variety of ways. It is important to note, that the correlation between poverty and negative health outcomes is clear, but barriers to health care resources, such as medical care and insurance, are the primary reason for these negative outcomes (Kaminski et al., 2013). Using U.S. Census data (1990) from Massachusetts and Rhode Island, researchers found individuals experiencing poverty have unhealthier births, increased infant mortality, higher rates of lead poisoning, increased sexually transmitted infections, greater incidences of tuberculosis, increased non-fatal weapons related injuries, higher cancer incidences, and general all cause and cause specific mortality (Krieger, Chen, Waterman, Rehkopf, & Subramanian, 2005). Poverty increases mortality in general (Krieger et al., 2005).

Like adults, children who experience poverty experience negative health outcomes and long-term effects of adverse childhood poverty experiences concurrent with educational, developmental, and behavioral health outcomes (Kaminski et al., 2013; Landes, Ardel, Vaillant, & Waldinger, 2014; Raphael, 2011). These experiences, although not directly associated with poverty, are correlated with experiences of an impoverished environment, such as community violence, exposure to pollutants and toxins, food insecurity, and barriers to health care (Kaminski et al., 2013). Children experiencing poverty have higher rates of chronic disease, increased cardiovascular dysregulation, depressed immune function, high blood pressure, respiratory illness, and increased levels of injury overall. Children in poverty are less frequently vaccinated, exposing them to various diseases and infections that may be preventable. Poverty exposure is also positively correlated with the onset of developmental and cognitive delays in children (Kaminski et al., 2013).

Even if persons only experience poverty during childhood, negative health outcomes persist across their lifespan. Adults who experienced poverty in childhood have higher levels of cardiovascular disease/stroke, diabetes, and respiratory illnesses than those who do not experience childhood poverty (Raphael, 2011). The acute and chronic impact of poverty across an individual's lifespan is well documented and impactful to healthy development (Kaminski et al., 2013; Krieger et al., 2005; Landes et al 2014; Raphael, 2011).

Mental Health and Mental Illness

Poverty experiences are linked to higher rates of mental illness (Hanandita & Tampubolon, 2014; Lund et al., 2010; Mickelson & Hazlett, 2014; Weissman et al., 2015; WHO, 2007). Globally, poverty is correlated with an increase in mental illness; in two studies (i.e. Hanandita & Tampubolon, 2014; Lund et al., 2004) exploring the correlation between poverty

experiences and incidents of mental illness it was indicated that increased poverty experiences – in time, severity, or both – were linked to increased the likelihood of mental illness (WHO, 2007). These studies also found that the presence of financial barriers were linked to significant stressors leading to mental illness (Hanandita & Tampubolon, 2014; Lund et al, 2004). The WHO (2007) reports that individuals experience poverty are twice as likely to experience mental health disorders and eight times as likely to present with a severe mental illness such as schizophrenia.

In the U.S., poverty is also related to an increase in rates of mental illness (Hong, Zhang, & Walton, 2014; Mickelson & Hazlett, 2014; Weissman et al., 2015). Data from the 2009-2013 National Institute of Health survey showed that higher income was linked to lower psychological distress (Weissman et al., 2015). Of adults in poverty, 8.7% had severe psychological distress, compared to only 1.2% of adults who lived above federal poverty levels (Weissman et al., 2015). In a study of 66 low-income mothers, Mickelson & Hazlett (2014) found that such women had higher levels of depression and anxiety in relation to women and mothers who did not have low-income experiences.

Multiple studies have indicated that poverty and low-income levels negatively impact parent and caregiver mental health, noting the impact that poverty has not only on parents and caregivers, but also the children who receive their care (Elder, Eccles, Ardel, & Lord, 1995; Jackson, Brooks-Gunn, Huang, & Glassman, 2000). In one study, negative symptoms associated with Major Depressive Disorder were reduced by simply discussing and addressing client economic concerns, highlighting the importance of class conscious treatment (Falconnier & Elkin, 2008). Poverty also impacts how adverse events are experienced and the speed of mental health recovery following traumatic events; experiences of poverty increased rates of depression,

post-traumatic stress disorder, and drug use in survivors of sexual assault as compared to survivors who did not experience poverty (Bryant-Davis, Ullman, Tsong, Tillman, & Smith, 2010). Poverty increases the risk of mental illness for those who experience it.

The Cycle of Poverty and Mental Illness

Poverty is linked to higher risks for mental illness, and the relationship between these two factors is bidirectional and cyclical (Weissman et al., 2015; WHO, 2007, 2010). Increased poverty correlates with increased mental illness risk, and mental illness increases the likelihood one may experience poverty (Anakwenze & Zuberi, 2013; Hanandita & Tampubolon, 2014; Lund et al., 2010; Mickelson & Hazlett, 2014; Weissman et al., 2015; WHO, 2007, 2010). The WHO (2010) identifies persons with mental health conditions as a vulnerable and marginalized group; this marginalization often leads to experiences of poverty, increasing the risk for mental illness. People with mental health disorders are vulnerable to stigma, discrimination, sexual and physical abuse, as well as educational and employment barriers (WHO, 2010). Employment and educational barriers of those with mental health disorders makes them at risk for poverty experiences based on earning capabilities. Specifically, persons with schizophrenia are four times more likely to be unemployed (WHO, 2007). Further, experiences of poverty are intergenerational and long-lasting, impacting mental health for a lifetime (Kaminiski et al., 2013; Landes et al., 2014; WHO, 2007, 2010). Mental illness in itself creates additional barriers that increase poverty incidents but also limit a person's ability to exit poverty.

Persons in poverty are more likely to live in violent, crowded, and substandard dwellings and neighborhoods (Anakwenze & Zuberi, 2013; Goodman et al., 2012). Exposure to violence and crime is linked to increased risk for mental illness (Saris & Johnson-Robeldo, 2000); this exposure to crime and violence is also linked to higher incarceration rates, decreasing mental

health outcomes as well as employability (Freudenburg, Galea, & Vhalov, 2006). Decreased employability can lead to financial barriers that increase psychological distress (Anakwenze & Zuberi, 2013; Freudenburg et al., 2006; WHO, 2007). Mental illness is disproportionately expressed in the urban poor; urban poverty and mental illness are mutually reinforcing (Anakwenze & Zuberi, 2013).

Poverty and mental illness exacerbate each other while barriers limit access to treatment (Anakwenze & Zuberi, 2013; Hanandita & Tampubolon, 2014; Lund et al., 2010; Mickelson & Hazlett, 2014; Weissman et al., 2015; WHO, 2007, 2010). Persons in poverty face significant barriers to mental health treatment, impeding wellness or relief from symptoms (Goodman et al., 2012; Weissman et al., 2015). Persons in poverty are less likely to be in mental health treatment: less than 10% of low-income women with mental health disorders seek treatment (Nadeem, Lange, & Miranda, 2008). For many, mental health treatment is not affordable due to lack of insurance (Goodman et al., 2012; WHO, 2010). Persons with serious psychological distress are uninsured at higher rates than persons without serious psychological impairments (20.5% uninsured) (Weissman et al., 2015). For others access to treatment is difficult, as many geographical areas lack adequate mental health facilities or they do not have transportation to access requisite treatment (Goodman et al., 2012; Myers & Gill, 2004). Due to barriers of poverty, mental health treatment is inaccessible for many; this inaccessibility exacerbates the impact that mental health has on lived experiences and can deepen poverty.

Perceptions of Poverty

Classism and negative poverty attitudes are common in American culture (Atherton & Gemmel, 1993; Beck, Whitley, & Wolk, 1999; Bullock, Wyche, & Williams, 2001; Cozzarelli et al., 2001; Hunt, 1996; Lott, 2002, 2012; Yun & Weaver, 2010). Americans distance themselves

from, ostracize, and marginalize individuals experiencing poverty (Lott, 2002, 2012). This downward classism is reflected in general attitudes and media portrayals of those experiencing poverty (Beck et al., 1999; Bullock, Wyche, & Williams, 2001; Cozzarelli et al., 2001; Hunt, 1996).

Cozzarelli et al. (2001) explored attitudes towards poverty and individuals experiencing poverty among 209 undergraduate students. Findings showed that attitudes toward the poor were significantly more biased than those towards the middle class (Cozzarelli et al., 2001). This study is one of few that outline individuals' attitudes toward poverty. In another study exploring poverty attitudes, 2854 persons in southern California indicated more individualistic beliefs about poverty, or that poverty was the fault of the person experiencing it (Hunt, 1996). Although these studies are not wholly generalizable, they provide an understanding that individuals may have less desirable attitudes towards those experiencing poverty than towards persons of other social classes. The results of these studies also indicate significant levels of downward classism present in their samples (Cozzarelli et al., 2001; Hunt, 1996; Lott, 2002).

Generally, people from marginalized groups tend to have more positive poverty beliefs (Beck et al., 1999; Hunt, 1996). In a study exploring poverty attitudes of southern Californians, women and persons of color were more likely than men and European Americans to have more positive poverty attitudes (Hunt, 1996). The poverty attitudes have also been found to be more positive in minority groups including women and people of color when exploring poverty attitudes of members of the Georgia General Assembly (Beck et al., 1999). Beck et al. (1999) found that elected officials who identified as Democrats tended to have more positive poverty attitudes.

Poverty Perceptions of Mental Health Professionals

Counselors and professionals in other allied fields have been shown to have negative poverty beliefs (Schnitzer, 1996; Smith et al., 2011; Toporek & Pope-Davis, 2005; Weiss-Gal, Benyamini, Ginzburg, Savaya, & Peled, 2009). Multiple studies explore mental health practitioners' attitudes toward poverty, beliefs about poverty, and the relationship between poverty attitudes and clinical skills and practices.

Allied Mental Health Fields

Multiple studies have explored poverty perceptions of general mental health professionals, social workers, and counseling psychologists (Schnitzer, 1996; Smith et al., 2011; Weiss-Gal et al., 2009). These negative beliefs can stem from personal biases, social attitudes about individuals experiencing poverty, and even the way social class is presented to beginning helpers in their graduate training (Lott, 2002, 2012; Schnitzer, 1996). In some ways, graduate training in social class reinforces stereotypes of persons in poverty (Schnitzer, 1996). Graduates are trained to expect that clients in poverty are more unreliable, disorganized, irresponsible, and less likely to commit and follow through with therapy, reinforcing classism in mental health training (Schnitzer, 1996; Smith, 2005). Because of these training practices, it is not surprising to find that many professionals have negative poverty attitudes.

In a study using case vignettes, therapists' impressions of clients of all social classes, participants responded to lower SES clients in a more negative way, and sessions with these clients were less smooth and lacked depth (Smith et al., 2011). Findings indicated that therapists with higher levels of just world beliefs (i.e., an understanding that the world is just and persons experiencing poverty deserve to be in poverty) saw poor and working class clients as significantly more dysfunctional and unpleasant (Smith et al., 2011). Just world beliefs have also been explored in relation to 181 mental health professionals' beliefs about helping the poor; as

participants' just world beliefs increased, participants' expressed increased negative poverty attitudes and decreased confidence that lower-SES clients could benefit from psychotherapy (Shapiro, 2004). Participants with more negative poverty attitudes are less willing to provide services to lower-SES clients (Shapiro, 2004). These studies indicate that mental health professionals respond to lower-SES persons in more negative ways while holding beliefs and attitudes that may hinder the helping process, contrary to ethical codes and multicultural competencies (ACA, 2014; Shapiro, 2004; Smith et al., 2011).

Similar results reflecting negative poverty attitudes were found among social workers (Bullock, 2004; Moraes, Durrant, Brownridge, & Reid, 2006; Weiss-Gal et al., 2009). In comparison to welfare recipients, social workers believed at higher rates that poverty was fatalistic or motivational (on the part of the person in poverty) persons in poverty are more likely than social workers to believe that structural forces (such as discrimination) are the reasons for poverty experiences (Bullock, 2004). An Israeli study using a sample of 401 service users and 401 social workers provides supporting results (Weiss-Gal et al., 2009). The social workers believed that poverty was caused by client motivational and/or psychological deficits while consumers of services were more likely to believe that structural or fatalistic forces were the causes of poverty (Weiss-Gal et al., 2009). These studies both highlight that social workers may believe that poverty is related to an internal deficit such as motivational levels or psychological factors rather than structural factors including racism, classism, and discrimination (Bullock, 2004; Weiss-Gal et al., 2009). The internalization of poverty responsibility can be dangerous to the helping relationship, promoting classist ideas and distance in the therapeutic relationship (Lott, 2002; Smith, 2005).

Counselors

Although social class competence is an assumed component of overall multicultural counseling competence, the poverty attitudes of counselors are relatively unexplored (Myers & Gill, 2004; Smith, 2005). In a sample of 200 counselor trainees, participants were analyzed for biases towards various social and cultural groups on the basis of race and ethnicity, gender, sexual identity, ability status, and social class (Neynaber, 1992). Counselor trainees had more significant biases towards persons with physical disabilities and those of lower social classes than towards any other diverse group (Neynaber, 1992). This is one of the few that compare biases based on class to biases related to other social/cultural factors. However, the study is dated, only samples counselor trainees, and uses instruments in data collection that were created by the author without being validated.

In more recent research, 513 American School Counseling Association (ASCA) school counselors were surveyed to compare their poverty beliefs and ways of knowing using the Attributions for Poverty Questionnaire (APQ) (Bray & Schommer-Aikins, 2015). The APQ indicates three causes of poverty: individual characteristics such as motivation; societal factors such as structures like, policies, economy, or oppression; and bad luck or fatalism (Bray & Schommer-Aikins, 2015). Using canonical correlation analysis, researchers discovered that school counselors who believed poverty was caused by individual factors had lower levels of connected knowing, perceiving knowing as a hierarchy or competition, and had less multicultural courses and training. School counselors who believed poverty was caused by societal factors balanced levels of separate and connected knowing, had less years of experience, and had more students in poverty in their school. It is possible that counselors who have more connected understandings of the world and have more experience with students in poverty will have more structural understandings of poverty. More multicultural training may also lead to more

structural attributions for poverty (Bray & Schommer-Aikins, 2015). While this study provides insight of school counselors' understandings of poverty and social class, it fails to illuminate the experiences of counselors across specialties.

Social Class Competence and Multicultural Competence

Counselors are ethically mandated to provide efficacious counseling services to all persons regardless of cultural identification or socioeconomic class background (ACA, 2014). However, mental health literature, theory, and practice often exclude the experiences and specific needs of individuals experiencing poverty (Smith, 2005; Smith, Foley, & Chaney, 2008). Despite a demonstrated connection between ethical and multiculturally competent counseling, only one study exists which explores poverty attitudes of counselors in relation to their multicultural counseling training (Toporek & Pope-Davis, 2005). In a sample of 158 White and African American graduate counseling students' poverty attributions, the study measured racial identity development and multicultural counseling training (Toporek & Pope-Davis, 2005). Using a regression analysis, authors found that increased multicultural counseling training predicts the understanding of structural oppressive forces, such as racism and classism, as well as racial awareness and structural understandings of poverty (Toporek & Pope-Davis, 2005). Decreased amounts of multicultural counseling training were predictive of less racially sensitive attitudes and increased individual explanations for poverty (Toporek & Pope-Davis, 2005). This study helps to establish the relationship between increased multicultural counseling training and structural attributions for poverty; however, the authors did not control for demographic variables other than race and gender. The need for social class competence in counseling becomes increasingly apparent when considering mental health risk factors increase for persons experiencing poverty (WHO, 2007).

The *ACA Code of Ethics* (2014) outlines the importance of multicultural competence in the preamble and four specific ethical codes. In the preamble, the ACA states “...honoring diversity and embracing a multicultural approach in support of worth, dignity, potential, and honoring uniqueness of people within their social and cultural contexts...” highlighting the importance of acceptance and empowerment of all persons in all social and cultural contexts. Discrimination on the basis of socioeconomic status is not acceptable or ethical in counseling, as illustrated by code C.5 “non-discrimination:”

Counselors do not condone or engage in discrimination...based on age, culture, disability, ethnicity, race, religion/spirituality, gender/gender identity, sexual orientation, marital/partnership status, language preference, socioeconomic status, immigration status, or any basis proscribed by law.

Social class and classism are markedly absent from the *ACA Code of Ethics* (2014) as both concepts are not mentioned in the document.

In addition to the *ACA Code of Ethics* (2014), the ACA has endorsed the *Multicultural Counseling Competencies* (MCCs) (Arredondo et al., 1996; Sue et al., 1982, 1992) and more recently the *Multicultural and Social Justice Counseling Competencies* (MSJCC) (Ratts et al., 2016) to serve as guides for best practice in multicultural counseling. The MCCs discuss counselor competence in relation to their multicultural attitudes and beliefs, knowledge, and skills. The MSJCCs are expanded and include the domain of action (AKSA) to highlight the increasing importance of advocacy in professional counseling (Ratts, et al., 2016). The MSJCC model includes four quadrants and four levels. The four quadrants include privileged counselor, marginalized client, marginalized counselor, and privileged client. These quadrants illustrate the

complex cultural relationships between various counselors and clients based on their own experiences of privilege and oppression.

Each of the quadrants has four levels. The first and innermost level in the model is counselor self-awareness level. The MSJCCs state that counselors must have self-awareness in terms of their own attitudes and beliefs, knowledge, skills, the ability to take action in relation to social identities, social group statuses, power, privilege, and oppression (Ratts et al., 2016). Therefore, counselors must be familiar with their biases toward diverse populations (Ratts et al., 2016). The next level is the client worldview level. counselors must understand their clients' worldviews, how intersecting cultural identities influence the counseling relationship, and understanding advocacy at multiple levels (intrapersonal, interpersonal, institutional, community, public policy, and international and global affairs) (Ratts et al., 2016). The third level is the counseling relationship level. At this level counselors must implement culturally appropriate and sensitive relationships skills to build and enhance the therapeutic relationship (Ratts et al, 2016). The final and outmost level of the model is the counseling and advocacy interventions level. Building on the MCCs, the MSJCCs reinforce the need for counselors to have knowledge of and the counseling skills to work with varied, intersecting, and diverse cultural groups outside of their own. Additionally, the MSJCCs insist Counselor should be prepared to and engaged in action with or on behalf of clients. The MSJCCs do not specifically mention social class as an area for competency.

Counselors must continue to make an effort to expand knowledge, attitudes, skills, beliefs, and actions specifically related to experiences of poverty to improve service delivery for this population. Class bias in the mental health professions and counseling is noted in traditional counseling theories, modalities of psychotherapy, and the limited access persons in poverty have

to mental health resources (Liu, 2013; Lott, 2012; Smith, 2005). Focusing and remedying this class bias in counseling is ethically mandated and can be partially achieved through empirical research in the areas of poverty competency, the needs of persons in poverty, and effective interventions with persons in poverty.

Counseling Poverty Interventions

No empirically validated model or theory exists to guide counselors' responses to issues and concerns related to client experiences with poverty. Multiple calls for increased poverty and social class awareness have been published in counseling, counseling psychology, and psychology (e.g., Liu & Arguello, 2006; Liu, et al., 2007; Lott, 2012; Smith, 2005; Smith et al., 2008), yet little research has been conducted to gain further understanding regarding the impact that counselor poverty attitudes and counselor attributions for poverty have on counseling efficacy and client outcomes (Thompson & Dvorscek, 2013; Toporek, 2013). Limited research in this area has created deficits in counselor education and preparation, to include many programs failing to address social class and poverty as a counseling issue (Liu & Arguello, 2006; Liu et al., 2007). This lack of research and integration in counselor preparation reflects classism, institutional values of counseling, and class privilege experienced by many counseling professionals (Toporek, 2013).

Many articles suggest interventions and strategies for working with individuals in poverty (e.g., Baggerly, 2006; Cholewa & Smith-Adcock 2012; Clark & Bower, in press; Goodman et al., 2012; Myers & Gill, 2004; Tate, Lopez, Fox, Love, & McKinney, 2014), yet only two of these are based on empirical studies with persons experiencing poverty and other financial barriers. Suggested interventions include client empowerment, strengths based approaches, and advocacy (Baggerly, 2006; Cholewa & Smith-Adcock, 2012; Clark & Bower, in press; Myers &

Gill, 2004; Tate et al., 2014). It is reiterated that to be effective with persons experiencing poverty, counselors must understand poverty experiences, the impact poverty has on individuals, and the consequences of poverty (Myers & Gill, 2004). Additionally, counselors must examine their own poverty beliefs (Cholewa & Smith-Adcock, 2012; Myers & Gill, 2004). Although this literature provides helpful suggestions for poverty interventions, it originates from the belief that counselors have explored their attitudes towards persons in poverty, and that those attitudes are positive or at least neutral.

There are two distinct models for addressing social class and poverty in counseling and allied mental health fields (Foss, Generali, & Kress, 2011; Liu, 2001). The most recognizable and widely used model is Liu's (2001a, 2001b) *Social Class Worldview Model*. This model is based on the idea that each individual has unique lived experiences related to social class and on six domains of understanding: (a) an individual's perception of their social class environment creates their reality; (b) people perceive money, not for its objective value but for what personal meaning it holds; (c) people are motivated to seek acceptance within their peer group/social class; (d) people exist in social class environments that put certain cultural expectations and demands on them; (e) when persons have enough economic resources, they remain in harmony with the dominant economic culture; when they do not they behave in ways that allow them to maximize their resources; (f) one's perceptions of their world reflect the demands within their own social class context and culture (Liu, 2001a, 2001b). This model does provide a way at viewing the individual impact that social class can have on a client, but it does not provide concrete interventions that will enable a person in poverty to successfully complete counseling. The *Social Class Worldview Model* (2001a, 2001b) provides a context in which counselors can

limit the impact that their own social class biases and classism impacts clients of lower socioeconomic statuses. This model has not been empirically tested.

The *CARE model* (Foss et al., 2011) provides an outline for counseling professionals, suggesting concrete interventions. In the *CARE model*, counselors are encouraged to do the following: (a) Cultivate the relations with clients, (b) Acknowledge the realities of poverty, (c) Remove barriers, and (d) Expand strengths (Foss et al., 2011). To cultivate the relationship, counselor should build the therapeutic alliance, recognize client challenges based on poverty, do not stereotype, explore their own social class biases, and recognize racial and structural injustices related to poverty. This can be achieved through acknowledging the realities of poverty and the economic injustices faced by clients. Counselors should also remove barriers through advocacy and action; this could include logistic barriers (transportation or affordability of services), as well as micro-, meso-, and macro-level advocacy for clients experiencing poverty. Finally, in therapeutic work counselors are called to identify client strengths, to empower clients, and avoid focusing on barriers and deficits clients may experience (Foss et al., 2011). This model has not been empirically tested.

The *Social Class Worldview Model* (Liu, 2001) and the *CARE model* (Foss et al., 2011) focus on different strategies for working with persons in poverty; the former focuses on classism and classist attitudes while the latter provides a framework that counselors can use as a scaffold in their therapeutic work with clients experiencing poverty (Foss et al., 2011; Liu, 2001). Both of these models have practical and theoretical implications in counseling, yet fail to address how counselors identify their poverty attitudes and what poverty attitudes and orientations a counselor should have when working with clients. Current models and existing literature fail to establish a

baseline of counselor poverty attitudes and how these attitudes will impact client treatment and outcomes.

Summary

Counselors have clearly begun to commit to understanding the implications that poverty competence and attitudes have on counseling practice, but should increase access and quality of care for all persons, regardless of social class (Bray & Schommer-Aikins, 2015; Toporek & Pope-Davis, 2005; Smith, 2005). Poverty attitudes of the general population have been explored (e.g., Cozzarelli et al., 2001), yet limited empirical evidence exists regarding the poverty beliefs of mental health professionals. This lack of research is especially concerning as persons in poverty are significantly more likely to experience mental illness (Hong et al., 2014; Mickelson & Hazlett, 2014; Weissman et al., 2015).

The *ACA Code of Ethics* (2014) and the MSJCCs (Ratts et al., 2016) reflect the counseling professions' commitment to equal access and treatment for all persons, yet it is clear that many counselors still hold classist beliefs and attributions towards those in poverty (Bray & Schommer-Aikins, 2015; Ratts et al., 2015; Toporek & Pope-Davis, 2005). While multiple conceptual models exist outlining the treatment of persons in poverty (Foss et al., 2011; Liu, 2001), no empirically tested models are currently available. Available literature exploring the relationship between poverty attitudes and multicultural competence is a beginning step into further understanding the impact that class and classism have on the counseling relationship.

Increased multicultural training and experiences in the realm of social class have been found to increase positive poverty attitudes (Bray & Schommer-Aikins, 2015; Toporek & Pope-Davis, 2005). However, available studies connecting multicultural competence with poverty attitudes lack depth and breadth, having only taken a small sample of specific counseling

specialties (counselors in training and school counselors) (Bray & Schommer-Aikins, 2015; Toporek & Pope-Davis, 2005). To further understand the poverty attitudes of all counselors, a broader sample must be studied. This study sought to explore the poverty attitudes and attributions of counselors, regardless of specialty, and explore the relationship between those factors and MCC.

CHAPTER 3

METHODOLOGY

This chapter describes the methods used to explore the relationship between participants' MCC and their beliefs about poverty, including the relationship that participant identity factors have with these two variables of interest. This chapter includes an overview of research design, research questions, hypotheses, participants, participant selection criteria, descriptions of instrumentation, data collection procedures, power analysis, data analysis, and a statement of study limitations.

Research Design

This study explored the relationship between counselor MCC and poverty beliefs to increase the awareness of poverty and social class issues within counseling literature and provide implications for counselor preparation and practice. The contribution of this study is unique, as no research exists exploring the relationship between MCC and poverty beliefs in a diverse group of counseling professionals.

Electronic surveys were used to collect data in this study. Electronic surveys are a useful method when collecting data in correlational studies due to the pre-existing nature of the variables of interest (Granello & Wheaton, 2011). Variables measured in this study are pre-existing and develop over time, making survey methods an appropriate way to measure these variables (Granello & Wheaton, 2011; Kelley, Clark, Brown, & Sitzia, 2003). Additionally, surveys are a popular way to access a specific population in a short time at a low cost (Granello & Wheaton, 2011). A survey method allowed for the inclusion of a sample of counselors across specialties, expanding on previous research and increasing the generalizability of this study

(Granello & Wheaton, 2011). A qualitative design would not allow the inclusion of as many varied participants, limiting generalizability.

The sample ($N= 251$) identified as professional counselors from any specialty; graduate students in counseling with previous field experiences (practicum or internship) were also included in the sample. Participants completed a consent form, a short demographic questionnaire, and two assessments, the Multicultural Knowledge and Awareness Scale (MCKAS) (Ponterotto et al., 2002) and the Beliefs About Poverty Scale (BAPS) (Smith & Stone, 1989). The electronic surveys were distributed via various listservs related to counseling practice, education, and preparation including COUNSGRADS, CESNET, ACA Connect, Counselors' for Social Justice (CSJ) listserv, and the American Mental Health Counselors Association listserv (AMHCA).

Participant scores on the MCKAS (Ponterotto et al., 2002) and BAPS (Smith & Stone, 1989) represent the two main variables of interest: MCC and poverty beliefs. Additional demographic data were used to explore the relationship between counselor demographic factors and to control for possible confounding variables (i.e., age, gender, ethnocultural identity) as identified in previous studies (Bray & Schommer-Aikins, 2015; Chao, 2013; Toporek & Pope-Davis, 2005); these were controlled by including these variables in the regression model according to their causal priority (Petrocelli, 2003). Correlating participant scores on the MCKAS, BAPS, along with the constructs of gender, ethnocultural identity, age, personal poverty experience, and poverty counseling experience and then utilizing multivariate statistics allowed for a deeper exploration of relationships among these constructs within the sample.

Data were entered into SPSS 22 for statistical analysis. Data were screened and participants with missing values were excluded from the sample, as the survey electronic survey

construction included force complete pages (i.e., if a page was not completed a large portion of data was missing). Demographic information, necessary for all research questions, was the last page of the electronic survey. If this page was not completed, participants were eliminated because all components of the survey (MCKAS, BAPS, and demographic information) were necessary for statistical analyses in all three research questions. After removing incomplete entries, 251 completed surveys were used. A sample size of approximately 120 was determined sufficient for the purposes of this study and to achieve Power of at least .80 at a significance level of $p \leq .05$ (Cohen, 1988); the present sample exceeded this number ($N = 251$). Tabachnick and Fidell (2013) suggest that $104 + k$ (number of variables in the regression equation) as an appropriate minimum sample size yielding adequate power; for the purposes of this study that would be 113. Power of .80 is appropriate for correlational research, and $p \leq .05$ is an appropriate significance level in counseling research (Balkin & Sheperis, 2009; Cohen, 1988).

The MCKAS subscales of knowledge and awareness and BAPS subscales of individualistic and structural beliefs about poverty were used in analyses to establish the relationship between MCC and poverty beliefs. Raw subscale scores were used. BAPS subscale scores were used because the BAPS does not provide a total score, rather the subscales represent participant poverty beliefs across the three subscale domains, fatalistic, individualistic, and structural beliefs about poverty.

Appropriate MCKAS items were reversed scored, and raw totals for the knowledge subscale, the awareness subscale, and the MCKAS overall were computed. The BAPS items were totaled for each individual subscale (fatalistic beliefs about poverty, individualistic beliefs about poverty, and structural beliefs about poverty). The demographic variables gender, ethnocultural identity, counseling specialty, poverty counseling experience, and personal poverty

experiences were dummy coded and used as dichotomous variables for use in the regression models. Demographic variables were coded in ways to express their experiences of privilege on that particular identity factor (i.e., gender, ethnocultural identity). Counseling specialty was coded as “mental health” and “not mental health” as way to balance counseling specialty groups. Gender was coded as “female” (1) and “not female” (0). Ethnocultural identity was coded as “White” (1) and “non-White” (0). Counseling specialty was coded as “mental health” (1) or “non-mental health” (0). Poverty counseling experiences was coded as “poverty counseling experience” (1) or “no poverty counseling experience” (0). Finally, personal poverty experiences were coded “yes” (1) or “no” (0). Age was entered into the models as a continuous variable.

The assumptions of regression, independence, homoscedasticity, and normality were tested on each continuous variable using scatterplots. Tested continuous variables included participant MCKAS knowledge raw score, MCKAS awareness raw score, BAPS individualistic raw score, BAPS structuralism raw score, and age. All variables met the assumptions of regression except the BAPS individualistic raw scores. The BAPS individualistic raw score was transformed using a cube root transformation. This transformation is useful to normalize non-normal, particularly leptokurtic, data (Cox, 2011).

Two hierarchical multiple regressions were used to determine if counselor MCC predicted counselor poverty beliefs. The first regression tested the relationship between MCC and individualistic beliefs about poverty, as measured by the BAPS individualistic subscale. The second regression tested the relationships between MCC and structural beliefs about poverty, as measured by the BAPS structural subscale. Variables were entered in step-wise; the first step included the demographic variables gender, age, and ethnocultural identity. The second step included participants’ poverty counseling experience and personal poverty experiences. MCKAS

knowledge raw total and MCKAS awareness raw total were entered in the final step. Two separate regressions were conducted because of the independence of the BAPS individualistic and structural subscales, represented by their insignificant correlation ($r = .03$, $p = .67$). The BAPS individualistic and structural subscales represent two distinct concepts that must be analyzed independently (Smith & Stone, 1989).

A factorial multivariate analysis of variance (MANOVA) was conducted to explore the differences between counselors' select demographic factors (i.e., gender, counseling specialty, ethnocultural identity, personal poverty experiences, and professional exposure to poverty). BAPS individualistic and structural subscale scores were entered into SPSS 22 as the dependent variables and the select demographics were entered as the independent variables.

Participants

Participants in this study ($N=251$) identified as professional counselors or counselor trainees with field experience (practicum and/or internship). Expanding on the work of previous studies (e.g. Bray & Schommer-Aikins, 2015; Toporek & Pope-Davis, 2005), the sample included counselors from multiple counseling specialties: mental health ($n=146$, 58.2%), school ($n=29$, 11.6%), Other ($n=18$, 7.2%), marriage and family ($n=16$, 6.4%), college ($n=15$, 6%), community ($n= 11$, 4.4%), addictions ($n= 6$, 2.4%), rehabilitation ($n= 6$, 2.4%), and career ($n= 4$, 1.6%) counseling. Counselors who selected the "Other" specialty included grief and loss/bereavement counselors, play therapists, and a combination of counseling specialties (such as mental health and school counseling).

Participants' age ranged from 22 years to 81 years ($M= 40.98$ years, $SD= 14.34$ years). Regarding gender, 198 participants identified as female (78.9%), 47 participants identified as male (18.7%), four participants identified as Trans* (1.6%), one participant identified as agender

(.4%), and one participant identified as Other (.4%). Ethnoculturally, 178 participants identified as White (70.9%), 24 as African American (9.6%), 18 as multiple heritage (7.2%), 14 as Hispanic/Latin(o/a) (5.6%), 9 identified as Asian (3.6%), 7 identified as Other (2.8%), and one identified as American Indian/Alaska Native (.4%). In terms of professional poverty counseling experience, 212 (84.5%) participants had worked in a setting serving persons in poverty and 39 (15.5%) participants had not worked in a setting serving persons in poverty (15.5%). 149 participants had no personal experiences of poverty (59.4%) and 102 participants had personally experienced poverty (40.6%).

Sampling Procedures

Purposive, convenience, and snowball sampling were used to achieve desired sample size. Participants were recruited via email; prospective participants were emailed through a variety of listservs specifically for professional counselors and counseling graduate students including: CESNET (counselor educators and counselor education students with approximately 3400 members), COUNSGRADS (counseling graduate students), Counselors for Social Justice (CSJ), and the American Counseling Association interest network, ACA Connect. To solicit their participation, 2000 Members of the American Mental Health Counseling Association (AMHCA) were emailed. Participants were asked complete an electronic survey; this survey included a demographic sheet, informed consent, the MCKAS, and the BAPS.

The first call for participants occurred in early November 2015 (see Appendix E for the full call to participants), and the survey closed ended in early December 2015; data were collected over five weeks. Each listserv was solicited three times except the AMHCA listserv; those email addresses were purchased and were only contacted once. The second call for participants occurred after two weeks, and the final call for participants occurred four weeks

from the initial call, two weeks following the second call. Following the first call, 202 participants began the survey. Following the second call, 314 surveys were initiated, an increase in 112 participants. Following the third and final call, 346 surveys were initiated, an increase of 32 participants. Survey participation was also tracked on a weekly basis. Following the first week 115 surveys were initiated. Following the second, third, fourth, and fifth weeks 226, 303, 315, and 346 surveys were initiated, respectively.

Instrumentation

Participants were emailed a link to the survey which contained four components: MCKAS) (Ponterotto et al., 2002), the BAPS (Smith & Stone, 1989), a demographic sheet, and an informed consent document. The informed consent document was the first page of the survey, followed by the MCKAS, BAPS, and concluding with the demographic sheet. Order of instrumentation was the same for all participants.

MCKAS

The MCKAS (Ponterotto et al., 2002) was developed to measure the MCC of counseling professionals and graduate students. The MCKAS is a 32-item self-report inventory that has been validated via exploratory and factor analysis (Ponterotto et al., 2002). This assessment was validated on 525 students and professionals in counseling and counseling psychology; after this initial validation the MCKAS was tested for goodness of fit on 199 counselors-in-training from 5 Northeastern universities (Ponterotto et al., 2002). The MCKAS is a two-factor assessment with the subscales of knowledge (20 items) and awareness (12 items) (Ponterotto et al., 2002). The alpha coefficients are .92 for the knowledge subscale and .78 for the awareness subscale, with an overall alpha of .90. The correlation between the two subscales is not strong ($r = .36$) and the author recommends the two subscales be analyzed independently (Ponterotto et al., 2002). The

32 items on the MCKAS are self-report items on a scale of 1 to 7, with 1 indicating *not at all* and 7 indicating *totally true*. The minimum MCKAS score is 32 and the maximum is 224. Higher scores indicate increased multicultural knowledge, awareness, and overall MCC. Sample MCKAS questions include: “I believe all clients should maintain direct eye contact during counseling,” “I think clients should perceive the nuclear family as the ideal social unit,” and “I am aware of institutional barriers which may inhibit minorities from using mental health services” (Ponterotto et al., 2002).

The correlation between the MCKAS knowledge and awareness subscales in the present study was $r = .40$ ($p < .001$). The MCKAS scale and subscales all had high levels of internal consistency; The total scale alpha in the present study was .89, the knowledge subscale alpha was .88, and the awareness subscale had an alpha of .83 (Kline, 2011). The MCKAS can be found in Appendix A.

BAPS

The BAPS was developed to measure beliefs for about and wealth on six subscales: fatalistic, individualistic, or structural causes of poverty and individualistic, fatalistic, or structural causes of wealth (Smith & Stone, 1989). Individualistic attributions for poverty include personal deficits such a motivation or skill levels, indicating poverty biases. Fatalistic attributions for poverty indicate a belief that a person was born to be poor, and structural/situational attributions for poverty include social barriers, the economy, and oppression as causes of poverty (Smith & Stone, 1989).

Higher scores in each of the subscales indicate participant poverty or wealth attributions. The six subscales have varying alpha coefficients as presented in the original study: individualistic attributions for poverty ($\alpha = .73$), structural attributions for poverty ($\alpha = .72$),

fatalistic attributions for poverty ($\alpha = .54$), individual attributions for wealth ($\alpha = .62$), structural attributions for wealth ($\alpha = .81$), and fatalistic attributions for wealth ($\alpha = .44$) (Smith & Stone, 1989). The BAPS has been used in previous research related to counselor poverty beliefs (Toporek & Pope-Davis, 2005). In the previous study, the BAPS individualistic subscale had moderately high Cronbach's alpha ($\alpha = .77$) and significantly correlated with multicultural training ($r = .28, p < .01$) (Toporek & Pope-Davis, 2005).

The individualistic and structural poverty beliefs subscales had acceptable internal consistency: .85 and .75, respectively, in the present sample. Further, the individualistic and structural poverty beliefs subscales were not significantly correlated ($r = .03, p = .67$). Because the BAPS fatalistic subscale did not have an acceptable internal consistency value (i.e., .58), the subscale was not included in any study analysis. Further, the BAPS fatalistic subscale was significantly correlated with both the individualistic and structural subscales (i.e., $r = .48 [p < .001]$ and $r = -.13 [p = .04]$, respectively).

The 44-item BAPS is broken into two sections, one related to poverty and one related to wealth (Smith & Stone, 1989). Each section has a prompt: (a) "poor people (poorest 20%) exist in the world today because..." and (b) "wealthy people (wealthiest 20%) exist in the world today because... (Smith & Stone, 1989)." The BAPS represents a relational definition of poverty defined by the participants' interpretation of the "poorest 20%." Items are answered based on a three-point prompt of "not at all important," "somewhat important," or "very important" (Smith & Stone, 1989). Poverty items include: (a) "not motivated because of welfare," (b) "are lazy," (c) "are born inferior," and (d) "are taken advantage of by the rich (Smith & Stone, 1989)." Wealth items include: (a) "drive and perseverance," (b) "are hard working," (c) "are born superior," and (d) "are greedy" (Smith & Stone, 1989). For the purposes

of this research only the poverty items were included in the survey (22-items). The BAPS can be found in Appendix B.

Demographic information

Participants were asked to complete a short demographic questionnaire asking them to identify their counseling specialty, age, gender, ethnocultural identity, and personal and professional exposures to poverty. The demographic sheet can be found in Appendix C.

Counseling specialty. Previous research on counselor poverty beliefs has only included graduate students in counseling (i.e., Toporek & Pope-Davis, 2005) and professional school counselors (i.e., Bray & Schommer-Aikins, 2015). This study includes diverse counseling specialties to broaden current research.

Age. When exploring the poverty attributions of professional school counselors, younger school counselors expressed more positive poverty beliefs, which could indicate a relationship between these two variables (Bray & Schommer-Aikins, 2015). This demographic variable was included as it may have a relationship with poverty beliefs and should be further explored in a sample of counselors from diverse professional groups.

Gender. In multiple studies gender was a predictor for more positive poverty beliefs and higher levels of multicultural counseling competence (Beck et al., 2001; Brown, Parham, & Yonker, 2001; Constantine, 2000). In this study, participants indicated their gender identity as female, male, trans*, or could self-identify; previous studies have only analyzed gender as a binary (male-female) (Bray & Schommer-Aikins, 2015; Toporek & Pope-Davis, 2005). Including persons who identify under the trans* umbrella is more inclusive and allows for a diverse sample that is more representative of counselors' genders.

Ethnocultural identity. Ethnocultural identities, specifically experiences as a person of color or a minority, have been shown to increase multicultural counseling competence (Brown, et al., 2001; Chao, 2012; Toporek & Pope-Davis, 2005). Persons who identify as White or European American tend to have lower levels of MCC, indicating the need to control for ethnocultural identity in data analysis (Brown et al., 2001; Chao, 2012)

Personal and professional exposure to poverty. Previous research indicates that school counselors who have experiences working in Title I schools have more positive poverty beliefs (Bray & Schommer-Aikins, 2015). These professional experiences working with persons in poverty could act as an immersion, increasing positive views of this social group. It may be possible that personal experiences of poverty may increase positive poverty attitudes and attributions, which have never been measured in relation to counselor MCC or poverty attitudes.

Data Collection Procedure

An informed consent document, demographic sheet, and the two assessments were distributed to all participants using a Qualtrics electronic survey. Participants electronically consented to participation in this research. Completion of the forms alone did not indicate consent for the purposes of this study; the informed consent was collected first and participants could not continue with the survey unless they agreed to participate in this research. Risks were actively minimized through confidentiality and anonymity, and there is was foreseeable harm in participants indicating through self-report their MCC or poverty beliefs. Participation in this study was voluntary and participants could withdraw at any time. Data were stored in a password-protected spreadsheet that was accessible by the researcher. This study was subjected to Human Subjects Review at Old Dominion University before data collection began and was approved as an exempt study.

Data Analysis

Participant data were collected from the demographic questionnaire, MCKAS, and BAPS. Data were entered into the SPSS 22 program for statistical analysis.

Data Cleaning

The first step of data analysis was to screen the data to ensure it was usable, reliable, and valid to proceed with statistical analyses. 346 surveys were initiated by participants. Surveys with incomplete entries were screened from analysis, yielding 251 fully completed surveys. First, the researcher reverse coded MCKAS items 1, 4, 7, 10, 11, 18, 20, 24, 25, and 30. The researcher then computed the MCKAS knowledge subscale score using MCKAS items 2, 3, 5, 6, 8, 9, 12, 13, 14, 15, 16, 17, 19, 21, 22, 23, 27, 28, 31, and 32. The MCKAS knowledge subscale scores were raw totaled and another new variable was created using the knowledge subscale average. The researcher then computed the MCKAS awareness subscale using MCKAS items 1, 4, 7, 10, 11, 18, 20, 24, 25, 26, 29, and 30. The MCKAS awareness subscale was raw totaled and a new variable was created using the awareness subscale average. All MCKAS items were totaled to yield an MCKAS total raw score.

The BAPS item subscales were then computed. The individualistic subscale was computed using BAPS items 1 through 8. An individualistic subscale raw score and average was created. The structural subscale score was computed using BAPS items 9 through 15. A raw score and average score was also created for this subscale.

Following the cleaning of the main variables of interest demographic variables were cleaned. Counseling specialties were coded 1 through 19: addictions (1), career (2), college (3), community (4), gerontological (5), marriage and family (6), mental health (7), rehabilitation (8), school (9), and Other (10). The demographic variable age was not cleaned and used as an

interval variable in the regression model. Gender was coded as 1 through 4, where 1 was attributed to woman, 2 to man, 3 to transgender*, and 4 to other. A new gender variable was then created and dummy coded for use in the regression model where 0 was attributed to Non-females ($n=53$, 21.2%) and 1 was attributed to females ($n=198$, 78.8%). Gender was coded in this manner as previous research has indicated that women have increased levels of MCC (Beck et al., 2001; Brown et al., 2001; Constantine, 2000).

Ethnocultural identities were coded one through eight: African American/Black (1), American Indian/Pacific Islander (2), Asian (3), Hispanic/Latino/a (4), Native Hawaiian/Pacific Islander (5), multiple heritage (6), White (7), and other (8). A new ethnocultural identity variable was then created and dummy coded for use in the regression model. In this new variable 0 was attributed to non-White participants ($n=73$, 29.1%) and 1 was attributed to White ($n=178$, 70.9%) participants. Ethnocultural identity was dummy coded in this way similar to gender, to reflect the ethnocultural and racial privilege experienced by white participants as previous research has indicated people of color have increased levels of MCC (Brown et al., Chao, 2012; Toporek & Pope-Davis, 2005).

In addition to these demographic descriptor variables poverty exposure variables were also cleaned. The first poverty exposure variable was counseling work experiences with persons in poverty. This variable was dummy coded to reflect no poverty work experiences (0) ($n=39$, 15.5%) and participants with poverty work experiences (1) ($n=212$, 84.5%). Poverty work experiences included work in a community mental health agency that served persons experiencing poverty, a non-profit organization providing counseling services to persons in poverty, private practice counseling with persons experiencing poverty, pro-bono counseling work with persons experiencing poverty, or experience as a school counselor in a Title I school.

The second exposure variable was the participants' personal experiences of poverty, operationalized on the demographics sheet as financial barriers, barriers to healthcare, transportation, work, or education. This variable was dummy coded for use in the regression model where 0 attributed to participants with no personal poverty experiences ($n=149$, 59.4%) and 1 was attributed to participants who had personally experienced poverty ($n=102$, 40.6%).

Data Analysis

Following data cleaning procedures, data from the MCKAS, BAPS, and demographic form were entered into SPSS 22 for data analysis. To answer the first research question, two hierarchical linear regressions were used to establish the relationship between participant MCC and poverty beliefs. There were multiple significant correlations between MCKAS, BAPS, and demographic variables, as determined by Pearson product moment correlations. The BAPS fatalistic subscale was significantly correlated with both the BAPS individualistic ($r= .48$, $p<.001$) and structural subscales ($r= -.13$, $p= .04$). The MCKAS total score was significantly correlated with the knowledge ($r= .92$, $p< .001$) and awareness subscales ($r= .74$, $p< .001$). As previously mentioned the MCKAS knowledge and awareness subscales were also significantly correlated ($r= .40$, $p< .001$). BAPS and MCKAS subscale items were also significantly correlated. The BAPS individualistic is significantly correlated with MCKAS knowledge ($r= .16$, $p= .01$), and MCKAS awareness ($r= .52$, $p< .001$). The BAPS structural subscale scores were also significantly correlated with MCKAS knowledge ($r= .31$, $p<.001$), and MCKAS awareness ($r= .26$, $p< .001$).

In regards to demographic variables, the BAPS individualistic subscale was significantly correlated with ethnocultural identity in the present study ($r= .12$, $p= .05$). Age was significantly correlated with poverty counseling experience ($r= .16$, $p= .01$) and personal poverty experience

($r = .13, p = .05$). Poverty counseling experience was significantly correlated with personal poverty experience ($r = .13, p = .04$). The final significant correlation was person poverty experience and ethnocultural identity ($r = -.18, p = .004$). Correlations of all variables in used in this study can be found in the Correlation Table in Appendix F.

The first hierarchical multiple regression was conducted using age, gender, ethnocultural identity, personal poverty experience, counseling poverty experience the MCKAS subscale raw scores, and BAPS individualistic raw subscale scores. Entry of the variables occurred in three steps, congruent with the model and the causal priority of the variables (Petrocelli, 2003). This allowed for identification of the effect that independent variables (MCKAS subscale scores, age, gender, ethnocultural identity) have on the dependent variable (BAPS individualistic subscale score). Step one included participant gender (Chao, 2012), participant ethnocultural identity (Chao, 2012; Toporek & Pope-Davis, 2005), and participant age (Bray & Schommer-Aikins, 2015) that have been shown to be linked to MCC. The second step included the poverty exposure variables that required further exploration. These variables included poverty counseling experiences (Bray & Schommer-Aikins, 2015), and the participants' personal poverty experiences. The final step included the entry of the participants' MCKAS knowledge and awareness subscale raw scores as the variables of interest. Following the first regression a post-hoc analysis was conducted to explore the relationship between MCC, personal poverty exposure, poverty counseling experience, and individualistic beliefs about poverty. A two-step hierarchical linear regression was used; variables were entered into the model according to their causal priority.

The second regression was conducted in a similar manner, but in this model the BAPS structuralism subscale scores were used as the dependent variable. Variables were entered in

step-wise congruent with their causal priority (Petrocelli, 2003). The first step included the demographic predictor variables of gender, ethnocultural identity, and age. The second step included the poverty exposure variables of poverty counseling experiences and personal poverty experiences. The final step included the entry of the participants' MCKAS knowledge and awareness subscale raw score. Following the second regression a post-hoc analyses using a two-step hierarchical linear regression was conducted to explore the relationship between MCC, personal poverty experiences, poverty counseling experience, and structural beliefs about poverty. Variables were entered step-wise according to their causal priority.

To answer the second research question a factorial multivariate analysis of variance (MANOVA) was used. The selected demographic factors of gender, counseling specialty, ethnocultural identity, personal poverty experiences and professional poverty experiences were entered into the model as the independent variables/fixed factors as they are categorical variables. The BAPS subscale scores (structuralism and individualism) were entered as the dependent variables (continuous). A Bonferroni correction was used to limit family-wise error in the multiple comparisons. Results of these analyses are discussed in Chapter 4.

CHAPTER 4

RESULTS

Chapter four describes the results of data analyzed from participants who completed the MCKAS, BAPS, and demographic questionnaire. The research questions and hypotheses, data cleaning, description of participant demographics, correlations between variables of interest, and descriptions of the results of main statistical analyses are included in this chapter.

Research Question and Hypotheses

Research Question One

What is the relationship between MCC and individualistic and structural poverty beliefs in a sample of professional counselors and counselor trainees, adjusting for demographic variables (i.e., age, gender, ethnocultural identity, personal poverty experiences, and professional counseling poverty experiences)?

Null Hypothesis One

There will be no significant relationship ($p \leq .05$) between MCC and counselor and counselor trainee individualistic and structural poverty beliefs, after adjusting for knowledge and awareness, age, gender, ethnocultural identity, counselor personal poverty experiences, and professional counseling poverty experiences.

Research Hypothesis One

Counselor and counselor trainees' MCC will predict ($p \leq .05$) structural and individualistic poverty beliefs, adjusting for gender, ethnocultural identity, age, personal and professional poverty experiences.

Research Question Two

What is the relationship between counselor and counselor trainees' poverty beliefs and select demographic variables (i.e., gender, counseling specialty, ethnocultural identity, personal and professional exposure to poverty)?

Null Hypothesis Two

There will be no significant ($p \leq .05$) difference in individualistic and structural poverty beliefs for professional counselors and counselor trainees based on select demographic variables (i.e., gender, counseling specialty, ethnocultural identity, counselor personal poverty experiences, and professional poverty counseling experience).

Research Hypothesis Two

There will be a significant ($p \leq .05$) difference in poverty beliefs for professional counselors based on select demographic variables (i.e., gender, counseling specialty, ethnocultural identity, personal and professional exposure to poverty

Variables of Interest

MCC

Knowledge and Awareness subscale raw totals were computed along with MCKAS overall score to evaluate MCC levels of the sample. Protocol outlined by the scale's developers (Ponterotto et al., 2002; Ponterotto & Potere, 2003) indicate that separate analyses should be conducted using each of the subscales due to their limited correlation ($r = .36$). In this sample ($N=251$), the correlation between the MCKAS was moderate ($r = .40, p < .001$), similar to the original creation and validation of the instrument. Because of this moderate correlation, the protocol set by the scales creator, and previous research using MCKAS scores in regression, separate analyses were conducted using the MCKAS Knowledge and MCKAS Awareness

subscales, discussed later in this chapter (Chao, 2012; Ponterotto et al., 2002). Additional correlations are presented in Table 5.

The MCKAS scores are similar to score in previous studies using the MCKAS to measure MCC (Chao, 2012; Ponterotto et al., 2002). MCKAS knowledge average scores ($M=5.65$) and MCKAS awareness average scores ($M=6.12$) in the present sample are expected based on previous research exploring the MCC of counselors. For comparison, the average subscale scores in the original creation and validation of this instrument were 4.96 (knowledge) and 5.06 (awareness) (Ponterotto et al., 2002). In more recent studies measuring counselors' MCC (Chao, 2012) the average subscale scores were 5.62 (knowledge) and 5.45 (awareness). This sample's subscale average scores are slightly higher. The maximum possible score on both subscales is 7. Descriptives of MCKAS raw scores in the present sample, which were used for analyses, are presented below in Table 1.

Table 1

MCKAS Descriptives

	<i>M</i>	<i>SD</i>	Minimum	Maximum
MCKAS Raw	186.33	19.89	126	224
Total				
MCKAS	112.95	14.69	67	140
Knowledge				
MCKAS	73.38	8.73	40	84
Awareness				

Note. MCKAS= Multicultural Counseling Knowledge and Awareness Scale (Ponterotto et al., 2002). MCKAS scores are reported in raw form.

The MCKAS Knowledge and Awareness subscale scores were used in the hierarchical linear regression and factorial MANOVA analyses as continuous variables. The normality of these two variables is an assumption of both statistical tests. Both the MCKAS Knowledge and MCKAS Awareness variables are normally distributed (skewness and kurtosis less than ± 2) (Tabachnick & Fidell, 2013). The MCKAS Knowledge variable has a skewness of -.637 and kurtosis of .39. The MCKAS Awareness variable has a skewness of -1.14 and kurtosis of 1.35. Both are within parameters of normality (Tabachnick & Fidell, 2013).

Poverty Beliefs

The BAPS assessed participants' poverty beliefs (Smith & Stone, 1989). This scale includes three subscales indicating personal beliefs about the causes of poverty: fatalism (persons

are fated to experience poverty), individualism (internal individual deficits or choices lead to poverty), and structuralism (external structural forces such as the economic, racism, classism, sexism are the causes of poverty) (Smith & Stone, 1989). There is no total score for this scale. To obtain the appropriate subscale score, data were cleaned and subscale items were computed. Normality of the individualistic and structural subscales were explored. The BAPS structural subscale score was found to be normal, (skewness= -.32, kurtosis= -.49) (Tabachnick & Fidell, 2013). The BAPS individualistic subscale scores were not within the parameters of normality and required transformation. This variable was transformed using a cube root transformation. This transformation is useful to normalize non-normal, particularly leptokurtic, data (Cox, 2011). The new transformed variables fell within the appropriate limits of normality as per Tabachnick and Fidell (2013); the skewness and kurtosis was less than ± 2 (skewness= -1.06, kurtosis= .21).

The BAPS subscale scores are different than in previous research using this instrument with a sample of professional counselors (Toporek & Pope-Davis, 2005). In the present sample average subscale scores were: fatalism ($M= 5.05$, $SD= 1.34$); individualistic ($M= 9.94$, $SD= 2.7$); and structuralism ($M= 15.59$, $SD= 2.94$). The maximum possible score on the fatalism, individualism, and structuralism subscales are 4, 8, and 7, respectively. In a study examining the poverty beliefs of counseling graduate students (Toporek & Pope-Davis, 2005), the mean scores for the individualism subscale were 12.15 and the structural subscale were 12.39 (Toporek & Pope-Davis, 2005). Descriptives of BAPS scores in the present sample are presented in Table 2.

Table 2

BAPS Descriptives

	<i>M</i>	<i>SD</i>	Minimum	Maximum
BAPS Fatalism	5.05	1.34	4	12
BAPS	9.94	2.7	8	24
Individualism				
BAPS	15.59	2.94	7	21
Structuralism				

Note. BAPS= Beliefs About Poverty Scale (Smith & Stone, 1989). BAPS scores are reported in raw form.

Correlations of BAPS subscale scores indicate correlation between some subscales. The BAPS Individualism and BAPS Structuralism subscales were not significantly correlated ($r = .03$, $p = .67$). However, the BAPS Fatalism subscale score was significantly with both the BAPS Structuralism ($r = -.13$, $p = .04$) and BAPS Individualism subscales ($r = .48$, $p < .001$). Correlations are presented in Table 5 and discussed further below.

Additional Demographic Variables

The variables gender, age, ethnocultural identity, poverty counseling experience, and personal experiences of poverty were used as dependent variables in the hierarchical linear regression models. Counseling specialty, gender, ethnocultural identity, poverty counseling experience, and personal experiences of poverty were used as independent variables in the factorial MANOVA. These variables were measured using a demographic questionnaire that was

included in the electronic survey. All participants ($N=251$) indicated their counseling specialty, gender, age, ethnocultural identity, poverty counseling experience, and personal poverty experiences; there were no missing values following data cleaning. The categorical variables (counseling specialty, gender, ethnocultural identity, poverty counseling experience, and personal poverty experiences) were dummy coded for use in the regression model, as described in Chapter 3 and below in the description of the regression analyses. As these variables were categorical, they were not screened for normality. The continuous variable, age, met standards for normality (skewness=.74, kurtosis= -.54), as both skewness and kurtosis were less than ± 2 (Tabachnick & Fidell, 2013).

Correlations Between Research Variables of Interest

Pearson product moment correlations were calculated using SPSS 22 to explore the relationship and strength of these relationships between each variable of interest. These correlations were an important step before conducting any inferential statistical analyses, as correlational relationships between variables of interest will impact the design and interpretation of statistical models (Tabachnick & Fidell, 2013). Correlations among variables of interest (MCKAS subscale scores and BAPS subscale scores) are presented in Table 3. A full correlation table including all variables measured in this study (to include demographic dependent variables) is included in Appendix F.

Both the MCKAS and BAPS subscale scores are appropriate for correlational analyses as they are continuous variables. As previously mentioned, MCKAS subscales knowledge and awareness significantly moderately correlated in the present sample ($r= .40, p < .001$). This correlation indicates the need for separate regression models for the variables of MCKAS

knowledge and MCKAS awareness. Also as previously mentioned, the BAPS individualistic and structural subscales were not significantly correlated ($r = .03, p = .67$).

There were significant relationships between the MCKAS and BAPS subscales. The MCKAS knowledge subscale is significantly correlated with the BAPS individualism subscale ($r = .16, p = .01$) and the BAPS structuralism subscale ($r = .31, p < .001$) in the present sample. This signifies that that participants who have increased MCC knowledge are weakly correlated with lower individualistic beliefs about poverty in the present sample, due the transformation of this variable as noted above. Increased MCC knowledge scores are moderately correlated with increased structural beliefs about poverty in the present sample. MCKAS knowledge subscale scores and BAPS fatalism subscale scores are not significantly correlated ($r = .08, p = .24$).

MCKAS awareness subscale scores are significantly correlated with all BAPS subscales at $p < .001$. The MCKAS awareness subscale is moderately positively correlated with BAPS fatalism subscale scores in the present same ($r = .35, p < .001$). This correlation indicates a moderate correlation between increased MCC awareness and decreased fatalistic beliefs about poverty (due to the transformation of the BAPS fatalism variable). The MCKAS awareness subscale is strongly positively correlated with the BAPS individualism subscale ($r = .52, p < .001$). This correlation indicates that increased MCC awareness increases decreases individualistic beliefs about poverty (due the transformation of the BAPS individualism variable). Finally, the MCKAS awareness subscale is weakly positively correlated with the BAPS structuralism subscale ($r = .25, p < .001$). This correlation indicates that increased MCC awareness increases structural beliefs about poverty. It is of note that correlations presented using the constructs related to MCC and poverty beliefs above are theoretically consistent.

In regard to demographic variables, the BAPS individualistic subscale score was significantly correlated with ethnocultural identity ($r = .12, p = .05$). Additionally, age was significantly correlated with poverty counseling experience ($r = .16, p = .01$) and personal poverty experience ($r = .13, p = .04$). Poverty counseling experience was significantly correlated with personal poverty experience ($r = .13, p = .04$). The final significant correlation was personal poverty experience and ethnocultural identity ($r = -.18, p = .004$).

Table 3

Correlations: Variables of Interest

	1	2	3	4	5
1. MCKAS Knowledge	--	.40**	-.08	.16*	.31**
2. MCKAS Awareness	--	--	.35**	.52**	.26**
3. BAPS Fatalism+	--	--	--	.48**	-.13**
4. BAPS Individualism+	--	--	--	--	.03
5. BAPS Structuralism	--	--	--	--	--

Note. MCKAS= Multicultural Counseling Knowledge and Awareness Scale (Ponterotto et al., 2002), BAPS= Beliefs About Poverty Scale (Smith & Stone, 1989). += transformed variable, *= $p \leq .05$, **= $p < .001$.

Research Question One: MCC and Poverty Beliefs

Two hierarchical linear regressions were conducted to explore the relationship between the main variables of interest, MCC and poverty beliefs, while including other independent demographic variables (age, gender, ethnocultural identity, poverty counseling experience, and personal experiences of poverty). Categorical variables were dummy coded for the purposes of regression analyses (ex. 0= non-female, 1=female). Variables were entered into the regression model step wise, congruent with the causal priority of the variables (Petrocelli, 2003).

Assumptions of hierarchical linear regression include linearity, homoscedasticity, multicollinearity, the absence of outliers, and normality. Linearity and homoscedasticity of the data were tested using scatterplots; scatterplot testing indicated that there was a linear relationship between variables of interest and that residuals are even spread in the sample, meeting the assumptions of linearity and homoscedasticity. There were no outliers in this sample as outlined in Chapter three. Multicollinearity was tested using Pearson product moment correlations. No correlations between independent variables (MCKAS subscale scores, gender, age, ethnocultural identity, personal poverty experience, counseling poverty experience) were greater than .70, indicating that the assumption of was met and multicollinearity was not present in the sample (Tabachnick & Fidell, 2013).

The majority of variables in the present sample are normal by distribution. The MCKAS knowledge subscale raw scores, MCKAS awareness subscale raw scores, and BAPS structuralism subscale raw scores were distributed normally with skewness and kurtosis less than ± 2 (Tabachnick & Fidell, 2013). However, for use in the regression model the BAPS individualism scores were transformed using the cube root transformation, useful for normalizing leptokurtic data (Cox, 2011).

All categorical variables were dummy coded to reflect differing levels of measurement within the particular variable. Gender was dummy coded to reflect gender privilege experiences; non-females, which included men, trans*, agender, and other gender identities were coded as 0. Females were coded as 1 and to reflect the majority gender identity in the counseling field (CACREP, 2014). Ethnocultural identity was coded as non-White (0) and White (1), based on ethnocultural proximity to racial/ethnic privilege and to reflect the majority ethnocultural identity of professional counselors (CACREP, 2014). Poverty counseling experiences was coded as “no poverty counseling experience” (0) and “poverty counseling experience” (1). Finally, personal poverty experiences were coded as “no personal poverty experiences” (0) and “personal poverty experiences” (1). Variables were entered step wise, as described below, according to causal priority (Petrocelli, 2003).

Regression One

The first hierarchical linear regression to analyze the predictive capabilities of gender, age, ethnocultural identity, poverty counseling experience, personal poverty experience, and MCC knowledge and awareness as they related to individualistic beliefs about poverty. The dependent variable, individualistic beliefs about poverty, was represented by participants’ BAPS individualistic subscale scores. Variables were entered into the model according to their causal priority (Petrocelli, 2003). The first step (model) included participants’ identity demographics: ethnocultural identity, age, and gender. The second step (model) included the two exposure variables: poverty counseling experience and personal poverty experience. The third and final step included the constructs of MCC knowledge and awareness into the model, represented by participants’ MCKAS knowledge and awareness subscale raw scores. This model was chosen

because of the correlations between the BAPS individualism subscale scores and the MCKAS knowledge and awareness subscale scores, outlined above in Table 3.

Results of the first regression analysis and subsequent ANOVA are presented in Tables 4 and 5. The first two steps in the regression are not statistically significant (demographic variables of gender, age, and ethnocultural identity and personal and professional poverty exposure variables). However, the third and final step, where the MCC knowledge and awareness constructs were added to the model significantly influenced the predictability of individualistic poverty beliefs, in concert with all independent variables in the model. The addition of the MCKAS knowledge and awareness subscale raw scores (Model 3) led to a statistically significant increase in R^2 of .27, ($F[2, 243]= 45.68, p< .001$). As represented in Table 5, the full model of gender, ethnocultural identity, age, poverty counseling experience, personal poverty experiences, and MCC knowledge and awareness to predict individualistic poverty beliefs was statistically significant, $R^2= .29, (F[7, 243]= 14.15, p< .001)$; Adjusted $R^2= .27$. The effect size of the third step of the model is represented by ΔR^2 . The third step of the model accounts for 27% of the variance in the sample, which is a moderate effect size ($\Delta R^2= .27$) (Cohen, 1988).

Table 4

Summary of the Hierarchical Linear Regression One Analysis for Variables Predicting Individualistic Poverty Beliefs (N= 251)

Change Statistics									
Model	<i>R</i>	<i>R</i> ²	<i>Adj R</i> ²	Std. Error	ΔR^2	ΔF	df1	df2	Sig ΔF
1	.13	.02	.004	.04	.02	1.4	3	247	.26
2	.15	.02	.003	.04	.006	.79	2	245	.46
3	.54	.29	.27	.03	.27	45.68	2	243	.00

Note. Model 1 represents the variables ethnocultural identity, age, gender, and counseling specialty. Model 2 includes the Model 1 variables, poverty counseling experience, and personal poverty experiences. Model 3 includes all previous variables and MCKAS Knowledge and Awareness subscale scores.

Table 5

ANOVA Table for Hierarchical Linear Regression One, Predicting MCC Individualistic Poverty Beliefs (N= 251)

Model		Sum of Squares	df	Mean Square	F	Sig.
3	Regression	.09	7	.01	14.15	.000
	Residual	.22	243	.001	--	--
	Total	.31	250	--	--	--

Note. Model 3 represents the variables ethnocultural identity, age, gender, counseling specialty, poverty counseling experience, personal poverty experiences, and MCKAS Knowledge subscale scores.

Regression analyses indicate that the significant changes in this model are explained in the third step, where the MCC knowledge and awareness constructs are entered into the model. Table 6 presents the changes in the predictive relationship in all three steps of the regression. In step three, it appears that MCC awareness contributions to the significant changes in the model.

Table 6

Hierarchical Linear Regression Predicting Individualistic Poverty Beliefs from Age, Gender, Ethnocultural Identity, Poverty Counseling Experience, Personal Poverty Experience, and MCC Knowledge and Awareness (N= 251)

Variable	Individualistic Poverty Beliefs					
	Model 1		Model 2		Model 3	
	B	β	B	β	B	β
Constant	.32*	--	.32*	--	.18*	--
Gender	-.005	.005	-.01	-.07	-.01	-.10
Age	-5.201E-6	-.002	2.184E-5	.01	1.836E-4	.01
Ethnocultural Identity	.009	.11	.01	.09	.004	.05
Poverty Counseling Experience	--	--	.00	.001	-.003	-.03
Personal Poverty Experiences	--	--	-.01	-.08	-.004	-.05
MCC	--	--	--	--	-6.536E-5	-.03

Knowledge						
MCC	--	--	--	--	.002	.53*
Awareness						
R^2	.02		.02		.29	
F	1.36		1.13		14.15*	
ΔR^2	.01		.01		.27	
ΔF	1.36		.79		45.68*	

Notes. *= $p < .001$.

Regression Two

The second hierarchical linear regression was conducted to analyze the predictive capabilities of gender, counseling specialty, age, ethnocultural identity, poverty counseling experience, personal poverty experience, and MCC knowledge and awareness as they related to structural beliefs about poverty. The dependent variable, structural beliefs about poverty, are represented by participants' BAPS structural subscale scores. Variables were entered into the model according to their causal priority (Petrocelli, 2003). The first step (model) included participants' identity demographics: ethnocultural identity, age, and gender. The second step (model) included the two exposure variables: poverty counseling experience and personal poverty experience. The third and final step included the constructs of MCC knowledge and awareness into the model, represented by participants' MCKAS Knowledge and awareness subscale raw scores. This model was chosen because of the correlations between the BAPS

Individualism subscale scores and the MCKAS knowledge and awareness subscale scores, outlined in Table 3.

Results of the second regression analysis and subsequent ANOVA are presented in Tables 7 and 8. The first two steps in the regression are not statistically significant (step one including age, gender, and ethnocultural identity and step two including poverty exposure variables). However, the third and final step, where the MCC knowledge and awareness constructs were added to the model significantly influenced the predictability of structural poverty beliefs, in concert with all independent variables in the model. The addition of the MCKAS knowledge and awareness subscale raw scores (Model 3) led to a statistically significant increase in R^2 of .12, ($F[2, 243]= 16.95, p< .001$). As represented in Table 7, the full model of gender, ethnocultural identity, age, poverty counseling experience, personal poverty experiences, and MCC knowledge to predict individualistic poverty beliefs was statistically significant, $R^2= .13, (F[7, 243]= 5.28, p< .001)$; Adjusted $R^2= .11$. The effect size of the third step of the model is represented by ΔR^2 . The third step of the model accounts for 12% of the variance in the sample, which is a small effect size ($\Delta R^2= .12$) (Cohen, 1988).

Table 7

Summary of the Hierarchical Linear Regression Two Analysis for Variables Predicting Structural Poverty Beliefs (N= 251)

Change Statistics									
Model	<i>R</i>	<i>R</i> ²	<i>Adj R</i> ²	Std. Error	ΔR^2	ΔF	df1	df2	Sig ΔF
1	.07	.006	-.007	2.95	.006	.46	3	247	.71
2	.11	.01	-.009	2.96	.006	.76	2	245	.47
3	.36	.13	.11	2.78	.12	16.95	2	243	.00

Note. Model 1 represents the variables ethnocultural identity, age, and gender. Model 2 includes the Model 1 variables, poverty counseling experience, and personal poverty experiences. Model 3 includes all previous variables and MCKAS Knowledge and awareness subscale scores.

Table 8

ANOVA Table for Hierarchical Linear Regression Two, Predicting MCC Structural Poverty Beliefs (N= 251)

Model		Sum of Squares	df	Mean Square	F	Sig.
3	Regression	286.10	7	40.87	5.28	.00
	Residual	1880.81	243	7.74	--	--
	Total	2166.91	250	--	--	--

Note. Model 3 represents the variables ethnocultural identity, age, gender, poverty counseling experience, personal poverty experiences, and MCKAS Knowledge and awareness subscale scores.

Regression analyses indicate that the significant changes in this model are explained in the third step, where the MCC knowledge and awareness constructs are entered into the model. Table 9 presents the changes in the predictive relationship in all three steps of the regression. In step three, there are significant ($p = .01$) changes when MCC awareness is added to the model. There are also significant ($p < .001$) changes when MCC knowledge is added to the model.

Table 9

Hierarchical Linear Regression Predicting Structural Poverty Beliefs from Age, Gender, Ethnocultural Identity, Poverty Counseling Experience, Personal Poverty Experience, and MCC Knowledge and Awareness (N= 251)

Variable	Structural Poverty Beliefs					
	Model 1		Model 2		Model 3	
	B	β	B	β	B	β
Constant	16.31***	--	16.02***	--	6.73***	--
Gender	-.32	-.04	-.29	-.04	-.64	-.09
Age	-.004	-.20	-.01	-.03	-.009	-.05
Ethnocultural Identity	-.40	-.06	-.44	-.04	-.26	-.04
Poverty Counseling Experience	--	--	.53	.02	.02	-.002
Personal Poverty Experiences	--	--	.39	.08	.43	.07
MCC	--	--	--	--	.05**	.25**

Knowledge						
MCC	--	--	--	--	.06*	.17*
Awareness						
R^2	.006		.01		.13***	
F	.46		.58		5.28***	
ΔR^2	.006		.006		.120***	
ΔF	.458		.755		16.854***	

Notes. * = $p \leq .05$; ** = $p = .001$; *** = $p < .001$.

Research Question Two: Select Participant Demographics and Poverty Beliefs

To explore the differences in poverty beliefs in counselors across counseling specialty, gender, ethnocultural identity, poverty counseling experience, and personal experiences of poverty were included in a factorial multivariate analysis of variance (MANOVA). Variables of interest in this model included participants' BAPS subscale scores (individualistic, structural) and their select demographic variables (i.e., counseling specialty, gender, ethnocultural identity, poverty counseling experience, and personal experiences of poverty). Mean differences and standard deviations of demographic variables of interest are reported below.

Individualistic and Structural Poverty Beliefs by Select Demographic Group

Counseling specialty. Means and standard deviations of the BAPS individualistic and BAPS structural subscales are presented across counseling specialties in Table 10.

Table 10

Poverty Beliefs Across Participant Counseling Specialty

Counseling Specialty	BAPS Individualistic		BAPS Structural	
	μ	<i>SD</i>	μ	<i>SD</i>
Overall (<i>N</i> =251)	9.94	2.70	15.59	2.94
Addictions (<i>n</i> =6)	8.83	1.33	17.33	1.75
Career (<i>n</i> =4)	10.75	4.19	14.50	1.73
College (<i>n</i> =15)	10.60	3.46	17.07	2.12
Community (<i>n</i> =11)	9.27	1.62	14.82	3.34
Marriage & Family (<i>n</i> =16)	9.81	2.04	14.38	2.87
Mental Health (<i>n</i> = 146)	9.96	2.78	15.58	3.12

Rehabilitation (<i>n</i> = 6)	9.50	1.23	15.67	1.75
School (<i>n</i> = 29)	10.28	2.96	14.85	2.80
Other (<i>n</i> =18)	9.50	2.48	16.78	2.10

Gender. Means and standard deviations of the BAPS Individualistic and BAPS Structural subscales are presented across genders in Table 11.

Table 11

Poverty Beliefs Across Participant Gender

Gender	BAPS Individualistic		BAPS Structural	
	μ	<i>SD</i>	μ	<i>SD</i>
Overall (<i>N</i> =251)	9.94	2.70	15.59	2.94
Woman (<i>n</i> =198)	10.01	2.65	15.53	2.95
Man (<i>n</i> =47)	9.87	3.01	15.51	2.95
Trans* (<i>n</i> =4)	8.00	.00	18.75	.96
Other (<i>n</i> =2)	8.00	.00	17.00	1.41

Ethnocultural identity. Means and standard deviations of the BAPS individualistic and BAPS structural subscales are presented across ethnocultural identities in Table 12.

Table 12

Poverty Beliefs Across Participant Ethnocultural Identity

Ethnocultural Identity	BAPS Individualistic		BAPS Structural	
	μ	SD	μ	SD
Overall ($N=251$)	9.94	2.70	15.59	2.94
African American ($n=24$)	11.17	3.38	16.33	2.78
American Indian/Alaska Native ($n=1$)	10.00	--	15.00	--
Asian ($n=9$)	10.22	3.38	15.00	2.78
Hispanic/Latin(o/a) ($n=14$)	8.86	1.03	14.79	3.40
Multiple Heritage ($n=18$)	10.50	2.41	17.00	2.28
White ($n=178$)	9.76	2.62	15.40	2.98
Other ($n=7$)	9.94	2.70	16.43	2.82

Poverty counseling experience. Means and standard deviations of BAPS individualistic and BAPS structural subscales are presented Table 13.

Table 13

Poverty Beliefs Across Participant Poverty Counseling Experience

	BAPS Individualistic		BAPS Structural	
	μ	SD	μ	SD
Poverty Counseling Experience				
Overall (N=251)	9.94	2.70	15.59	2.94
Poverty Counseling Experience (n=212)	9.94	2.68	15.62	2.96
No Poverty Counseling Experience (n=39)	9.90	2.85	15.41	2.88

Personal poverty experiences

Means and standard deviations of the BAPS individualistic and BAPS structural subscales are presented Table 14.

Table 14

Poverty Beliefs Across Participant Personal Poverty Experience

	BAPS Individualistic		BAPS Structural	
	μ	SD	μ	SD
Personal Poverty Experience				
Overall (N=251)	9.94	2.70	15.59	2.94
No Personal Poverty Experiences (n=149)	9.72	2.40	15.38	2.95
Personal Poverty Experiences (n=102)	10.25	3.07	15.88	2.93

Factorial MANOVA

The assumptions of factorial MANOVA include independence, the absence of outliers, normality, homogeneity of variance, multicollinearity, and linearity. Additionally, dependent variables are continuous (BAPS individualistic and structural subscale scores) and independent variables (exposure variables) are categorical; this assumption is met in this sample.

Independence is met in this sample; participants were not members of multiple groups in the same category (i.e. participants were not members of multiple ethocultural identity groups or counseling specialties).

No outliers were present in this sample, meeting that assumption of factorial MANOVA. Homogeneity of variance can be assumed in the present sample, as indicated by the insignificant Box's M statistic (Box's $M = 93.22$, $p = .06$). The assumption of multicollinearity is also met in this sample; no correlations between dependent variables (BAPS individualistic and structural subscale scores) are greater than .90 (see Table 3). There was a relationship between select demographic variables (gender, counseling specialty, ethocultural identity, poverty counseling experience and personal poverty exposure) and BAPS subscale scores, as assessed by scatterplot; linearity can be assumed in this sample. In terms of normality, as outlined above, the BAPS individualistic scores required transformation due to their skewness and/or kurtosis being greater than ± 2 (Tabachnick & Fidell, 2013). This variable was transformed using a cube root transformation, useful for normalizing non-normal, leptokurtic data (Cox, 2011). The BAPS structuralism subscale fell within normal skewness and kurtosis ranges for normality, as outlined above. The factorial MANOVA was conducted using a Bonferroni correction to minimize family-wise error.

The factorial MANOVA found no statistical differences in poverty beliefs in select demographic groups: counseling specialty, ($F [16, 316] = 1.22$, $p = .25$, Wilks' $\lambda = .89$, partial $\eta^2 =$

.06); ethnocultural identity, ($F [12, 316] = 1.21, p = .27, \text{Wilks' } \lambda = .91, \text{partial } \eta^2 = .02$); gender, ($F [6, 316] = 1.25, p = .28, \text{Wilks' } \lambda = .95, \text{partial } \eta^2 = .02$); personal poverty experience, ($F [2, 158] = 2.38, p = .10, \text{Wilks' } \lambda = .97, \text{partial } \eta^2 = .03$); and poverty counseling experience, ($F [2, 158] = .95, p = .39, \text{Wilks' } \lambda = .99, \text{partial } \eta^2 = .01$). The results of the factorial MANOVA are represented below in Table 15. Implications of this analysis are discussed in Chapter 5.

Table 15

Factorial MANOVA Table

	Wilks' λ	<i>F</i>	Hypothesis df	Error df	Sig.	partial η^2
Intercept	.04	1725.20	2	158	.00*	.96
Counseling Specialty	.89	1.22	16	316	.25	.06
Ethnocultural Identity	.91	1.21	12	316	.27	.02
Gender	.95	1.25	6	316	.28	.02
Personal Poverty Experience	.97	2.38	2	158	.10	.03
Poverty Counseling Experience	.99	.95	2	158	.39	.01

Note. * = ($p < .001$)

Summary

The results of the research questions provide varying levels of support for research question hypothesis. The results of the first research question supported the research hypothesis.

exploring the relationship between MCC and poverty beliefs the null hypothesis was disproven, providing support for the research hypothesis. This indicates that MCC is predictive of poverty beliefs. MCC awareness is associated with lower individualistic poverty beliefs and MCC knowledge increases structural understandings of poverty. The second research hypothesis, which assumed significant differences between poverty beliefs and select participant demographics of counseling specialty, ethnocultural identity, gender, personal poverty experiences and poverty counseling experiences was not supported.

CHAPTER 5

DISCUSSION

This chapter discusses the results of this study presented in the previous chapter. In addition implication of results for future research, training, and practice are discussed. Further, limitations of this study are outlined.

Review of Study

The aim of this study was to explore the relationship between the MCC of professional counselors and their poverty beliefs. The purpose of this study was to contribute to the literature related to the poverty attitudes of counselors while also exploring the relationship between poverty attitudes, MCC, and various counselor demographic factors. This study was conducted using electronic survey methods participants were recruited from various professional counseling listservs to include CESNET, COUNSGRADS, and the AMHCA listserv. Participants were recruited over a 5-week period in late 2015.

The sample in the present study included 251 professional counselors from various professional counseling specialties, ethnocultural identities, genders, and ages. Participants also expressed if they had professional poverty counseling experience and person poverty experiences. The research questions outlined below were addressed using two hierarchical linear regressions and a factorial MANOVA in SPSS 22.

Major Findings

Research Question One

The first research question used two hierarchical linear regressions to assess the relationship between counselors' poverty beliefs and MCC, while adjusting for age, gender, ethnocultural identity, counseling specialty, poverty counseling experience, and personal poverty experience. The most essential finding in the present study indicates that MCC Knowledge and Awareness are significantly linked to poverty beliefs (individualistic and structural).

The first regression explored the relationship between participants' MCC knowledge and awareness and individualistic poverty beliefs while adjusting for age, gender, ethnocultural identity, counseling specialty, poverty counseling experience, and personal poverty experience. Individualistic poverty beliefs indicate more biases towards persons in poverty, as they represent the belief that poverty is the fault of the person experiencing poverty and any personal deficits they may have (Smith & Stone, 1989). The results of this regression were significant at the third step, indicating that MCC as measured by the MCKAS does significantly predict individualistic poverty beliefs. Higher levels of participant MCC was predictive of lower individualistic poverty beliefs. The MCKAS subscales of knowledge and awareness were entered together into step 3; examination of the standard beta weights suggest that only participant awareness contributed to their individualistic poverty belief scores. This result is hypothetically and theoretically consistent, indicating that increased MCC is linked to decreased poverty biases in the present sample.

The second regression tested if participants' MCC knowledge and awareness predicted structural poverty beliefs while adjusting for age, gender, ethnocultural identity, counseling specialty, poverty counseling experience, and personal poverty experience. Structural poverty beliefs represent more accepting and understanding beliefs about poverty. Structural understandings of poverty take into account external economic, social, political, and cultural

forces (e.g., sexism, racism, classism) that cause poverty (Smith & Stone, 1989). The results of this regression were significant at the third step, indicating that increased MCC does predict significantly predict structural poverty beliefs in the present sample. The impact of MCC knowledge and awareness both contributed to the prediction of participants' structural poverty beliefs in the regression model. MCC knowledge appears to be a stronger predictor based examination of the standardized beta weights, although it is important to note participants' MCKAS knowledge sub-scale scores were entered into the same step as their awareness scores. This result is also theoretically and hypothetically consistent, indicated that MCC knowledge and awareness impact structural understandings of poverty and that increased knowledge increases these understandings in an important way in the present sample.

Research Question Two

A factorial MANOVA was conducted to answer the second research question, which explored the relationship between counselors' exposure to poverty (personal poverty exposure and professional poverty counseling experience) and individualistic and structural poverty beliefs. The means and standard deviations of the individualistic and structural BAPS subscales were examined in terms of participants' counseling specialties, gender, ethnocultural identity, poverty counseling experience, and personal poverty experience.

Counseling specialty. Poverty beliefs varied in terms of counseling specialty. Career counselors had the highest individualistic poverty beliefs followed by college, school, mental health, marriage and family, Other, and rehabilitation counselors. Community counselors had the lowest individualistic poverty beliefs. Addictions counselors had the highest structural poverty beliefs, followed by college, Other, rehabilitation, mental health, school, community, and career counselors. Marriage and family counselors had the lowest structural poverty beliefs.

Gender. Poverty beliefs also varied by gender in the present sample. Individuals with non-binary gender identities have less biased poverty beliefs overall. Women had the highest individualistic poverty beliefs, followed by men and transgender* participants. Other genders had the lowest individualistic poverty beliefs. Transgender* participants had the highest structural poverty beliefs, followed by other genders and women. Men had the lowest structural poverty beliefs. In previous research measuring counselor poverty beliefs (ex. Bray & Schommer-Aikins, 2015; Toporek & Pope-Davis, 2005) gender has been measured on a binary; the inclusion of transgender* and other gender participants provides additional understandings of diverse counselor's poverty beliefs.

Ethnocultural identity. Differences in poverty beliefs also existed across ethnocultural groups in the present sample. African Americans had the highest levels of individualistic poverty beliefs, followed by multiple heritage, Asian, American Indian/Alaska Native, Other, and White counselors. Hispanic/Latin(o/a) participants had the lowest individualistic poverty beliefs. Multiple Heritage participants had the highest mean structural poverty beliefs. This was followed by Other, African American, White, Asian, and American Indian/Alaska Native participants. Hispanic/Latin(o/a) participants had the lowest structural poverty beliefs in the present sample. These numbers are also influenced by sample size; most participants in this study identified as White.

Poverty counseling experience. Counselors with poverty counseling experience had higher individualistic and structural poverty beliefs than counselors who did not have poverty counseling experience. Counselors with poverty counseling experience were also a majority of the sample, providing more variance. This result is opposite of results found in a similar study of

school counselors, where school counselors worked in Title I schools had more positive poverty beliefs (Bray & Schommer-Aikins, 2015).

Personal poverty experience. Counselors with personal poverty experiences had higher individualistic and structural poverty beliefs than counselors who did not have personal poverty beliefs. The mean differences between counselors with and without personal poverty experiences were slight across all three poverty belief subscales. This is supported by the insignificant factorial MANOVA used to answer research question 2.

Factorial MANOVA. The factorial MANOVA was not significant and indicates there are no significant differences in individualistic and structural poverty beliefs based on a counselor's gender, counseling specialty, ethnocultural identity, professional exposure to poverty, and personal exposure to poverty. This result indicates supports the result of research question one, which indicating MCC knowledge and awareness impacts counselor poverty beliefs in ways that select demographic features do not.

Implications for Counseling Practice

Results of the present study indicate that there is a significant relationship between counselor MCC Knowledge and Awareness and poverty beliefs. Participants who reported higher levels of MCC awareness were significantly indicated lower individualistic poverty beliefs. Increasing MCC awareness in professional counselors decreases individualistic poverty beliefs and biases, which implies that focusing on an increase in awareness could lead to decreased poverty biases in professional counselors and counselor trainees. MCC awareness and MCC knowledge are linked to structural beliefs about poverty. Increases in MCC awareness and knowledge were linked to increases in structural, or less bias, poverty beliefs. The results of the

present study imply that increasing MCC awareness and knowledge specifically increase structural, or more socio-political beliefs about poverty (Smith & Stone, 1989). However, this prediction is not complete, as the individual regressions only accounted for 27% and 12% of the variance in the models, respectively. This may indicate that the way MCC is conceptualized in current models is not comprehensive or that there are other components, outside of the demographic factors measured in this study, that add to the predictive ability of the MCC subscales.

It is important to consider how the MCC Knowledge and Awareness subscales correspond with the updated MSJCC (Ratts et al., 2016) subscales when discussing the implications of this study (which measured MCC). Regarding MSJCC, attitudes and beliefs and knowledge both provide a foundation for all multicultural interactions on all four client/counselor axes (privileged counselor, privileged client, marginalized counselor, and marginalized client). These four axes have the same four sublevels, all impacted by the counselors' MCC Awareness, which is anchored in counselor self-awareness, followed by client worldview, counseling relationship, and counseling and advocacy interventions (Ratts et al., 2016). MCC Awareness and Knowledge are synthesized throughout the updated MSJCC model (Ratts et al., 2016) on all four axes and on all four levels of competency.

Overall, the results of the present study imply that increased MCC and MSJCC may be linked to the capability to effectively counsel and limit biases when working with a diverse group, in this case, persons experiencing poverty. The significant link between MCC and poverty competence indicates that these two constructs may be able to be conceptualized together, with poverty competence under the umbrella of overall MCC/MSJCC. In the present sample higher MCC is linked to a decrease in poverty bias and an increase in healthier poverty beliefs.

Contrary to previous studies of MCC and/or poverty beliefs (e.g., Chao, 2012; Bray & Schommer-Aikins, 2015), demographic factors (counseling specialty, age, gender, ethnocultural identity) and poverty exposure variables (personal and professional) did not significantly account for changes in levels of poverty beliefs. This result indicates that in the present sample MCC is the best predictor for poverty beliefs, rather than any demographic or poverty exposure variable. Further, the notion that demographic factors (i.e., age, gender, and ethnocultural identity) in the present study did not impact poverty beliefs is an important implication. This is likely due to the lack of variance in the sample. Additionally, counter to theory and previous research (Bray & Schommer-Aikins, 2015) professional and personal poverty exposure did not influence poverty beliefs in the present sample.

Limited models exist outlining best practices for counseling with persons experiencing poverty. The results of the present study impacts both existing models, *The Social Class Worldview Model* (Liu, 2001a, 2001b) and the *CARE Model* (Foss et al., 2011). *The Social Class Worldview Model* is based on six domains of understanding and awareness based on client perceptions of their own social class shaping their reality, clients' relationships with money and its impact on their own lives and personal meanings, the idea that persons of all social groups have a desire to be accepted within their own social group, a lack of economic resources disrupts the social experience, and an individual's understanding is based on their own social class culture and context (Liu, 2001a, 2001b). *The Social Class Worldview* model encourages professional counselors to take the perspective of others from a variety of social classes (Liu, 2001a, 2001b). The results of this study imply a link between MCC & poverty beliefs, therefore counselors should endeavor to increase both awareness and knowledge as it relates to diverse and poverty. This perspective taking could lead to a decrease in poverty biases (individualistic

poverty beliefs). The Liu (2001a, 2001b) model does not specifically focus on domains that would impact increased MCC knowledge; therefore, this model is likely useful in decreasing individualistic poverty beliefs and biases but not increasing structural and socio-political beliefs about poverty. However, this model is significantly more aligned with socio-political concepts (e.g., client and counselor relationships to power and privilege) outlined in MSJCC (Ratts et al., 2016). *The Social Class Worldview Model* (Liu 2001a, 2001b) does focus on counselor self-awareness, corresponding with the core principle associated with MSJCC (Ratts et al., 2016); this counselor awareness of self and client is linked to a decrease in poverty biases (individualistic poverty beliefs); these components of both *The Social Class Worldview* and MSJCC models are congruent with the results of the present study.

The *CARE model* outlines steps counselors can take when working with persons experiencing poverty. Specifically, counselors should cultivate the therapeutic relationship with clients, acknowledge the realities of poverty experiences, work to remove barriers, and expand on client strengths. The *CARE model* provides more concrete and specific interventions, but also addresses concepts related to poverty knowledge and awareness (Foss et al., 2011). The results of this study, when synthesized with the *CARE model* (Foss et al., 2011), reiterate the importance of acknowledging the realities of impoverished experiences as awareness; this may be a way to reduce individualistic poverty beliefs and biases towards persons experiencing poverty. Additionally, acknowledging the realities of poverty and working with clients to remove barriers may increase knowledge of poverty realities and barriers. This increase in knowledge may impact and increase structural, or less biased, beliefs about poverty. The *CARE Model* (Foss et al., 2011) is congruent with the intervention and advocacy domains of the MSJCC model (Ratts et al., 2016).

The Social Class Worldview Model does not focus on increasing knowledge, which is a key component in increasing structural understandings of poverty. Understanding the structural forces behind poverty is key to understand how to address client barriers, which may impact treatment success. This concept of action is introduced in the *CARE model* (Foss et al., 2011). The *CARE Model* has less emphasis on awareness, but the focus on understanding barriers and action likely makes it congruent with an increase in structural poverty understandings and the action components addressed in the MSJCCs (Foss et al., 2011; Ratts et al., 2016). Both poverty counseling models do not directly address poverty beliefs and how they impact clients experiencing poverty; the results of the present study indicate that an update model outlining poverty competencies and best practices in counseling may be useful and warranted at this time.

Because of the link between MCC/MSJCC and poverty beliefs, counselors should integrate all four models (MCC, MSJCC, *The Social Class Worldview Model*, and *The Care Model*) (Foss et al., 2011; Liu, 2001a, 2001b; Ratts et al., 2016; Sue et al., 1992) into their counseling practice to increase structural (positive) poverty beliefs and decrease individualistic (negative) poverty beliefs). In accordance with MSJCC (Ratts et al., 2016), counselors should first work to increase awareness of their own poverty biases and experiences. This could be done through self-reflective practices, personal or professional poverty immersion (i.e., counseling work with the homeless population), counseling supervision, or personal counseling. This self-awareness is not only foundational to MCC and MSJCC, but also to decreasing poverty biases. In addition to self-awareness, counselors must endeavor to understand their clients' worldview (Foss et al., 2011; Liu, 2001a, 2001b; Ratts et al., 2016). This understanding increases awareness regarding the lived experiences of persons in poverty; this can be accomplished through poverty immersion as outlined above, especially if the counselor comes from a different social class

background. This can also be achieved through counseling sessions, by broaching social class, and allowed the client to share with and educate the counselor about the clients' poverty experiences.

Results of the current study imply that MCC and MSJCC knowledge is also linked to increased structural (positive) poverty beliefs; therefore, counselors should also engage in activities which will increase their knowledge not only about poverty, but socio-political policies and issues that impact social class (Foss, et al., 2011; Ratts et al., 2016). This knowledge can be gained through continued learning about social class and poverty related issues, including workshops, further education, conference presentations, and salient socio-political issues. Counselors can use this knowledge in two ways in their practice. First, counselors can use knowledge about social class issues to increase their positive understandings of poverty and work more effectively with clients. Second, counselors can use this knowledge to more effectively engage in intervention and advocacy with and on behalf of clients, an important component of MSJCC (Ratts et al., 2016). This knowledge of structural barriers could help counselors to become a resource for clients regarding information on how to navigate these barriers, which is micro level advocacy. Further, increased knowledge can increase and focus counselor advocacy at the meso and macro levels as well, especially in regards to local and national policy that impact persons experiencing poverty.

Implications for Counselor Education and Supervision

The results of this study also have implications for counselor education and supervision, including guidelines for MCC education set forth by ACA, ACES, and CACREP. MCC is an important aspect of counselor education and supervision (ACA, 2014; Borders et al., 2011; CACREP, 2016), and the results of the present study indicate that MCC has a significant

relationship with counselor's poverty beliefs, possibly impacting counselor self-awareness, client worldview, counselor-client relationship and counseling and advocacy interventions.

Poverty and MCC Educational Standards and Practices

Counselor educators are expected to infuse multicultural and diversity through all counseling courses; this infusion is intentional with the expected outcome that students will be expected to learn MCC from these courses (ACA, 2014). CACREP also outlines how multiculturalism and diversity should be infused in counselor education across courses to include knowledge of diverse groups, theories and models of multicultural counseling, MCC, the impact of culture on an individual's' worldview, the impact of power and privilege, how diverse clients seek counseling, and strategies for eliminating barriers such a racism, sexism, classism, etc. (CACREP, 2016). Although ACA and CACREP do not mention social class and poverty specifically, it is intimated that all socio-cultural diverse groups should a part of multicultural counseling curriculum. Although these standards require understanding of diverse cultural groups, as previously mentioned, strategies for educating students about poverty are markedly absent from counseling literature (Smith, 2005; Toporek, 2013).

MCC is typically taught in comportsment with current standards set forth by CACREP (2016) and based on the MCC and MSJCC models (Ratts et al, 2016; Sue et al, 1992). There are multiple articles, studies, and models for teaching MCC (Coleman, Morris, & Norton, 2006; Kim & Lyons, 2003; Prosek & Michel, 2016; Priester et al., 2008). There is only one article outlining strategies for teaching about and working with clients in poverty (Baggerly, 2005). The models for teaching MCC are experiential in nature, studying and detailing the impact that experiential activities (Kim & Lyons, 2003), multicultural immersion (Prosek & Michel, 2016), and student multicultural portfolios (Coleman et al, 2006) on student multicultural learning and competence.

It has also been suggested that poverty competence be taught using immersion and service learning (Baggerly, 2005).

The teaching strategies outlined above are awareness building, while standards outline knowledge that students should know. Results from the present study indicate that teaching MCC is necessary on both the knowledge and awareness subscales. Specifically, these experiential, or out class learning opportunities (i.e. immersion and service learning) provide students with opportunities to become more aware of the impact of poverty and lived experiences of persons experiencing poverty, possibly reducing individualistic poverty beliefs and biases. These experiences also increase knowledge of the barriers that exist for persons in poverty, possibly linked to increased structural poverty understandings. Didactic classroom learning about different cultures and socio-political structures such as privilege and oppression are outlined in the CACREP standards (2016). These structural learning opportunities may impact structural poverty beliefs, increasing student capabilities to effectively engage in advocacy with and on behalf of clients at the micro, meso, and macro levels; this action is in compartment with MSJCC and should be considered in counselor preparation (Ratts et al., 2016).

It is noted in the literature that social class and poverty are not distinctly mentioned in counselor preparation and education (Smith, 2005; Toporek, 2013). The results of this study imply that there is a distinct and significant relationship between MCC and poverty beliefs. It is clear that continued knowledge and awareness through immersion and service learning positively impact MCC (Coleman et al., 2006; Kim & Lyons, 2003; Prosek & Michel, 2016); poverty competence may also be positively impacted by service learning opportunities through increase knowledge and awareness and should be considered viable options for counselor education. A specific increase in poverty awareness and knowledge through didactic teaching, service

learning, immersion, and other awareness activities may also increase overall levels of MCC, as proposed by in previous conceptual research (Baggerly, 2005).

In the present study, MCC is a pre-cursor to poverty beliefs and competency; however, MCC only accounts for a moderate amount of variance in poverty beliefs in the present sample. Therefore, MCC in itself is not a sufficient measure of poverty competency. To truly increase poverty competency, social class and poverty issues must be synthesized into MCC curriculum and courses. Social class and poverty are not typically considered in popular models of multiculturalism and diversity or infused in MCC (Ratts et al., 2016; Smith, 2005; Sue et al., 1992). MCC Knowledge and Awareness are specifically linked to increased poverty competence; a focus on knowledge and awareness regarding social class and poverty could increase the poverty competence in counselor trainees. Poverty awareness could specifically be accomplished through immersion. Cultural immersions are common multiculturalism/diversity course interventions (Coleman et al., 2006; Kim & Lyons, 2003); a poverty immersion could include providing services (counseling or otherwise) to persons experiencing poverty through a community agency, non-profit, or other social services organization. Immersions focused on poverty and mental health or poverty in the schools would be specifically helpful for increasing counselor trainee poverty awareness. Increased poverty and social class knowledge could be increased through didactic pedagogical methods. Specifically, counselor educations should focus on teaching counselors in training about power, privilege, and oppression and their relationship to these structures as they relate to social class (Ratts et al., 2016). Barriers to wellbeing and mental health faced by persons experiencing poverty should be discussed at length; this could give students the knowledge to understand clients' worldviews and experiences and also prepare them to better advocate for clients who experience poverty. It is clear that counselor educators

cannot focus on only awareness or knowledge when preparing counselors trainees to be poverty competent counselors, a combination of experiential (awareness building) and didactic (knowledge building) interventions are both necessary.

Implications for Counselor Supervision

MCC and social class competencies are important aspects of counseling supervision included in the *ACA Code of Ethics* (2014) and *ACES Best Practices for Clinical Supervision* (Borders et al., 2011). The *ACA Code of Ethics* specifically addresses that multicultural counseling issues throughout the supervisory relationship (F.2.b). ACES further elaborates on the importance of MCC in counseling supervision, noting that not only should MCC addressed within the supervisory relationship, but also within the supervisee-client relationship; these standards specifically mention social class as an area of focus for best supervisory practices (Borders et al., 2011). Little research exists outlining how to specifically address poverty beliefs or competence working with persons in poverty.

The present study and existing standards indicate that multicultural issues, including social class and poverty must be addressed within supervision. This study particular highlights the need of supervisors to be aware of their own levels of MCC and poverty beliefs; supervisors must be aware of their own cultural identities to be effective in supervision (Borders et al., 2011). This includes their own biases, stereotypes, knowledge, awareness, and ability to act on behalf of persons in poverty (Ratts et al., 2016). Any poverty biases held by the supervisor may impact the supervisory relationship (if the supervisee is from a different social class) or may lead the supervisor to not see social class and poverty competence issues within their supervisees own sessions with clients. Supervisors are tasked with broaching difficult cultural topics, assessing supervisee capability for working with diverse populations, and supervisee MCC knowledge and

awareness (Borders et al., 2011). This includes supervisee capability work with and advocate for persons in poverty.

Supervisors must be aware of their own supervisee's knowledge, awareness, and beliefs about poverty (ACA, 2014; Borders et al., 2011). Based on results from the present study, supervisors could endeavor to increase MCC and poverty awareness to decrease poverty biases. This could include specific self-awareness building activities on the supervisee's own social class and poverty experiences and expectations, including how they predict these influence their counseling work. This may also be achieved through interpersonal process recall while reviewing sessions with supervisees. Reduction of individualistic poverty beliefs may impact the way counselors engage with clients, including the therapeutic relationship, diagnosis, and treatment planning, as research has found clients experiencing poverty are often diagnosed more harshly and sessions with these clients are less smooth (Smith, Mao, & Ampuero, 2011). More didactic methods could be used to increase supervisee structural understanding of poverty through an increase in knowledge to include articles, documentaries, and other learning opportunities that expand the supervisee's understanding of the socio-political and structural impact of poverty. This increased understanding of structural causes of poverty may be beneficial when addressing barriers and engaging in forms of advocacy for clients (at the micro, meso, or macro levels). This type of advocacy must be addressed in the supervisory relationship (Borders et al., 2011), is congruent with poverty counseling models (Foss et al., 2011), and MSJCC standards (Ratts et al., 2016).

Study Limitations

The present study has multiple limitations which should be considered when interpreting the results. Internal validity is the ability for a study, especially one measuring causal

relationships, to make true inferences about the studied relationships (Tabachnick & Fidell, 2013). Internal validity is particularly important in this study as the research seeks to measure the relationship between MCC and the poverty beliefs of professional counselors. Threats to internal validity in this study may include selection bias, self-report bias, social desirability, extreme response bias, ordering bias, and measurement bias. Participants who volunteered for this study may pose a threat to internal validity due to selection biases as this is a non-experimental design. Participants were not randomly selected or organized into groups; they chose to participate in this survey. Persons who decided to take this survey may have a special interest in poverty, classism, multicultural counseling, or other social justice related issues, possibly impacting results. This is typically addressed by doing further research with other sub-samples of the population of interest – in this case, professional counselors.

In addition to selection bias, self-report bias and social desirability bias likely limit this study. Participants may answer questions in the way they believe professional counselors should behave and think, rather than how they actually do behave and think. Because this is a self-report survey, results rely on participants being honest in their responses. Participants may have been inclined to not fully report factors related to multiculturalism or poverty beliefs, especially if they thought they would reflect negatively on themselves as professional counselors. Socially desirable responses and self-report represent a threat to internal validity.

Ordering bias and extreme response bias may have impacted how participants answer the survey questions. The order of the survey was the same for all participants, with the MCKAS items first, followed by the BAPS items, and the demographic questionnaire. The order of these items influenced what participants were included in final data analysis, as some participants only completed the MCKAS but did not complete BAPS or demographic items. Extreme responding

often impacts studies which use Likert-type items such as the MCKAS and BAPS. Participants may have chosen the most extreme items on the opposite ends of the scales, which may have influenced data.

There are also limits of measurement in the present study. This study was completed using electronic survey methods, although common (Granello & Wheaton, 2011), electronic survey methods have limitations. First, electronic surveys only allow for data collection over a short period of time (five weeks). This time may not have been sufficient to reach the targeted sample. Additionally, it is impossible to truly know the response rate to this survey as listservs were used to gain access to the sample. The listservs used did not have defined membership numbers and therefore a response rate could not be calculated. Additionally, pertinent listservs to the targeted population, unknown to the researcher, may have been excluded and may have limited the sample.

There were limitations of the variables measured in this study. MCC was measured by MCKAS, which is an assessment based on the original MCC (Sue et al., 1992; Ponterotto et al., 2002). This assessment does not apply to the newly endorsed MSJCC (Ratts et al., 2016), which are the new professional counseling standard for competence. This limits the results of research question 1; relationships measured are between MCC and poverty beliefs, not MSJCC.

Poverty beliefs as measured by the BAPS subscales also represent limitations. Although the scale defines poverty using the relational definition, each participant's understanding of this definition could vary; therefore, the operationalization of poverty may have varied across participants. The fatalistic subscale also had a low Cronbach's alpha, limiting the reliability of this subscale and excluding it from analysis in this study. The exclusion of the fatalistic subscale limits the results of the study overall represents limits of measurements as this construct was not

included in analysis. Finally, although the MCKAS and BAPS have been normed and validated, these scales have not been used together in previous studies.

The measurement of counselor poverty exposure variables also represents a study limitation. Personal definitions and understandings of poverty vary between individuals. This may have not been adequately captured when implementing a relational poverty definition to describe both personal and professional poverty exposure. Additionally, a participant could only indicate if they had worked in a setting that served individuals in poverty such as a community mental health clinic, a non-profit counseling agency, pro-bono counseling, or a Title I school. There was no “Other” category provided to participants. These responses were interpreted as “yes: poverty counseling experience” and “no: no poverty counseling experience.” There is no way to measure the amount, in time or proportion, that a participant had working with clients experiencing poverty. Personal poverty experiences were measured in a similar way; participants indicated whether they did or did not have personal poverty experiences in their lifetime. There was no way for participants to indicate the depth of poverty they experienced in their lives. For example, chronic deep poverty across the lifespan and brief poverty were measured and analyzed in the same manner. The present study is unable to explore the depth of personal and professional poverty exposure of counselors within the sample.

External validity is the extent to which this study can be generalized to the population. The present study is limited in terms of generalizability. As this study is exploratory, the results are only truly generalizable to the sample who participated in this study. The results of the present study are also limited by the composition of the sample. The majority of participants in the present study were white ($n= 178, 70.9\%$); non-white participants were a minority of this sample ($n= 73, 29.1\%$). Ethnocultural diversity was not represented in this sample, although

arguably, this sample may be comparable to the overall ethnocultural distribution of the counseling profession (CACREP, 2014). This sample overwhelmingly identified as women ($n=198$, 78.9%). Men ($n=47$, 18.7%), transgender persons ($n=4$, 1.6%), and other genders ($n=2$, .8%) were a minority of the sample. The study lacks gender diversity, but arguably represents the gender distribution of professional counseling overall (CACREP, 2014). The amount of mental health counselors ($n=146$, 58.2%) that comprise the sample also limit this study, as this unequal distribution of specialty inhibits generalizability to all professional counselors. Finally, although this sample size was robust for statistical analyses ($N=251$), the results of the present study represent a static measure of the participants' competencies and beliefs at the time the participants completed the survey.

Recommendations for Future Research

To expand the results of this study future research should continue to operationalized MCC and MSJCC. This research could be quantitative, through the creation and validation of a scale that can be used to measure MSJCC, or qualitative, exploring the MCC/MSJCC competencies of counselors (phenomenology). A grounded theory study may also be useful to qualitatively operationalize MCC and MSJCC. Further operationalization of MCC and MSJCC constructs could enhance understanding of the relationship between MCC/MSJCC and poverty beliefs.

The present study was initiated and conducted as exploratory research into the relationship between counselors' MCC and poverty beliefs. This research should be continued and expanded to increase generalizability by increasing diversity in the sample (i.e. ethnocultural identities, genders, and counseling specialties). Replicating this research with more specific populations of counselors (i.e. ethnocultural identities, genders, and counseling specialties,

among others) to further understand how poverty beliefs vary in diverse groups of counselors. Additionally, further exploration through qualitative and quantitative methods into the relationship between counselors' MCC and poverty beliefs is supported by the results of the present study.

A deeper understanding of counselors' poverty beliefs and poverty competency is necessary. Further quantitative research could be conducted to understand the factors, outside of MCC, do predict poverty beliefs. To explore the poverty beliefs of counselors in depth, qualitative methods would be beneficial research. Qualitative methods allow for more in-depth information to be collected, highlighting the essence of counselors' opinions, understandings, and beliefs about poverty and classism. Understandings of how counselors believe clients in poverty can be best served would be beneficial to understanding how counselors engage and work with clients in poverty and establish best practices for working with clients in poverty. All of these research methods could assist in model and standard development for working with clients experiencing poverty. Development of poverty counseling competence standards would be a beneficial step in establishing guidelines and standards to working with clients experiencing poverty. These standards should center on the wellbeing and best interest of clients (ACA, 2014), while integrating the expertise and experiences of counselors who work with clients experiencing poverty. These standards should also be measured empirically, to create poverty counseling competencies. This could be achieved by the creation and validation of a poverty competency scale. These poverty counseling competencies could establish a baseline of skills necessary for counselors to successfully work with clients experiencing poverty.

Client outcome research is an important future research direction that should be pursued. No research exploring the perspective of clients who experience poverty and who have received

counseling services has ever been conducted. Qualitative methods, such as a phenomenology, would be an effective way to measure the counseling perspectives of persons who have experience poverty. This research would assist counselors in understanding client perspectives of counseling treatment, efficacy of counseling treatment, and how clients in poverty experience class differences in counseling sessions. Quantitatively, outcome research may be effective. Client perceptions of therapeutic efficacy, counselor classism, and the counseling relationship could be evaluated. Additionally, pre-test post-test methods could be conducted to see how clients in poverty benefit from different types of therapeutic treatment or other factors (i.e., strength of the therapeutic alliance, levels of counselors' classism). Further understanding of the experience of clients in poverty is an important social justice issue, giving these often marginalized clients a voice in counseling treatment.

Future research should could also be conducted to evaluate the efficacy of existing models of counseling with persons in Poverty (Foss et al., 2011; Liu, 2001a, 2001b). No empirical research exists exploring the efficacy of existing models for counseling persons in poverty. Evaluation of these models is necessary for understanding their efficacy with clients and how counselors integrate those models into their clinical practice. Outcome research could be a valuable way to evaluate these models' efficacy. Evaluation of existing models will also allow for further understanding of how counselors choose to and can counsel persons in poverty, likely impacting future standard and model development.

A final research direction would include exploring and evaluating methods used by counselor educators and supervisors to increase poverty competency in students and supervisees. Qualitative exploratory work, outline how social class and poverty are addressed in coursework and supervision, respectively, would establish a baseline of understanding how students and

supervisees are taught about poverty and social class issues in counseling. Once these instructional and supervisory practices are outlined their efficacy should be tested using quantitative methods, such as pre-test post-test evaluations of student and/or supervisee poverty competency. The rigorous evaluation of the methods is necessary in order to ensure counselor education and supervision adequately prepares counselor trainees to work with clients experiencing poverty.

CHAPTER 6

MANUSCRIPT

In accordance with the American Counseling Association (ACA) *Code of Ethics* (2014), counselors should be willing and able to provide effective services to persons of all social classes (Standard A.2.c). In addition to this ethical mandate, professional counselors are expected to be multiculturally competent, implying counselors must cultivate the attitude, beliefs, knowledge, skills, awareness, and action to work with any diverse population including persons experiencing poverty (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016). Despite these professional standards, mental health theory, practice, and education often reinforce classist beliefs and practices, further marginalizing persons experiencing poverty (Liu, Pickett, & Ivey, 2007; Lott, 2002, 2012; Smith, 2005). Classism in counseling creates barriers for persons in poverty and often does not consider the therapeutic needs of this cultural group (Liu et al., 2007; Smith, 2005). Although, conceptually, the link between multicultural counseling competence (MCC) and awareness of tacit or explicit biases related to poverty seems clear, little empirical research in professional counseling literature exists assessing the relationship between these two concepts.

Classism in mental health treatment is not only unethical but also marginalizing; persons in poverty are vulnerable to psychological disorders, yet the creation or implementation of treatment modalities are frequently focused on White, middle class, male experiences (Liu et al., 2007; Smith, 2005; Weissman, Pratt, Miller, & Parker, 2015). Poverty and financial barriers impact 45.3 million Americans and approximately one-fifth of American children (U.S. Census Bureau, 2014). High incidences of poverty coupled with the increased likelihood that persons in poverty will experience mental illness, it is clear that counselors need to be adequately prepared

to work with this population (U.S. Census Bureau, 2014; Weissman et al., 2015). In this study the researcher seek to explore the relationship between counselor MCC and poverty beliefs in professional counselors. To evaluate the relationship between counselor MCC and poverty beliefs, identity factors were analyzed using hierarchical linear regression and a factorial MANOVA. This study sought to expand literature related to counselors' poverty beliefs and implications from the data for counselors working with individuals experiencing poverty.

Poverty, Mental Health, and Counselor Preparation

In 2013, 14.5% of Americans lived in poverty, with an individual yearly income below \$11,770 (U.S. Census Bureau, 2014). While 14.5% represents the poverty rate of all Americans, poverty is an intersectional issue: children, women, people of color, lesbian, gay, bisexual, and transgender persons, and immigrant groups all experience higher rates of poverty than persons occupying non-marginalized statuses (U.S. Census Bureau, 2014). Coupled with stress associated with financial barriers, many persons in poverty also experience racism, sexism, homophobia, and transphobia, leading to multiple minority stressors and possible negative physical and mental health outcomes (Bockting, Miner, Swinburne-Romine, Hamilton, & Coleman, 2013; Meyer, 2003; Wong et al., 2014).

Persons in poverty experience higher rates of mortality, chronic physical illness, developmental delays, violence, incarceration, barriers to health care, and barriers to housing (Kaminski et al., 2013; Krieger, Chen, Waterman, Rehkopf, & Subramanian, 2005). In addition, persons experiencing poverty are more likely to experience mental health concerns and psychological disorders (Weissman et al., 2015; World Health Organization [WHO], 2007). Poverty increases the risk for schizophrenia (WHO, 2007). The increased rates of mental illness expressed in persons experiencing poverty, coupled with the barriers to health insurance and to

quality, affordable mental health treatment, further marginalizes persons in poverty (Weissman et al., 2015; WHO, 2007; 2010). Without mental health care, persons in poverty presenting with mental illness have difficulty finding stable employment, further limiting their earning power and ability to financially support themselves and their families (Weissman et al., 2015; WHO, 2010).

Poverty and mental health are positively correlated, but little research in counseling and mental health is done to further support this vulnerable population (Liu et al., 2007; Smith, 2005; Weissman et al., 2015). Class biases are unethical in professional counseling, yet counseling theory, practice, and preparation marginalizes people of lower social classes through exclusion (Liu et al., 2007; Smith, 2005; Smith et al., 2011). Many persons have negative poverty beliefs, and counselors are no exception (Cozzarelli, Wilkinson, & Tagler; 2001; Neynaber, 1992; Shapiro, 2004; Smith et al., 2011). Counselors' class biases toward individuals experiencing poverty are evident throughout the literature and continue to perpetuate classism in mental health treatment (Neynaber, 1992; Shapiro, 2004; Smith et al., 2011). For example, counselors are less likely to want to provide services to persons in poverty (Smith et al., 2011).

MCC is a cornerstone of ethical professional counseling practice (ACA, 2014; Ratts et al., 2016). Counselors should be prepared to counsel without bias (ACA, 2014; Ratts et al., 2016). Despite this ethical mandate, counselor preparation programs devote little energy to preparing students to effectively counsel persons outside of their own social class and often perpetuate practices that further marginalize clients living in poverty (Liu et al., 2007; Smith, 2005).

A lack of preparation to work with persons experiencing poverty is noted when counselor poverty beliefs and therapeutic impressions of clients in poverty are measured (Bray &

Schommer-Aikins, 2015; Shapiro, 2004; Smith, Mao, Perkins, & Ampuero, 2011; Toporek & Pope-Davis, 2005). Counselors show the most bias toward clients occupying a lower social class (Shapiro, 2004), are less willing to work with clients from a lower social class (Smith et al., 2011; Shapiro, 2004), and counseling sessions with clients of a lower social class were likely to be less smooth and result in more severe diagnosis (Smith et al., 2011). Further, counselor trainees had the most significant biases towards two distinct groups, clients from a lower social classes and clients with disabilities (Neynaber, 1992). These biases in service delivery and general reluctance to work with this population are especially concerning considering persons experiencing poverty are more likely to present with mental illness; persons in poverty are eight times as likely to present with schizophrenia (Weissman et al., 2015; WHO, 2007). The cyclical relationship between negative mental health outcomes and increased poverty experiences highlights the importance of effective and accessible mental health services for persons experiencing poverty; possessing a healthy mental status can be a factor in breaking the cycle of poverty for some (Weissman et al., 2015; WHO, 2007, 2010). To promote positive mental health outcomes for all persons, regardless of social class, counselors must be prepared to work with persons experiencing poverty.

Little empirical research exists exploring how poverty impacts the counselor-client relationship, service delivery, or counseling efficacy (Smith, 2005; Toporek, 2013). Most literature regarding social class in counseling is conceptual, offering models for working with this population without evidence to support those models' efficacy (Baggerly, 2006; Foss, Generali, & Kress, 2011; Liu, 2001a, 2001b). Some research exists that explores how counselors understand social class and poverty (Bray & Schommer-Aikins, 2005; Neynaber, 1992; Shapiro, 2004; Toporek & Pope-Davis, 2005). For example, Bray and Schommer-Aikins (2015) found

increased multicultural training was linked to positive poverty beliefs in a sample of 513 school counselors; however the study only included one counseling specialty and MCC measured through self-reported levels of multicultural counseling training rather than a validated instrument. In the only study measuring the relationship between multicultural counseling training and poverty beliefs (Toporek & Pope-Davis, 2005), only counseling graduate students were sampled. Further, researchers failed to control for previous multicultural training, a confounding variable identified in subsequent literature (Bray & Schommer-Aikins, 2015). It is clear that current research exploring how MCC relates to poverty beliefs including of counselors of all specialties using validated instruments is needed.

Method

Procedure

Electronic surveys were used to collect data in this study. Electronic surveys are a useful method when collecting data in correlational studies due to the pre-existing nature of the variables of interest (Granello & Wheaton, 2011). Variables measured in this study are pre-existing and develop over time, making survey methods an appropriate way to measure these variables (Granello & Wheaton, 2011; Kelley, Clark, Brown, & Sitzia, 2003). Additionally, surveys are a popular way to access a specific population in a short time at a low cost (Granello & Wheaton, 2011). A survey method allowed for the inclusion of a sample of counselors across specialties, expanding on previous research and increasing the generalizability of this study (Granello & Wheaton, 2011). A qualitative design would not allow the inclusion of as many varied participants, limiting generalizability.

The sample ($N= 251$) identified as professional counselors from any specialty; graduate students in counseling with previous field experiences (practicum or internship) were also included in the sample. Participants completed a consent form, a short demographic questionnaire, and two assessments, the Multicultural Knowledge and Awareness Scale (MCKAS) (Ponterotto et al., 2002) and the Beliefs About

Poverty Scale (BAPS) (Smith & Stone, 1989). The electronic surveys were distributed via various listservs related to counseling practice, education, and preparation including COUNSGRADS, CESNET, ACA Connect, Counselors' for Social Justice (CSJ) listserv, and the American Mental Health Counselors Association listserv (AMHCA). Responses were collected over a period of 5 weeks in late 2015.

Participants

Participants in this study ($N=251$) identified as professional counselors or counselor trainees with field experience (practicum and/or internship). Expanding on the work of previous studies (e.g. Bray & Schommer-Aikins, 2015; Toporek & Pope-Davis, 2005), the sample included counselors from multiple counseling specialties: mental health ($n=146$, 58.2%), school ($n=29$, 11.6%), Other ($n=18$, 7.2%), marriage and family ($n=16$, 6.4%), college ($n=15$, 6%), community ($n= 11$, 4.4%), addictions ($n= 6$, 2.4%), rehabilitation ($n= 6$, 2.4%), and career ($n= 4$, 1.6%) counseling. Counselors who selected the "Other" specialty included grief and loss/bereavement counselors, play therapists, and a combination of counseling specialties (such as mental health and school counseling).

Participants' age ranged from 22 years to 81 years ($M= 40.98$ years, $SD= 14.34$ years). Regarding gender, 198 participants identified as female (78.9%), 47 participants identified as male (18.7%), four participants identified as Trans* (1.6%), one participant identified as agender (.4%), and one participant identified as Other (.4%). Ethnographically, 178 participants identified as White (70.9%), 24 as African American (9.6%), 18 as multiple heritage (7.2%), 14 as Hispanic/Latin(o/a) (5.6%), 9 identified as Asian (3.6%), 7 identified as Other (2.8%), and one identified as American Indian/Alaska Native (.4%). In terms of professional poverty counseling experience, 212 (84.5%) participants had worked in a setting serving persons in poverty and 39 (15.5%) participants had not worked in a setting serving persons in poverty (15.5%). 149 participants had no personal experiences of poverty (59.4%) and 102 participants had personally experienced poverty (40.6%).

Instrumentation

Participants were emailed a link to the survey which contained four components: MCKAS) (Ponterotto et al., 2002), the BAPS (Smith & Stone, 1989), a demographic sheet, and an informed consent document. The informed consent document was the first page of the survey, followed by the MCKAS, BAPS, and concluding with the demographic sheet. Order of instrumentation was the same for all participants.

MCKAS

The MCKAS (Ponterotto et al., 2002) was developed to measure the MCC of counseling professionals and graduate students. The MCKAS is a 32-item self-report inventory that has been validated via exploratory and factor analysis (Ponterotto et al., 2002). This assessment was validated on 525 students and professionals in counseling and counseling psychology; after this initial validation the MCKAS was tested for goodness of fit on 199 counselors-in-training from 5 Northeastern universities (Ponterotto et al., 2002). The MCKAS is a two-factor assessment with the subscales of knowledge (20 items) and awareness (12 items) (Ponterotto et al., 2002). The alpha coefficients are .92 for the knowledge subscale and .78 for the awareness subscale, with an overall alpha of .90. The correlation between the two subscales is not strong ($r = .36$) and the author recommends the two subscales be analyzed independently (Ponterotto et al., 2002). The 32 items on the MCKAS are self-report items on a scale of 1 to 7, with 1 indicating *not at all* and 7 indicating *totally true*. The minimum MCKAS score is 32 and the maximum is 224. Higher scores indicate increased multicultural knowledge, awareness, and overall MCC. Sample MCKAS questions include: “I believe all clients should maintain direct eye contact during counseling,” “I think clients should perceive the nuclear family as the ideal social unit,” and “I am aware of institutional barriers which may inhibit minorities from using mental health services” (Ponterotto et al., 2002).

The correlation between the MCKAS knowledge and awareness subscales in the present study was $r = .40$ ($p < .001$). The MCKAS scale and subscales all had high levels of internal consistency; The total scale alpha in the present study was .89, the knowledge subscale alpha was .88, and the awareness subscale had an alpha of .83 (Kline, 2011). The MCKAS can be found in Appendix A.

BAPS

The BAPS was developed to measure beliefs for about and wealth on six subscales: fatalistic, individualistic, or structural causes of poverty and individualistic, fatalistic, or structural causes of wealth (Smith & Stone, 1989). Individualistic attributions for poverty include personal deficits such a motivation or skill levels, indicating poverty biases. Fatalistic attributions for poverty indicate a belief that a person was born to be poor, and structural/situational attributions for poverty include social barriers, the economy, and oppression as causes of poverty (Smith & Stone, 1989).

Higher scores in each of the subscales indicate participant poverty or wealth attributions. The six subscales have varying alpha coefficients as presented in the original study: individualistic attributions for poverty ($\alpha = .73$), structural attributions for poverty ($\alpha = .72$), fatalistic attributions for poverty ($\alpha = .54$), individual attributions for wealth ($\alpha = .62$), structural attributions for wealth ($\alpha = .81$), and fatalistic attributions for wealth ($\alpha = .44$) (Smith & Stone, 1989). The BAPS has been used in previous research related to counselor poverty beliefs (Toporek & Pope-Davis, 2005). In the previous study, the BAPS individualistic subscale had moderately high Cronbach's alpha ($\alpha = .77$) and significantly correlated with multicultural training ($r = .28, p < .01$) (Toporek & Pope-Davis, 2005).

The individualistic and structural poverty beliefs subscales had acceptable internal consistency: .85 and .75, respectively, in the present sample. Further, the individualistic and structural poverty beliefs subscales were not significantly correlated ($r = .03, p = .67$). Because the BAPS fatalistic subscale did not have an acceptable internal consistency value (i.e., .58), the subscale was not included in any study analysis. Further, the BAPS fatalistic subscale was significantly correlated with both the individualistic and structural subscales (i.e., $r = .48 [p < .001]$ and $r = -.13 [p = .04]$, respectively).

The 44-item BAPS is broken into two sections, one related to poverty and one related to wealth (Smith & Stone, 1989). Each section has a prompt: (a) "poor people (poorest 20%) exist in the world today because....," and (b) "wealthy people (wealthiest 20%) exist in the world today because... (Smith &

Stone, 1989).” The BAPS represents a relational definition of poverty defined by the participants’ interpretation of the “poorest 20%.” Items are answered based on a three-point prompt of “not at all important,” “somewhat important,” or “very important” (Smith & Stone, 1989). Poverty items include: (a) “not motivated because of welfare,” (b) “are lazy,” (c) “are born inferior,” and (d) “are taken advantage of by the rich (Smith & Stone, 1989).” Wealth items include: (a) “drive and perseverance,” (b) “are hard working,” (c) “are born superior,” and (d) “are greedy” (Smith & Stone, 1989). For the purposes of this research only the poverty items were included in the survey (22-items). The BAPS can be found in Appendix B.

Demographic information

Participants were asked to complete a short demographic questionnaire asking them to identify their counseling specialty, age, gender, ethnocultural identity, and personal and professional exposures to poverty. The demographic sheet can be found in Appendix C.

Counseling specialty. Previous research on counselor poverty beliefs has only included graduate students in counseling (i.e., Toporek & Pope-Davis, 2005) and professional school counselors (i.e., Bray & Schommer-Aikins, 2015), This study includes diverse counseling specialties to broaden current research.

Age. When exploring the poverty attributions of professional school counselors, younger school counselors expressed more positive poverty beliefs, which could indicate a relationship between these two variables (Bray & Schommer-Aikins, 2015). This demographic variable was included as it may have a relationship with poverty beliefs and should be further explored in a sample of counselors from diverse professional groups.

Gender. In multiple studies gender was a predictor for more positive poverty beliefs and higher levels of multicultural counseling competence (Beck et al., 2001; Brown, Parham, & Yonker, 2001; Constantine, 2000). In this study, participants indicated their gender identity as female, male, trans*, or

could self-identify; previous studies have only analyzed gender as a binary (male-female) (Bray & Schommer-Aikins, 2015; Toporek & Pope-Davis, 2005). Including persons who identify under the trans* umbrella is more inclusive and allows for a diverse sample that is more representative of counselors' genders.

Ethnocultural identity. Ethnocultural identities, specifically experiences as a person of color or a minority, have been shown to increase multicultural counseling competence (Brown, et al., 2001; Chao, 2012; Toporek & Pope-Davis, 2005). Persons who identify as White or European American tend to have lower levels of MCC, indicating the need to control for ethnocultural identity in data analysis (Brown et al., 2001; Chao, 2012)

Personal and professional exposure to poverty. Previous research indicates that school counselors who have experiences working in Title I schools have more positive poverty beliefs (Bray & Schommer-Aikins, 2015). These professional experiences working with persons in poverty could act as an immersion, increasing positive views of this social group. It may be possible that personal experiences of poverty may increase positive poverty attitudes and attributions, which have never been measured in relation to counselor MCC or poverty attitudes.

Power Analysis

A sample size of approximately 120 was determined sufficient for the purposes of this study and to achieve Power of at least .80 at a significance level of $p \leq .05$ (Cohen, 1988); the present sample exceeded this number ($N = 251$). Tabachnick and Fidell (2013) suggest that $104 + k$ (number of variables in the regression equation) as an appropriate minimum sample size yielding adequate power; for the purposes of this study that would be 113. Power of .80 is appropriate for correlational research, and $p \leq .05$ is an appropriate significance level in counseling research (Balkin & Sheperis, 2009; Cohen, 1988).

Data Analysis

Data were entered into SPSS 22 for statistical analysis. Data were screened and participants with missing values were excluded from the sample, as the survey electronic survey construction included force complete pages (i.e., if a page was not completed a large portion of data was missing). Demographic information, necessary for all research questions, was the last page of the electronic survey. If this page was not completed, participants were eliminated because all components of the survey (MCKAS, BAPS, and demographic information) were necessary for statistical analyses in all three research questions. After removing incomplete entries, 251 completed surveys were used.

The MCKAS subscales of knowledge and awareness and BAPS subscales of individualistic and structural beliefs about poverty were used in analyses to establish the relationship between MCC and poverty beliefs. Raw subscale scores were used. BAPS subscale scores were used because the BAPS does not provide a total score, rather the subscales represent participant poverty beliefs across the three subscale domains, fatalistic, individualistic, and structural beliefs about poverty.

Appropriate MCKAS items were reversed scored, and raw totals for the knowledge subscale, the awareness subscale, and the MCKAS overall were computed. The BAPS items were totaled for each individual subscale (fatalistic beliefs about poverty, individualistic beliefs about poverty, and structural beliefs about poverty). The demographic variables gender, ethnocultural identity, counseling specialty, poverty counseling experience, and personal poverty experiences were dummy coded and used as dichotomous variables for use in the regression models. Demographic variables were coded in ways to express their experiences of privilege on that particular identity factor (i.e., gender, ethnocultural identity). Counseling specialty was coded as “mental health” and “not mental health” as way to balance counseling specialty groups. Gender was coded as “female” (1) and “not female” (0). Ethnocultural identity was coded as “White” (1) and “non-White” (0). Counseling specialty was coded as “mental health” (1) or

“non-mental health” (0). Poverty counseling experiences was coded as “poverty counseling experience” (1) or “no poverty counseling experience” (0). Finally, personal poverty experiences were coded “yes” (1) or “no” (0). Age was entered into the models as a continuous variable.

Two hierarchical multiple regressions were used to determine if counselor MCC predicted counselor poverty beliefs. The first regression tested the relationship between MCC and individualistic beliefs about poverty, as measured by the BAPS individualistic subscale. The second regression tested the relationships between MCC and structural beliefs about poverty, as measured by the BAPS structural subscale. Variables were entered in step-wise; the first step included the demographic variables gender, age, and ethnocultural identity. The second step included participants’ poverty counseling experience and personal poverty experiences. MCKAS knowledge raw total and MCKAS awareness raw total were entered in the final step. Two separate regressions were conducted because of the independence of the BAPS individualistic and structural subscales, represented by their insignificant correlation ($r = .03$, $p = .67$). The BAPS individualistic and structural subscales represent two distinct concepts that must be analyzed independently (Smith & Stone, 1989).

Results

Assumptions

Assumptions of hierarchical linear regression include linearity, homoscedasticity, multicollinearity, the absence of outliers, and normality. Linearity and homoscedasticity of the data were tested using scatterplots; scatterplot testing indicated that there was a linear relationship between variables of interest and that residuals are even spread in the sample, meeting the assumptions of linearity and homoscedasticity. There were no outliers in this sample as outlined in Chapter three. Multicollinearity was tested using Pearson product moment correlations. No correlations between independent variables (MCKAS subscale scores, gender, age, ethnocultural identity, personal poverty experience, counseling

poverty experience) were greater than .70, indicating that the assumption of was met and multicollinearity was not present in the sample (Tabachnick & Fidell, 2013).

The majority of variables in the present sample are normal by distribution. The MCKAS knowledge subscale raw scores, MCKAS awareness subscale raw scores, and BAPS structuralism subscale raw scores were distributed normally with skewness and kurtosis less than ± 2 (Tabachnick & Fidell, 2013). However, for use in the regression model the BAPS individualism scores were transformed using the cube root transformation, useful for normalizing leptokurtic data (Cox, 2011).

Correlations

There were multiple significant correlations between MCKAS, BAPS, and demographic variables, as determined by Pearson product moment correlations. The BAPS fatalistic subscale was significantly correlated with both the BAPS individualistic ($r = .48, p < .001$) and structural subscales ($r = -.13, p = .04$). The MCKAS total score was significantly correlated with the knowledge ($r = .92, p < .001$) and awareness subscales ($r = .74, p < .001$). As previously mentioned the MCKAS knowledge and awareness subscales were also significantly correlated ($r = .40, p < .001$). BAPS and MCKAS subscale items were also significantly correlated. The BAPS individualistic is significantly correlated with MCKAS knowledge ($r = .16, p = .01$), and MCKAS awareness ($r = .52, p < .001$). The BAPS structural subscale scores were also significantly correlated with MCKAS knowledge ($r = .31, p < .001$), and MCKAS awareness ($r = .26, p < .001$).

In regards to demographic variables, the BAPS individualistic subscale was significantly correlated with ethnocultural identity in the present study ($r = .12, p = .05$). Age was significantly correlated with poverty counseling experience ($r = .16, p = .01$) and personal poverty experience ($r = .13, p = .05$). Poverty counseling experience was significantly correlated with personal poverty experience ($r = .13, p = .04$). The final significant correlation was person poverty experience and ethnocultural identity ($r = -.18, p = .004$).

Hierarchical Linear Regression

Two hierarchical linear regressions were used to establish the relationship between participant MCC and poverty beliefs.

Regression One. The first two steps in the regression are not statistically significant (demographic variables of gender, age, and ethnocultural identity and personal and professional poverty exposure variables). However, the third and final step, where the MCC knowledge and awareness constructs were added to the model significantly influenced the predictability of individualistic poverty beliefs, in concert with all independent variables in the model. The addition of the MCKAS knowledge and awareness subscale raw scores (Model 3) led to a statistically significant increase in R^2 of .27, ($F[2, 243]= 45.68, p < .001$). As represented in Table 5, the full model of gender, ethnocultural identity, age, poverty counseling experience, personal poverty experiences, and MCC knowledge and awareness to predict individualistic poverty beliefs was statistically significant, $R^2 = .29, (F[7, 243]= 14.15, p < .001)$; Adjusted $R^2 = .27$. The effect size of the third step of the model is represented by ΔR^2 . The third step of the model accounts for 27% of the variance in the sample, which is a moderate effect size ($\Delta R^2 = .27$) (Cohen, 1988). Regression analyses indicate that the significant changes in this model are explained in the third step, where the MCC knowledge and awareness constructs are entered into the model. In step three, it appears that MCC awareness contributions to the significant changes in the model.

Regression Two. The first two steps in the regression are not statistically significant (step one including age, gender, and ethnocultural identity and step two including poverty exposure variables). However, the third and final step, where the MCC knowledge and awareness constructs were added to the model significantly influenced the predictability of structural poverty beliefs, in concert with all independent variables in the model. The addition of the MCKAS knowledge and awareness subscale raw

scores (Model 3) led to a statistically significant increase in R^2 of .12, ($F[2, 243]= 16.95, p < .001$). The full model of gender, ethnocultural identity, age, poverty counseling experience, personal poverty experiences, and MCC knowledge to predict individualistic poverty beliefs was statistically significant, $R^2 = .13$, ($F[7, 243]= 5.28, p < .001$); Adjusted $R^2 = .11$. The effect size of the third step of the model is represented by ΔR^2 . The third step of the model accounts for 12% of the variance in the sample, which is a small effect size ($\Delta R^2 = .12$) (Cohen, 1988). Regression analyses indicate that the significant changes in this model are explained in the third step, where the MCC knowledge and awareness constructs are entered into the model. In step three, there are significant ($p = .01$) changes when MCC awareness is added to the model. There are also significant ($p < .001$) changes when MCC knowledge is added to the model.

Discussion

The first regression explored the relationship between participants' MCC knowledge and awareness and individualistic poverty beliefs while adjusting for age, gender, ethnocultural identity, counseling specialty, poverty counseling experience, and personal poverty experience. Individualistic poverty beliefs indicate more biases towards persons in poverty, as they represent the belief that poverty is the fault of the person experiencing poverty and any personal deficits they may have (Smith & Stone, 1989). The results of this regression were significant at the third step, indicating that MCC as measured by the MCKAS does significantly predict individualistic poverty beliefs. Higher levels of participant MCC was predictive of lower individualistic poverty beliefs. The MCKAS subscales of knowledge and awareness were entered together into step 3; examination of the standard beta weights suggest that only participant awareness contributed to their individualistic poverty belief scores. This result is hypothetically and theoretically consistent, indicating that increased MCC is linked to decreased poverty biases in the present sample.

The second regression tested if participants' MCC knowledge and awareness predicted structural poverty beliefs while adjusting for age, gender, ethnocultural identity, counseling specialty, poverty counseling experience, and personal poverty experience. Structural poverty beliefs represent more accepting and understanding beliefs about poverty. Structural understandings of poverty take into account external economic, social, political, and cultural forces (e.g., sexism, racism, classism) that cause poverty (Smith & Stone, 1989). The results of this regression were significant at the third step, indicating that increased MCC does predict significantly predict structural poverty beliefs in the present sample. The impact of MCC knowledge and awareness both contributed to the prediction of participants' structural poverty beliefs in the regression model. MCC knowledge appears to be a stronger predictor based examination of the standardized beta weights, although it is important to note participants' MCKAS knowledge sub-scale scores were entered into the same step as their awareness scores. This result is also theoretically and hypothetically consistent, indicated that MCC knowledge and awareness impact structural understandings of poverty and that increased knowledge increases these understandings in an important way in the present sample.

Implications for Counselor Education and Supervision

The results of this study also have implications for counselor education and supervision, including guidelines for MCC education set forth by ACA, ACES, and CACREP. MCC is an important aspect of counselor education and supervision (ACA, 2014; Borders et al., 2011; CACREP, 2016), and the results of the present study indicate that MCC has a significant relationship with counselor's poverty beliefs, possibly impacting counselor self-awareness, client worldview, counselor-client relationship and counseling and advocacy interventions.

Counselor educators are expected to infuse multicultural and diversity through all counseling courses; this infusion is intentional with the expected outcome that students will be expected to learn MCC from these courses (ACA, 2014). CACREP also outlines how multiculturalism and diversity should be infused in counselor education across courses to include knowledge of diverse groups, theories and models of multicultural counseling, MCC, the impact of culture on an individual's' worldview, the impact of power and privilege, how diverse clients seek counseling, and strategies for eliminating barriers such a racism, sexism, classism, etc. (CACREP, 2016). Although ACA and CACREP do not mention social class and poverty specifically, it is intimated that all socio-cultural diverse groups should a part of multicultural counseling curriculum. Although these standards require understanding of diverse cultural groups, as previously mentioned, strategies for educating students about poverty are markedly absent from counseling literature (Smith, 2005; Toporek, 2013).

MCC is typically taught in comporment with current standards set forth by CACREP (2016) and based on the MCC and MSJCC models (Ratts et al, 2016; Sue et al, 1992). There are multiple articles, studies, and models for teaching MCC (Coleman, Morris, & Norton, 2006; Kim & Lyons, 2003; Prosek & Michel, 2016; Priester et al., 2008). There is only one article outlining strategies for teaching about and working with clients in poverty (Baggerly, 2005). The models for teaching MCC are experiential in nature, studying and detailing the impact that experiential activities (Kim & Lyons, 2003), multicultural immersion (Prosek & Michel, 2016), and student multicultural portfolios (Coleman et al, 2006) on student multicultural learning and competence. It has also been suggested that poverty competence be taught using immersion and service learning (Baggerly, 2005).

The teaching strategies outlined above are awareness building, while standards outline knowledge that students should know. Results from the present study indicate that teaching MCC is necessary on both the knowledge and awareness subscales. Specifically, these experiential, or out class learning opportunities (i.e. immersion and service learning) provide students with opportunities to become more aware of the impact of poverty and lived experiences of persons experiencing poverty, possibly reducing individualistic poverty beliefs and biases. These experiences also increase knowledge of the barriers that exist for persons in poverty, possibly linked to increased structural poverty understandings. Didactic classroom learning about different cultures and socio-political structures such as privilege and oppression are outlined in the CACREP standards (2016). These structural learning opportunities may impact structural poverty beliefs, increasing student capabilities to effectively engage in advocacy with and on behalf of clients at the micro, meso, and macro levels; this action is in comportment with MSJCC and should be considered in counselor preparation (Ratts et al., 2016).

It is noted in the literature that social class and poverty are not distinctly mentioned in counselor preparation and education (Smith, 2005; Toporek, 2013). The results of this study imply that there is a distinct and significant relationship between MCC and poverty beliefs. It is clear that continued knowledge and awareness through immersion and service learning positively impact MCC (Coleman et al., 2006; Kim & Lyons, 2003; Prosek & Michel, 2016); poverty competence may also be positively impacted by service learning opportunities through increase knowledge and awareness and should be considered viable options for counselor education. A specific increase in poverty awareness and knowledge through didactic teaching, service learning, immersion, and other awareness activities may also increase overall levels of MCC, as proposed by in previous conceptual research (Baggerly, 2005).

In the present study, MCC is a pre-cursor to poverty beliefs and competency; however, MCC only accounts for a moderate amount of variance in poverty beliefs in the present sample. Therefore, MCC in itself is not a sufficient measure of poverty competency. To truly increase poverty competency, social class and poverty issues must be synthesized into MCC curriculum and courses. Social class and poverty are not typically considered in popular models of multiculturalism and diversity or infused in MCC (Ratts et al., 2016; Smith, 2005; Sue et al., 1992). MCC Knowledge and Awareness are specifically linked to increased poverty competence; a focus on knowledge and awareness regarding social class and poverty could increase the poverty competence in counselor trainees. Poverty awareness could specifically be accomplished through immersion. Cultural immersions are common multiculturalism/diversity course interventions (Coleman et al., 2006; Kim & Lyons, 2003); a poverty immersion could include providing services (counseling or otherwise) to persons experiencing poverty through a community agency, non-profit, or other social services organization. Immersions focused on poverty and mental health or poverty in the schools would be specifically helpful for increasing counselor trainee poverty awareness. Increased poverty and social class knowledge could be increased through didactic pedagogical methods. Specifically, counselor educations should focus on teaching counselors in training about power, privilege, and oppression and their relationship to these structures as they relate to social class (Ratts et al., 2016). Barriers to wellbeing and mental health faced by persons experiencing poverty should be discussed at length; this could give students the knowledge to understand clients' worldviews and experiences and also prepare them to better advocate for clients who experience poverty. It is clear that counselor educators cannot focus on only awareness or knowledge when preparing counselors trainees to be poverty

competent counselors, a combination of experiential (awareness building) and didactic (knowledge building) interventions are both necessary.

Implications for Counselor Supervision

MCC and social class competencies are important aspects of counseling supervision included in the *ACA Code of Ethics* (2014) and *ACES Best Practices for Clinical Supervision* (Borders et al., 2011). The *ACA Code of Ethics* specifically addresses that multicultural counseling issues throughout the supervisory relationship (F.2.b). ACES further elaborates on the importance of MCC in counseling supervision, noting that not only should MCC addressed within the supervisory relationship, but also within the supervisee-client relationship; these standards specifically mention social class as an area of focus for best supervisory practices (Borders et al., 2011). Little research exists outlining how to specifically address poverty beliefs or competence working with persons in poverty.

The present study and existing standards indicate that multicultural issues, including social class and poverty must be addressed within supervision. This study particular highlights the need of supervisors to be aware of their own levels of MCC and poverty beliefs; supervisors must be aware of their own cultural identities to be effective in supervision (Borders et al., 2011). This includes their own biases, stereotypes, knowledge, awareness, and ability to act on behalf of persons in poverty (Ratts et al., 2016). Any poverty biases held by the supervisor may impact the supervisory relationship (if the supervisee is from a different social class) or may lead the supervisor to not see social class and poverty competence issues within their supervisees own sessions with clients. Supervisors are tasked with broaching difficult cultural topics, assessing supervisee capability for working with diverse populations, and supervisee MCC knowledge and

awareness (Borders et al., 2011). This includes supervisee capability work with and advocate for persons in poverty.

Supervisors must be aware of their own supervisee's knowledge, awareness, and beliefs about poverty (ACA, 2014; Borders et al., 2011). Based on results from the present study, supervisors could endeavor to increase MCC and poverty awareness to decrease poverty biases. This could include specific self-awareness building activities on the supervisee's own social class and poverty experiences and expectations, including how they predict these influence their counseling work. This may also be achieved through interpersonal process recall while reviewing sessions with supervisees. Reduction of individualistic poverty beliefs may impact the way counselors engage with clients, including the therapeutic relationship, diagnosis, and treatment planning, as research has found clients experiencing poverty are often diagnosed more harshly and sessions with these clients are less smooth (Smith, Mao, & Ampuero, 2011). More didactic methods could be used to increase supervisee structural understanding of poverty through an increase in knowledge to include articles, documentaries, and other learning opportunities that expand the supervisee's understanding of the socio-political and structural impact of poverty. This increased understanding of structural causes of poverty may be beneficial when addressing barriers and engaging in forms of advocacy for clients (at the micro, meso, or macro levels). This type of advocacy must be addressed in the supervisory relationship (Borders et al., 2011), is congruent with poverty counseling models (Foss et al., 2011), and MSJCC standards (Ratts et al., 2016).

Limitations

The present study has multiple limitations which should be considered when interpreting the results. Internal validity is the ability for a study, especially one measuring causal relationships, to make true inferences about the studied relationships (Tabachnick & Fidell, 2013). Internal validity is particularly

important in this study as the research seeks to measure the relationship between MCC and the poverty beliefs of professional counselors. Threats to internal validity in this study may include selection bias, self-report bias, social desirability, extreme response bias, ordering bias, and measurement bias.

Participants who volunteered for this study may pose a threat to internal validity due to selection biases as this is a non-experimental design. Participants were not randomly selected or organized into groups; they chose to participate in this survey. Persons who decided to take this survey may have a special interest in poverty, classism, multicultural counseling, or other social justice related issues, possibly impacting results. This is typically addressed by doing further research with other sub-samples of the population of interest – in this case, professional counselors.

In addition to selection bias, self-report bias and social desirability bias likely limit this study. Participants may answer questions in the way they believe professional counselors should behave and think, rather than how they actually do behave and think. Because this is a self-report survey, results rely on participants being honest in their responses. Participants may have been inclined to not fully report factors related to multiculturalism or poverty beliefs, especially if they thought they would reflect negatively on themselves as professional counselors. Socially desirable responses and self-report represent a threat to internal validity.

Ordering bias and extreme response bias may have impacted how participants answer the survey questions. The order of the survey was the same for all participants, with the MCKAS items first, followed by the BAPS items, and the demographic questionnaire. The order of these items influenced what participants were included in final data analysis, as some participants only completed the MCKAS but did not complete BAPS or demographic items. Extreme responding often impacts studies which use Likert-type items such as the MCKAS and BAPS. Participants may have chosen the most extreme items on the opposite ends of the scales, which may have influenced data.

There are also limits of measurement in the present study. This study was completed using electronic survey methods, although common (Granello & Wheaton, 2011), electronic

survey methods have limitations. First, electronic surveys only allow for data collection over a short period of time (five weeks). This time may not have been sufficient to reach the targeted sample. Additionally, it is impossible to truly know the response rate to this survey as listservs were used to gain access to the sample. The listservs used did not have defined membership numbers and therefore a response rate could not be calculated. Additionally, pertinent listservs to the targeted population, unknown to the researcher, may have been excluded and may have limited the sample.

There were limitations of the variables measured in this study. MCC was measured by MCKAS, which is an assessment based on the original MCC (Sue et al., 1992; Ponterotto et al., 2002). This assessment does apply to the newly endorsed MSJCC (Ratts et al., 2016), which are the new professional counseling standard for competence. This limits the results of research question 1; relationships measured are between MCC and poverty beliefs, not MSJCC.

Poverty beliefs as measured by the BAPS subscales also represent limitations. Although the scale defines poverty using the relational definition, each participant's understanding of this definition could vary; therefore, the operationalization of poverty may have varied across participants. The fatalistic subscale also had a low Cronbach's alpha, limiting the reliability of this subscale and excluding it from analysis in this study. The exclusion of the fatalistic subscale limits the results of the study overall represents limits of measurements as this construct was not included in analysis. Finally, although the MCKAS and BAPS have been normed and validated, these scales have not been used together in previous studies.

The measurement of counselor poverty exposure variables also represents a study limitation. Personal definitions and understandings of poverty vary between individuals. This may have not been adequately captured when implementing a relational poverty definition to

describe both personal and professional poverty exposure. Additionally, a participant could only indicate if they had worked in a setting that served individuals in poverty such as a community mental health clinic, a non-profit counseling agency, pro-bono counseling, or a Title I school. There was no “Other” category provided to participants. These responses were interpreted as “yes: poverty counseling experience” and “no: no poverty counseling experience.” There is no way to measure the amount, in time or proportion, that a participant had working with clients experiencing poverty. Personal poverty experiences were measured in a similar way; participants indicated whether they did or did not have personal poverty experiences in their lifetime. There was no way for participants to indicate the depth of poverty they experienced in their lives. For example, chronic deep poverty across the lifespan and brief poverty were measured and analyzed in the same manner. The present study is unable to explore the depth of personal and professional poverty exposure of counselors within the sample.

External validity is the extent to which this study can be generalized to the population. The present study is limited in terms of generalizability. As this study is exploratory, the results are only truly generalizable to the sample who participated in this study. The results of the present study are also limited by the composition of the sample. The majority of participants in the present study were white ($n= 178, 70.9\%$); non-white participants were a minority of this sample ($n= 73, 29.1\%$). Ethnocultural diversity was not represented in this sample, although arguably, this sample may be comparable to the overall ethnocultural distribution of the counseling profession (CACREP, 2014). This sample overwhelmingly identified as women ($n= 198, 78.9\%$). Men ($n= 47, 18.7\%$), transgender persons ($n=4, 1.6\%$), and other genders ($n=2, .8\%$) were a minority of the sample. The study lacks gender diversity, but arguably represents the gender distribution of professional counseling overall (CACREP, 2014). The amount of mental

health counselors ($n=146$, 58.2%) that comprise the sample also limit this study, as this unequal distribution of specialty inhibits generalizability to all professional counselors. Finally, although this sample size was robust for statistical analyses ($N= 251$), the results of the present study represent a static measure of the participants' competencies and beliefs at the time the participants completed the survey.

Recommendations for Future Research

To expand the results of this study future research should continue to operationalized MCC and MSJCC. This research could be quantitative, through the creation and validation of a scale that can be used to measure MSJCC, or qualitative, exploring the MCC/MSJCC competencies of counselors (phenomenology). A grounded theory study may also be useful to qualitatively operationalize MCC and MSJCC. Further operationalization of MCC and MSJCC constructs could enhance understanding of the relationship between MCC/MSJCC and poverty beliefs.

The present study was initiated and conducted as exploratory research into the relationship between counselors' MCC and poverty beliefs. This research should be continued and expanded to increase generalizability by increasing diversity in the sample (i.e. ethnocultural identities, genders, and counseling specialties). Replicating this research with more specific populations of counselors (i.e. ethnocultural identities, genders, and counseling specialties, among others) to further understand how poverty beliefs vary in diverse groups of counselors. Additionally, further exploration through qualitative and quantitative methods into the relationship between counselors' MCC and poverty beliefs is supported by the results of the present study.

A deeper understanding of counselors' poverty beliefs and poverty competency is necessary. Further quantitative research could be conducted to understand the factors, outside of MCC, do predict poverty beliefs. To explore the poverty beliefs of counselors in depth, qualitative methods would be beneficial research. Qualitative methods allow for more in-depth information to be collected, highlighting the essence of counselors' opinions, understandings, and beliefs about poverty and classism. Understandings of how counselors believe clients in poverty can be best served would be beneficial to understanding how counselors engage and work with clients in poverty and establish best practices for working with clients in poverty. All of these research methods could assist in model and standard development for working with clients experiencing poverty. Development of poverty counseling competence standards would be a beneficial step in establishing guidelines and standards to working with clients experiencing poverty. These standards should center on the wellbeing and best interest of clients (ACA, 2014), while integrating the expertise and experiences of counselors who work with clients experiencing poverty. These standards should also be measured empirically, to create poverty counseling competencies. This could be achieved by the creation and validation of a poverty competency scale. These poverty counseling competencies could establish a baseline of skills necessary for counselors to successfully work with clients experiencing poverty.

Client outcome research is an important future research direction that should be pursued. No research exploring the perspective of clients who experience poverty and who have received counseling services has ever been conducted. Qualitative methods, such as a phenomenology, would be an effective way to measure the counseling perspectives of persons who have experience poverty. This research would assist counselors in understanding client perspectives of counseling treatment, efficacy of counseling treatment, and how clients in poverty experience

class differences in counseling sessions. Quantitatively, outcome research may be effective. Client perceptions of therapeutic efficacy, counselor classism, and the counseling relationship could be evaluated. Additionally, pre-test post-test methods could be conducted to see how clients in poverty benefit from different types of therapeutic treatment or other factors (i.e., strength of the therapeutic alliance, levels of counselors' classism). Further understanding of the experience of clients in poverty is an important social justice issue, giving these often marginalized clients a voice in counseling treatment.

Future research should also be conducted to evaluate the efficacy of existing models of counseling with persons in Poverty (Foss et al., 2011; Liu, 2001a, 2001b). No empirical research exists exploring the efficacy of existing models for counseling persons in poverty. Evaluation of these models is necessary for understanding their efficacy with clients and how counselors integrate those models into their clinical practice. Outcome research could be a valuable way to evaluate these models' efficacy. Evaluation of existing models will also allow for further understanding of how counselors choose to and can counsel persons in poverty, likely impacting future standard and model development.

A final research direction would include exploring and evaluating methods used by counselor educators and supervisors to increase poverty competency in students and supervisees. Qualitative exploratory work, outline how social class and poverty are addressed in coursework and supervision, respectively, would establish a baseline of understanding how students and supervisees are taught about poverty and social class issues in counseling. Once these instructional and supervisory practices are outlined their efficacy should be tested using quantitative methods, such as pre-test post-test evaluations of student and/or supervisee poverty competency. The rigorous evaluation of the methods is necessary in order to ensure counselor

education and supervision adequately prepares counselor trainees to work with clients experiencing poverty.

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Appendix A: The Multicultural Knowledge and Awareness Scale (MCKAS)

Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at			somewhat			totally
all true			true			true

1. I believe all clients should maintain direct eye contact during counseling.

2. I check up on my minority/cultural counseling skills by monitoring my functioning – via consultation, supervision, and continuing education.

3. I am aware some research indicates that minority clients receive “less preferred” forms of counseling treatment than majority clients.

4. I think that clients who do not discuss intimate aspects of their lives are being resistant and defensive.

5. I am aware of certain counseling skills, techniques, or approaches that are more likely to transcend culture and be effective with any clients.

6. I am familiar with the “culturally deficient” and “culturally deprived” depictions of minority mental health and understand how these labels serve to foster and perpetuate

discrimination.

7. I feel all the recent attention directed toward multicultural issues in counseling is overdone and not really warranted.

8. I am aware of individual differences that exist among members within a particular ethnic group based on values, beliefs, and level of acculturation.

9. I am aware some research indicates that minority clients are more likely to be diagnosed with mental illnesses than are majority clients.

10. I think that clients should perceive the nuclear family as the ideal social unit.

11. I think that being highly competitive and achievement oriented are traits that all clients should work towards.

12. I am aware of the differential interpretations of nonverbal communication (e.g., personal space, eye contact, handshakes) within various racial/ethnic groups.

13. I understand the impact and operations of oppression and the racist concepts that have permeated the mental health professions.

14. I realize that counselor-client incongruities in problem conceptualization and counseling goals may reduce counselor credibility.
15. I am aware that some racial/ethnic minorities see the profession of psychology functioning to maintain and promote the status and power of the White Establishment.
16. I am knowledgeable of acculturation models for various ethnic minority groups.
17. I have an understanding of the role culture and racism play in the development of identity and worldviews among minority groups.
18. I believe that it is important to emphasize objective and rational thinking in minority
19. I am aware of culture-specific, that is culturally indigenous, models of counseling for various racial/ethnic groups.
20. I believe that my clients should view a patriarchal structure as the ideal.
21. I am aware of both the initial barriers and benefits related to the cross-cultural counseling relationship.
22. I am comfortable with differences that exist between me and my clients in terms of race and beliefs.

23. I am aware of institutional barriers which may inhibit minorities from using mental health services.
24. I think that my clients should exhibit some degree of psychological mindedness and sophistication.
25. I believe that minority clients will benefit most from counseling with a majority who endorses White middle-class values and norms.
26. I am aware that being born a White person in this society carries with it certain advantages.
27. I am aware of the value assumptions inherent in major schools of counseling and understand how these assumptions may conflict with values of culturally diverse clients.
28. I am aware that some minorities see the counseling process as contrary to their own life experiences and inappropriate or insufficient to their needs.
29. I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.
30. I believe that all clients must view themselves as their number one responsibility.

31. I am sensitive to circumstances (personal biases, language dominance, stage of ethnic identity development) which may dictate referral of the minority client to a member of his/her own racial/ethnic group.

32. I am aware that some minorities believe counselors lead minority students into non-academic programs regardless of student potential, preferences, or ambitions.

Appendix B: The Beliefs About Poverty Scale (BAPS)

Using the following scale, rate each item.

1	2	3
Not at all important	somewhat important	very important

POOR PEOPLE (poorest 20%) exist today because they...

- A. are not motivated because of welfare
- B. lack drive and perseverance
- C. have loose morals and abuse drugs and alcohol
- D. have too many children
- E. are not thrifty
- F. are unwilling to take risks
- G. are lazy
- H. are not greedy
- I. live in weak, often broken families
- J. do not have contacts or "pull"
- K. are victims of discrimination in hiring
- L. are victims of discrimination in promotions and wages
- M. are taken advantage of by rich people
- N. are victims of the federal government which is insensitive to their plight
- O. are forced to attend bad schools
- P. lack the talent and ability to succeed
- Q. are born with low intelligence
- R. are victims of bad luck
- S. are born inferior

WEALTHY PEOPLE (Wealthiest 20%) exist in America because they...
(Note. This part of the scale was excluded.)

- A. possess drive and perseverance
- B. are willing to take risks
- C. are hard-working
- D. are thrifty
- E. live in strong, intact families
- F. have high moral standards
- G. are greedy
- H. have contacts and "pull"
- I. attend good schools
- J. receive large inheritances
- K. receive favoritism in hiring
- L. receive special treatment from the federal government
- M. are shown favoritism in promotions and wages
- N. sacrifice their families for their careers
- O. take advantage of the poor
- P. have the talent and ability to succeed
- Q. are lucky and get breaks
- R. are born with high intelligence
- S. are born superior

Appendix C: Demographic Sheet

Counseling Specialty: Addictions Career
 College Community
 Gerontological Marriage & Family
 Mental Health Rehabilitation
 School Other

Age: _____

Gender: Female Male Trans* Other

Race: African American/Black
 American Indian/Alaska Native
 Asian
 Hispanic/Latin(o/a)
 Native Hawaiian/Pacific Islander
 Multiple Heritage
 White
 Other: _____

Have you ever worked in the following settings (check all that apply)?:

_____ Community mental health agency/private practice setting serving persons in poverty

_____ Non-profit agency serving persons in poverty

___ Pro-bono counseling with persons in poverty

___ Title I School

___ Unsure

Have you ever personally experienced poverty (such as financial barriers related to food, shelter, education, transportation, and/or healthcare) in your life?:

Yes

No

Appendix D: Informed Consent

**INFORMED CONSENT DOCUMENT
OLD DOMINION UNIVERSITY**

PROJECT TITLE: The Relationship Between Counselors' Multicultural Counseling Competence and Poverty Beliefs

INTRODUCTION

The purposes of this form are to give you information that may affect your decision whether to say YES or NO to participation in this research, and to record the consent of those who say YES. The research involves the completion of a survey that should take approximately 15-20 minutes. This survey will ask you questions about your multicultural counseling competence (MCC) and beliefs about poverty, to include demographic information.

RESEARCHERS

Primary Researchers:

Madeline Clark, MEd, NCC

Old Dominion University, College of Education, Department of Counseling & Human Services

Responsible Project Investigator: Jeffry Moe, PhD, Old Dominion University, College of Education, Department of Counseling & Human Services

DESCRIPTION OF RESEARCH STUDY

Limited research exists exploring the poverty beliefs of professional counselors across specialties. This research seeks to explore how counselors' poverty beliefs relate to their multicultural counseling competence (MCC).

RISKS AND BENEFITS

RISKS: With participation in any research there are risks of discomfort in reporting beliefs. Data will remain confidential and anonymous. The researchers will reduce risks by removing any linking identifying information when reporting on results. And, as with any research, there is some possibility that you may be subject to risks that have not yet been identified.

BENEFITS: There are no benefits for your participation in this study.

COSTS AND PAYMENTS

If you choose to provide your email address at the end of the survey you will be eligible to win one of 5 \$25.00 amazon gift cards.

NEW INFORMATION

If the researchers find new information during this study that would reasonably change your decision about participating, then they will inform you.

CONFIDENTIALITY

All information obtained about you in this study is strictly confidential unless disclosure is required by law. The results of this study may be used in reports, presentations and publications, but the researcher will not identify you personally.

WITHDRAWAL PRIVILEGE

It is OK for you to say NO. Even if you say YES now, you are free to say NO later, and walk away or withdraw from the study -- at any time. The researchers reserve the right to withdraw your participation in this study, at any time, if they observe potential problems with your continued participation.

COMPENSATION FOR ILLNESS AND INJURY

If you say YES, then your consent in this document does not waive any of your legal rights. However, in the event of harm or discomfort arising from this study, neither Old Dominion University nor the researchers are able to give you any money, insurance coverage, free medical care, or any other compensation for such injury. In the event that you suffer injury as a result of participation in any research project, you may contact Dr. Jeffry Moe at jmoe@odu.edu or Dr. Ed Gomez, Chair of the Darden College of Education Human Subjects Review Committee, Old Dominion University, at egomez@odu.edu, who will be glad to review the matter with you.

VOLUNTARY CONSENT

By signing this form, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researchers should have answered any questions you may have had about the research. If you have any questions later on, then the researchers should be able to answer them:

Madeline Clark
mclar051@odu.edu
 757-289-2578

If at any time you feel pressured to participate, or if you have any questions about your rights or this form, then you should contact Dr. Ed Gomez, Chair of the Darden College of Education Human Subjects Review Committee, Old Dominion University, at egomez@odu.edu.

And importantly, by signing below, you are telling the researcher YES, that you agree to participate in this study. You may keep this form for your records.

Participant's Printed Name & Signature	Date

INVESTIGATOR'S STATEMENT

I certify that I have explained to this participant the nature and purpose of this research, including benefits, risks, costs, and any experimental procedures. I have described the rights and protections afforded to human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws, and promise compliance. I have answered the participant's questions and have encouraged him/her to ask additional questions at any time during the course of this study. I have witnessed the above signature(s) on this consent form.

Investigator's Printed Name & Signature	Date

Appendix E: Call for Participants

Hello,

My name is Madeline Clark and I am a doctoral candidate in Counselor Education and Supervision at Old Dominion University. I would like to invite you to participate in my dissertation research exploring counselors' multicultural counseling competence and poverty beliefs. This study has been approved by the institutional review board at Old Dominion University and is under the supervision of my dissertation chair and responsible project investigator, Dr. Jeffry Moe, Assistant Professor of Counseling.

The purpose of this study is to explore the relationship between professional counselors' multicultural competence, poverty beliefs, and demographic factors. Survey responses will be confidential and will remain anonymous.

Professional counselors across various specialties and graduate students in counseling are invited to participate. If you agree to participate you will complete the survey (below), including an informed consent document and demographic questionnaire. If you agree to participate in this study you have permission to withdraw at anytime.

Participants who complete the survey can be entered to win one of five \$25.00 Amazon gift cards with the inclusion of their email address.

Please consider forwarding this link to any professional counselor or graduate student in counseling that may be interested in this research.

Please respond to mclar051@odu.edu to if you have any questions.

Thank you,

Madeline Clark (mclar051@odu.edu)

Dr. Jeffry Moe (jmoe@odu.edu)

Appendix F: Correlation Table

	1	2	3	4	5	6	7	8	9	10	11	12
1. BAPS Fatalism+	--	.48**	-.13*	-.21**	-.08	.35**	.06	-.04	.07	.06	-.03	-.01
2. BAPS Individualism+	--	--	.03	.35**	.16*	.52**	.01	.11	.01	.12*	-.01	-.09
3. BAPS Structuralism	--	--	--	.34**	.31**	.26**	-.06	-.01	-.02	-.06	.03	.08
4. MCKAS Total	--	--	--	--	.92**	.74**	.04	-.18*	.03	-.03	.06	.02
5. MCKAS Knowledge	--	--	--	--	--	.40**	-.01	-.11	.04	-.10	.06	.07
6. MCKAS Awareness	--	--	--	--	--	--	.10	-.10	.01	.09	.04	-.07
7. Counseling Specialty	--	--	--	--	--	--	--	.01	.04	.01	.02	-.06
8. Gender	--	--	--	--	--	--	--	--	.15*	.03	.04	.003
9. Age	--	--	--	--	--	--	--	--	--	.08	.16*	.13*
10. Ethnocultural Identity	--	--	--	--	--	--	--	--	--	--	.06	-.18*

11. Poverty Counseling Experience	--	--	--	--	--	--	--	--	--	--	--	.13*
12. Personal Poverty Experience	--	--	--	--	--	--	--	--	--	--	--	--

Note. BAPS= Beliefs about Poverty Scale (Smith & Stone, 1989); MCKAS= Multicultural Counseling Knowledge and Awareness Scale (Ponterotto et al., 2002). + = a transformed variable, * = ($p \leq .05$), ** = ($p < .001$).

VITA

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EDUCATION

Old Dominion University, Ph.D. Counselor Education and Supervision (CACREP)	May 2016 Norfolk, VA
Old Dominion University, M.S.Ed. Clinical Mental Health Counseling (CACREP)	May 2013 Norfolk, VA
Old Dominion University, B.S. Major: Sociology	August 2009 Norfolk, VA

PROFESSIONAL PROFILE

Old Dominion University <i>Graduate Teaching and Research Assistant</i>	May 2013-May 2016 Norfolk, VA
ForKids, Inc. <i>Counselor in Residence</i>	May 2013-May 2016 Norfolk, VA
Norfolk Community Services Board <i>Counseling Intern</i>	August 2012-May 2013 Norfolk, VA

SELECTED PUBLICATIONS

Clark, M. (2015). Considering intersectionality in multiculturalism. *School Psychology Forum*, 9(2), 96-100.

Clark, M. & Bower, J.D. (in press). The career experiences of women with major financial barriers. *The Career Development Quarterly*.

SELECTED PRESENTATIONS

Clark, M. (October 2015). *Using visual methods in qualitative research*. Association for Counselor Education and Supervision (ACES) INFORM Conference, Philadelphia, Pennsylvania.

Clark, M. (September 2015). *Counselor educators' experiences infusing social justice into pedagogy*. Association for Assessment and Research in Counseling (AARC) Annual Conference, Memphis, Tennessee.