PROFESSIONAL COUNSELORS' SELF-PERCEIVED MULTICULTURAL COUNSELING

COMPETENCY PRACTICING IN RURAL, SUBURBAN, & URBAN COMMUNITIES

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Dissertation submitted to the faculty of the Virginia Polytechnic Institute and State University

in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

In

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March 19, 2019

Blacksburg, VA

Keywords: multicultural counseling competency; intersectional feminist lens; professional counselors;

rural and urban practice settings

Professional counselors' self-perceived multicultural counseling competency practicing in rural,

suburban, and urban communities

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Abstract

The purpose of this study was to examine counselor's self- perceived multicultural counseling competency (MCC) between counselors working in rural, suburban and urban communities across the Commonwealth of Virginia. The study compared professional counselors' perceptions of their own multicultural counseling competence based on the counselor's geographic area of origin, current geographic practice setting, and counselors' intersections of identities to better understand counselor MCC as it relates to cultural diversity. Sample data was collected through professional counseling organizations in Virginia. Participants completed a demographic survey as well as the Multicultural Awareness Knowledge Skills Survey-Counselor Edition-Revised (MAKSS-CE-R) to measure self-perceived MCC. Results indicate that there was no difference in self-perceived MCC among professional counselors in Virginia based on their practice location or area of origin (i.e. hometown). However, counselor's identified race/ethnicity were predictor's of self-perceived MCC. Findings suggest that training programs may be providing adequate opportunities for counselors to develop MCC. Allowing innovative approaches through technology, consultation, and adherence to the ACA Code of Ethics (2014) could be sufficient in counselor MCC regardless of geographic practice location.

Professional counselors' self-perceived multicultural counseling competency practicing in rural, suburban, and urban communities

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GENERAL AUDIENCE ABSTRACT

The purpose of this study was to understand how counselors in Virginia perceived their cultural competence. The researcher examined how counselors rated their own cultural competence in relation to the geographic location in which they grew up, currently work, as well as general demographic characteristics, to better understand counselors' competence when working with diverse peoples. Participants completed a demographic survey as well as the Multicultural Awareness Knowledge Skills Survey-Counselor Edition-Revised (MAKSS-CE-R), which measures counselor cultural competence. Results indicate that there was no difference in perceived cultural competence among professional counselors in Virginia based on the geographic area where they worked or grew up. However, counselors who identified as a racial/ethnic minority also perceived themselves as having greater cultural competency. Findings suggest that training programs may be providing adequate opportunities for counselors to develop cultural competence. Allowing creative approaches through technology, consultation, and implementation of counselor's professional codes of ethics could be enough for counselors to feel competent when working with diverse peoples, regardless geographic practice location.

Acknowledgements

I have an indescribable sense of gratitude for the opportunity to complete this journey and conduct this study. I never imagined myself as a scholar, nor as a person who would be capable of a doctoral degree; neither did I anticipate many of the personal hurdles I encountered along the way. While I have grown as a counselor educator, supervisor, and counselor, I think the most notable accomplishment throughout this process was the gained self-awareness of my own resiliency… I formed a sense of grit that I didn't know I was capable of.

I am indebted to my dad who has always encouraged me to continue with pursuing my education and dreams, never making me to feel anything was outside of my reach. Your constant love, support, and encouragement have made me the person I am today. Without you, this work would not be possible.

I must also acknowledge my grandparents who were instrumental in my success. My paternal grandparents invested their lives savings into seeing me through an undergraduate degree. My maternal grandparents were ongoing sources of support. Until my grandmother Alice's passing just a month prior to completing this document, she would ask each time we spoke about my progress. Without the selfless love and support that my grandparents extended to me, my story may have been very different. My gratitude is immeasurable.

Throughout my doctoral work, I maintained a senior level position with a behavioral health organization, working countless hours most days the week. My husband, Chuck has been a continual support by always keeping things "going" and never questioning what needed to be done. We welcomed two perfect baby girls during the course of this journey, and all the while his unwavering

support allowed me to complete a doctoral degree, work full-time, and be a new mom. Thank you for

"holding down the fort" and being my constant all these years.

To my sweet Adaline and Esme: You fill me with purpose each and every day. You already

make this world a brighter place, just with your being in it. You both are my ongoing motivation when

things are tough, when I am tired, or when I wanted to give up during this process. I hope that the

temporary sacrifices made to complete this journey will provide you many opportunities for years to

come.

I would like to acknowledge my sister and extended support system that offered continuous

encouragement. To my chair, Dr. Laura Farmer thank you for continuing to push me forward, even

when I wasn't always readily coachable. To my dearest friends, thank you for always listening and

supporting, however you could. Finally, I would like to acknowledge my work family who saw

potential in my development, allowing me to have a flexible work schedule to complete this degree. I

could not have completed this journey without you.

Thank you to each person who has made me the person I am today, and capable of completing

this work. I am hopeful that this will be the beginning to a chapter in which my life's mission is to give

back to others, in the way that you have so selflessly chosen to give to me. I love you all.

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CHAPTER ONE

Introduction

By the year 2044 more than half of Americans will identify as belonging to a minority group (Colby & Ortman, 2015). Additionally, Colby and Ortman (2015) stated that by 2060, one in five of the nation's population will be foreign born. While these statistics importantly identify a significant increase in racial and ethnic diversity within the U.S., it does not account for the nuanced intersections of identity as the society becomes more diverse and expansive. This ongoing shift in national demographics has important implications for the counseling field. The purpose of this study is to examine counselors' self-perceived multicultural competency between counselors working in rural, suburban, and urban communities.

The significance of the rapidly changing population, as experienced by professional counselors in the United States, is reflected in the characteristics of clients, the issues and problems they present, and the level of preparedness of counselors. Counselors are working with clients from many different cultural, ethnic, racial, gender, and sexual identities than ever before. Due to the rapid growth and evolution of the population across the United States, counselors have an ethical obligation to be prepared to serve clients across intersections of identity. Further, counselors can no longer operate in silos based upon practice location or the present cultural make-up of their current client caseloads. Rather, counselors must be prepared to serve a more diverse population than ever before.

Diversity is often approached as a check-list item for regulatory bodies or agency mission statements that must be included in documentation, but not as something that is truly considered in client treatment. The disconnect between merely inquiring about cultural diversity and true inclusion into treatment, becomes increasingly problematic as the field continues to shift towards more individualized and client centered care. Additionally, the American Counseling Association (ACA)

Code of Ethics (2014), Council for Accreditation of Counseling and other Related Educational Programs (CACREP), and many state licensure boards are mandating inclusion of multicultural competency when serving clients. The rapid shift of the demographic make-up of the U. S. population, paired with the increased awareness surrounding inclusion of multicultural competence within the profession, has sparked a renewed focus of examining counselor readiness and ability to serve diverse clients.

Context of Study

The definition of multicultural counseling competence (MCC) that is most widely recognized in the profession is defined by the ACA as, "counselors' cultural and diversity awareness and knowledge about self and others, and how this awareness and knowledge are applied effectively in practice with clients and client groups" (*ACA Code of Ethics*, 2014, p. 20). The Association of Multicultural Counseling and Development (AMCD) established "Multicultural Counseling Competencies" (Arredondo, Toporek, Brown, Jones, Locke, Sanchez, & Stadler,1996) providing the guiding philosophy surrounding the profession's stance on awareness, knowledge, and skills required to provide culturally competent care. The document provided specific suggestions for becoming a "culturally-skilled counselor" to include recognizing oneself as a cultural being through increased self-awareness, sensitivity, recognition, and specific knowledge of populations (Arredondo et al., 1996). The initial drafts proposed in 1991 by the AMCD, led to drafts that were shared in 1992 by the American Association for Counseling and Development (AACD) that included multicultural standards; these standards were later implemented into the professional identity (Sue, D. W., Arredondo, P., & McDavis, R. J. 1992a). Nearly 25 years later, the AMCD gathered a committee to review the initial proposed competencies and in 2015 a revised version of the competencies was established (Ratts,

Singh, Nassar, McMillan, Butler, & McCullough, 2016). The ACA then adopted the tenets outlined by the AMCD and AACD into the professional *Code of Ethics* (ACA, 2014).

The recent changes in the ACA's *Code of Ethics* (2014) call for a deepening of core competencies regarding multicultural issues, which include serving clients with varying attitudes, beliefs, and experiences. Previous versions of the code contained ambiguous language that could be used to support a counselor's decision to refer or refuse to work with a client based on a conflict of values. In Strohmer, Wilson, Kaplan, Gladding, & Gazda (2015), 29 of the 31 counseling associations collaborated for 2 ½ years to establish a concise consensus of "what counseling is" and provided language that could be uniformly used across the profession (Strohmer et al., 2015). Further, Strohmer et al., (2015) stated, "it is important that the counseling profession is seen as the central authority in articulating the essence of what it is that professional counselors do". The use of concise language as a profession limits the possibility of ambiguity for counselors to misinterpret guidelines when considering client referrals based upon conflicting values between the counselor and client; most importantly, it provides clarity to the professional stance and calls for an ethical obligation to obtain specialized training to improve multicultural awareness and delivery of services (Strohmer et al., 2015).

Counselor education programs rely on established accreditation standards such as the Council for Accreditation of Counseling & Related Educational Programs [CACREP], (2015) to inform best practices within the field of counseling, including multicultural competence. CACREP Standards (2015) are designed to "promote a unified counseling profession" and "ensure that students graduate with a strong professional identity" (p. 4). The standards provide structure but allow for creativity and flexibility within counselor education programs to fulfill, meet, or exceed requirements (CACREP, 2015). A study of graduates of CACREP programs over a five-year period found that students graduating from CACREP programs typically score higher on the National Counselor Examination

(Adams, 2006). CACREP-accredited program graduates are also less likely to commit ethical violations (Even & Robinson, 2013). Similar to the *ACA Code of Ethics* (2014), CACREP Standards (2015) address diversity using general terminology and also call for advocacy processes to navigate institutional and social barriers that may prevent "access, equity, and success for clients" (p. 9). CACREP (2015) also requires programs to implement curricula that focus on tenets of multicultural competence – appropriate theoretical models, cultural identity development, and social justice advocacy.

While many training programs and professional development experiences have provided opportunities for increasing cultural awareness both of the counselor and that of the client, less focus has been given to skill development (Hill, Vereen, McNeal, & Stotesbury, 2013). The AMCD calls on counselors to develop skillful interventions, which are developed through "educational, consultative, and training experiences" (Arredondo et al., 1996; p. 1). Further, the *Code of Ethics* (2014) directs counselors to recognize their personal limitations, and in doing so, engage in an ethical decision making process in which the counselor can provide access to culturally competent services. The lack of focus on skill development can create "cultural encapsulation which puts counselors at risk of using stereotypes, becoming judgmental, and imposing their values on their clients" (Ahmed, Wilson, Henriksen, & Jones, 2011).

Problem Statement

Across the United States, there are varying licensure standards for professional counselors. Currently, there is a push from the ACA, CACREP, and the Department of Defense to standardize requirements in order to promote licensure portability and strengthen professional identity (Lawson, 2016). Virginia was the first state to issue licenses to counselors for independent practice over 40 years ago, and California was the 50th state to license counselors in 2009 (Lawson, 2016). The Virginia

Board of Counseling (2016), for example, requires that Licensed Professional Counselors (LPCs) complete 3,400 supervised residency hours after graduating from a master's level program. However, that board has not yet joined the list of state boards that require graduation from a CACREP-accredited counselor education program (Lawson, 2016). In Virginia, LPCs must complete 60 hours of coursework including three credit hours related to multicultural counseling theories and techniques (Virginia Board of Counseling, 2016), which is congruent with current CACREP standards (CACREP, 2015).

The lack of standardization across counselor education programs and professional licensure inevitably creates variation in the delivery of mental health services throughout the profession. This is particularly problematic when considering the ACA's initiative for providing multiculturally competent counseling to clients. Because counselor training on multicultural competence may vary based on particular aspects of a program's curriculum, it is likely that the focus of expanded awareness related to counselor beliefs, values, and attitudes may differ. Further, with variations in training and licensure requirements, multicultural counseling preparation may vary. The distinction between including multicultural considerations to the therapeutic work with a client, and the acquisition of multicultural counseling competencies (MCCs), while seemingly subtle, can have stark implications at each level of professional identity to include: counselors-in-training (CITs), licensed professional counselors (LPCs), clinical supervisors, and counselor educators. As ethical standards have shifted within the profession to encompass multicultural competencies throughout the training experience, as well as through ongoing professional development supported by the ethical code, there has been limited consideration about how these competencies are measured (Barden & Greene, 2015; Constantine & Ladany, 2000; De-Andre & Heck, 1991; Sheu & Lent, 2007; Sodowsky, Taffe, Gutkin, & Wise, 1994).

Through inclusion of multicultural coursework and training, the counseling profession has made significant strides to include multicultural awareness for CITs, but the development of culturally informed practices and theories are needed. Counselor awareness of cultural diversity is not sufficient to possess multicultural counseling competencies. Many counselors and counselor educators may have increased awareness of culturally sensitive practices, yet do not possess the skills to provide them. This could be due to a multitude of factors, such as the counselor's own unconscious cultural biases, limited exposure to minoritized populations, or a perceived self-efficacy that is incongruent with MCC. The gap that currently exists within the profession lies between having knowledge and demonstrating awareness and skill (Arredondo et al., 1996; Barden & Green, 2015; Barden, Sherrell, & Matthews, 2017; Holcomb-McCoy & Myers, 1999; Malott & Schaefle, 2015; Ratts, 2011; Sue & Arredondo, & Davis, 1992a; Sue, 1992b).

This gap is further compounded for counselors who practice in rural communities. Rural communities often have less access to resources, including options for higher education. Due to limited interactions with culturally diverse peoples, counselors who practice in these settings may be less exposed to diversity based upon experience than counselors who practice in urban areas where the population is more diverse. Rural counselors experience "professional isolation" with regards to supervision, collaborating professionals, training, and consultation. Further, when considering exposure to various diverse populations, counselors in rural communities may have limited, if any, exposure to cultures that are different than their own. This is particularly troublesome as counselor education programs may not have opportunities for application of skills in order to measure MCC during training, outside of textbook knowledge.

In 2011, the U. S. Department of Health and Human Services reported disparities in health for populations of people who experience negative obstacles related to ethnicity, race, socioeconomic

status, sexual orientation, and gender expression (U.S.Census Bureau, 2015). In 2016, the largest

household survey in the United States, the *American Community Survey* collected statistics for the

3,142 counties. From this data, "rural areas cover 97% of the nation's land area but contain 19.3% of

the population, or about 60 million people" (U.S. Census Bureau, 2016). Previous research suggests

that minoritized populations are less likely to receive mental health treatment, and further the treatment

received is often of poorer quality, when compared to White, non-Latino counterparts (Abe-Kim,

Takeuchi, Hong, Zane, Sue, Spencer, & Alegria, 2007; Alegría, Chatterji, Wells, Cao, Chen, Takeuchi,

& Meng, 2008; Atdjian & Vega, 2005; Cabassa, Zayas, & Hansen, 2006; Dobalian & Rivers, 2008;

Harris, Edlund, & Lar-son, 2005; Lasser, Himmelstein, Woolhandler, McCormick, & Bor, 2002;

Novins, Beals, Sack, & Manson, 2000; Sorkin, Pham, & Ngo-Metzger, 2009; Wang, Berglund, &

Kessler, 2000; Wells, Klap, Koike, & Sherbourne, 2001). With minoritized populations reportedly

receiving fewer mental health services, having a higher rate of missed appointments (Atdjian et al.,

2005), and more negative experiences in counseling (Diala, Muntaner, Walrath, Nickerson, LaVeist, &

Leaf, 2000) it becomes a social justice issue to ensure culturally competent treatment is provided. This

is further complicated by the lack of counselors trained in cultural competence who are accessible to

minoritized populations (Imel, Baldwin, Atkins, Owen, Baardseth, & Wampold, 2011; Van Ryn & Fu,

2003).

Purpose of the Study

The purpose of this study was to examine counselors' self-perceived multicultural competency

between counselors working in rural, suburban, and urban communities. There is limited research on

how practice settings inform counselors' MCC, and no current research in comparing the perceived

MCC of counselors in rural, suburban, or urban settings. As a profession, we are in need of additional

research and assessment tools in assessing multicultural counseling competencies across the profession,

but especially for counselors treating diverse clients in rural communities. It is imperative that the research focus on measures that capture not only awareness and knowledge when considering MCC, but also factors that impact counselor skill, since this is a significant component of providing culturally competent counseling. This study examined the following research questions:

1. What are the differences in counselors' self-perceived MCC based on their practice location in rural, suburban, or urban communities?

2. What are the differences in counselors' self-perceived MCC based on area of origin (e.g. hometown or other location of significant influence) in rural, suburban, and urban communities?

3. Does a counselor's a) practice location, b) area of origin, c) gender identity, d) race/ethnicity, and e) number of racially/ethnically different clients served in the past year *predict* self-perceived MCC?

Key Terms

Included in this study, there are key terms that are important to define when discussing MCC. The professional literature often uses the following terms related to understanding MCC:

Client: "an individual seeking or referred to the professional services of a counselor" (ACA Code of Ethics, 2014, p.20)

Counselor Educator: "a professional counselor engaged primarily in developing, implementing, and supervising the educational preparation of professional counselors" (ACA Code of Ethics, 2014, p.20)

*Counselor-in-training/Supervisee/Resident: "*A counselor or counselor-in-training who is engaged in a formal supervisory relationship in which his/her clinical work is reviewed and monitored by a trained supervisor" (ACA Code of Ethics, 2014, p.20)

Licensure/Licensed Professional Counselor: "the process by which a state agency or government grants permission to a person to engage in a given profession and to use the designated title of that profession after the applicant has attained the minimal degree of competency necessary to ensure that public health, safety, and welfare are reasonably well protected" (CACREP, 2016, p.46)

Multicultural Counseling Competence (MCC): Mio, Barker-Hackett and Tumambing (2012) define MCC as skills which encompass:

1. Developing an awareness of one's own cultural values and biases.

2. Learning to value others worldviews.

3. Developing a set of culturally appropriate interpersonal skills.

*Minoritized population: minority is defined as "*a racial, ethnic, religious, or social subdivision of a society that is subordinate to the dominant group in political, financial, or social power without regard to the size of these groups" (Dictionary, 2017). The definition of minority implies a power differential with a group that is perceived to be in a different status, as reflected in the word subordinate; therefore, minoritized better describes the phenomenon of the sociopolitical influencers that are placed upon a person as opposed to being given the identity of minority

Multicultural/Diversity Competence: "counselors' cultural and diversity awareness and knowledge about self and others, and how this awareness and knowledge are applied effectively in practice with clients and client groups" (ACA *Code of Ethics*, 2014, p. 20)

Multicultural/Diversity Counseling: "counseling that recognizes diversity and embraces approaches that support the worth, dignity, potential, and uniqueness of individuals within their historical, cultural, economic, political, and psychosocial contexts" (ACA *Code of Ethics*, 2014, p. 20)

Rural: geographical areas or communities that have a density of 15 to 50 people per square mile, and total town populations of 2500 or less (United States Census Bureau, 2017).

Social Justice: "the promotion of equity for all people and groups for the purpose of ending oppression and injustice affecting clients, students, counselors, families, communities, schools, workplaces, governments, and other social and institutional systems" (ACA Code of Ethics, 2014, p.21)

Suburban: type of urban community, and includes a population of 2500-50,000 (United States Census Bureau, 2017)

Urban: geographical area or community with populations of 50,000 or more people (United States Census Bureau, 2017).

Summary of Chapter One

Historically, training standards and programs have varied for licensed professional counselors. Most recently, organizations such as ACA and CACREP have made strides to ensure consistency among standards throughout the United States. MCC are an increasingly important area of focus for the profession as urbanization continues and more rural communities experience more rapid diverse population growth. This study examined counselors' self-perceived levels of competence when working with diverse populations in rural, suburban, and urban communities.

CHAPTER 2

LITERATURE REVIEW

The purpose of this study is to examine counselors' self-perceived multicultural competency between counselors working in rural, suburban, and urban communities. Variation in counselor education training programs and requirements for professional counselors creates a gap in understanding how cultural competence is integrated into the therapeutic relationship. Further, various practice settings to include rural, suburban, or urban that counselors may work, could influence counselors MCC as there is more limited interaction with diverse clients, fewer opportunities to seek consult, supervision, and training. Chapter two will review literature related to multicultural counseling competence in counselors, establish the researcher's lens, include discussion of Multicultural Counseling Theory, and address concerns for providing MCC in rural communities.

Researcher's Lens

Feminist, multicultural, and social justice theories are common theories that are acknowledged when examining multicultural competency. The common thread between the theories is the influence of a feminist perspective. A key focus of feminist theory is that all people are influenced by political constructs of oppression or privilege, cultural influences, and their positionality in society (Crethar & Winterowd, 2012). All three paradigms focus heavily on the egalitarian perspective of the relationship. Forming a relationship and establishing a strong therapeutic working alliance is paramount when evoking client change (Thomas, 2006). Counselors who use this model acknowledge the power differentials that exist in the counseling relationship. Another important factor is the role that the counselor plays in validating the client's experiences with oppression. It is through the development of a strong therapeutic working alliance, that the feminist counselor strives to empower clients. Through empowerment, counselors work alongside their clients to dismantle oppressive systems. Lastly,

counselors from these theories tend to reject the "disease model" and rather focus on the social and political influences of each person's individual experience. It is through the rejection of the disease model that feminist counselors normalize mental health diagnoses as symptomology of oppressive and stressful systems (Brady-Amoon, 2011).

In many disciplines, there is a tendency to investigate either the construct of gender or race, perhaps as a result of parsimony, which may be too simplistic, by omitting either variable (Cole, 2009). As a result, the focus tends to narrow in on only the statistically significant results, and therefore further minoritizes certain groups. Even less research acknowledges that each individual makes up multiple groups, and does not exist in isolation such as gender, class, race, etc. (Cole, 2009). However, the "intersectionality framework does ask researchers to examine categories of identity, difference, and disadvantage with a new lens" (Cole, 2009, p. 1). Cole (2009) further suggests that when incorporating intersectionality into research, the added "insight invites us to approach the study of social categories with more complexity and suggests ways to bring more nuance and context to our research on the social categories that matter most in a stratified society" (Cole, 2009; p. 179).

Feminist Theory

Frisby, Maguire, & Reid (2009) surmises that theories are essential as they create frameworks to explain "physical, spiritual, and social worlds," which then perpetuate creating systems change (p. 15). The feminist movement is often discussed in three distinct waves; however, there is debate if a fourth wave exists. For the purposes of this review, focus will be on the predominant three waves of feminism, as the literature is conflicting for support of a defined fourth wave.

First Wave. The first wave focused on issues surrounding women's suffrage, abolition of slavery, education, and working rights in the 19th through early 20th century (Wrye, 2009). Early feminist movements focused on grassroots efforts to raise awareness of women's oppression; these

movements were not solely focused in academia, however transcended into the academic arena (Brady-Amoon, 2011; Reynolds & Constantine, 2004).

Second Wave. The second wave gained momentum during the 1960's-1980s. Feminists focused on the "personal and political" as interdependent phenomenon which impact a person's experience (Brady-Amoon, 2011, p. 137). During the second wave, feminists advocated for equity in the workplace for women through equal pay and opportunity. It was during the second wave that feminists questioned "rigid sex roles, claimed economic parity; validated women's desire for sexual pleasure; and widened feminism's scope to take in critical differences among women, from sexuality to class to race and ethnicity" (Wrye, 2009, p. 185).

Third Wave. The most recent third wave focused on continuing to build off of the early failures of the first two waves, and give consideration to the intersections of identity. The initial waves of feminism while intending to advocate for women's rights, failed to recognize the experiences of women of color (Hewitt, 2010). While feminist approaches had addressed topics such as race, sexuality, and class, it had previously not given the breadth of attention to understanding the perspectives of women of color, which perpetuated the distinction of a third wave (Hewitt, 2010). Hewitt (2010 p. 101) states, "Third wave feminism is an expansion of the subject to include the voices and experiences of women marked by a diverse set of identities."

Intersectionality

Intersectionality is the process of identifying how different systemic conditions vary by time, place, and how circumstances work together to reproduce conditions of inequality (Morris & Bunjun, 2007). More formally defined, "Intersectionality is an analytical tool for studying, understanding and responding to the ways in which gender intersects with other identities and how these intersections contribute to unique experiences of oppression and privilege (Morris & Bunjun, 2007).

The Combahee River Collective (1977) consisted of a group of black feminists who stated, "We find it difficult to separate race from class from sex oppression because in our lives they are the most often experienced simultaneously" (Combahee River Collective, 1977, p. 267). Early social activists focused on race, class, and gender but failed to consider the intersections of these identities. Kimberle Crenshaw is credited with the term *intersectionality* (1989/1993), highlighting the limitations of analyses that focus solely on gender or race as the primary identity, difference, or disadvantage. In *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique* (1989*)*, Crenshaw introduced intersectionality as a way to address the marginalization of black women in policy and theory. In *Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color* (1991) Crenshaw expanded the term to capture the violence experienced by women of color. She further noted how feminist and antiracism theories could further marginalize. Further, intersectionality can be used as a framework to understand privileged groups; it is important to note that disadvantaged groups may also hold aspects of privilege such as a white-woman, or a middle-class black male. Thus, scholars often focus on the additive or multiple approach of intersectionality, as it can be diversely defined among communities and even individuals. Morris & Bunjun (2007) highlight that the perception of equality is based upon an individual's experience and, therefore, is not fluid. This is an important concept, as it further supports Crenshaw's consideration regarding which groups an individual may have been excluded. Therefore, intersectionality gives consideration to the multiple groups that a person may or may not hold membership and acknowledges both systemic and institutional oppressive systems.

Feminist Identities

There are many feminist identities that have been coined throughout the years. The following are only a few types of feminist identities: radical, liberal, equality, religious, lesbianism, black

feminism, womanism, and white feminism (Mackay, 2015). Both feminists and action researchers are interested in the ways in which individual identities and experiences, shape a person's understanding of theories or explanations. Feminist theories additionally challenge theorists to unlearn their privilege, as traditional theories may be influenced by the personal and political causes. In the therapeutic relationship, feminist counselors challenge power differentials by forming non-hierarchal partnerships with clients (Brady-Amoon, 2011). Feminist theorists have noted that even among feminist research, certain groups of men, women, and children have been excluded. Additionally, feminist theorists stress the importance of acknowledging gender inequalities, as it may be "overlooked, misunderstood, or difficult to name," due to power differentials (Frisby et al., 2009).

Feminist theories, which historically have highlighted issues surrounding gender inequality, have much to offer to the field of research. Feminist research typically includes involvement from its participants in order to gather more information about the subaltern voice. Maguire (2001) adds that research should be equally concerned about how gender shapes men's lives since men, women, and those who do not identify with either male/female category, as gendered beings. Frisby et al., (2009) further states, "Gender expectations, socializations and how gender is performed also impact men and boys, and a transformative approach would help them see how gender influences their actions and those around them" (Frisby et al., 2009, p. 15).

While individual paradigms have often been studied as separate phenomenon, feminism and intersectionality attempt to allow counselors to recognize the intersections related to practice. Both feminists and action researchers are interested in the ways in which individual identities and experiences shape a person's understanding of theories or explanations. The researcher's lens includes an integration of feminism and intersectionality to explore the phenomenon of individual counselors' self-perceptions of identity and multicultural competence.

Working from a Feminist Intersectional Lens

In conceptualizing intersectionality for a research lens, important considerations are given to the implications of the research. Morris & Bunjun (2007) state, "making a commitment to intersectional feminist frameworks means making a commitment to thinking carefully about placing the experiences and perspectives of people with the least social, economic and political power front and center throughout the research process. Feminist researchers give significant consideration to the question, 'Who is included within the category?' Shifting focus to the "who" when considering research, researchers can begin to include minoritized people who have historically been excluded. This approach allows the researcher to better understand contextualized group experiences, rather than superficial comparison to the normed group. It also allows exploration of studies that may only focus on one intersection, such as gender, which fails to examine other social statuses such as class, able-bodiness, etc. (Sue, 2004). By examining these intersections, a researcher is able to better define privilege, and therefore disrupt the assumptions (Farough, 2006; Kuriloff & Reichert, 2003). When considering the role that inequality plays, it gives attention to the ways in which multiple category membership and social processes rather than the characteristics of an individual, perpetuate constructs such as race. Intersectionality allows the researcher to conceptualize research to find commonality among difference. Cole (2009) states, "Looking for commonality across difference entails viewing social categories as reflecting what individuals, institutions, and cultures do, rather than simply as characteristics of individuals" (Cole, 2009, p. 177).

Through the lens of feminism and thus intersectionality, consideration can be given to all of the intersections that make up an individual's identity. Levy & Sidel (2006) outlined multiple critical factors for mental health professionals while acknowledging intersectionality. The first, is that counselors who have awareness of intersectionality, are therein able to better predict outcomes and

establish empirical relationships. These outcomes and relationships are crucial for engaging the empowerment phase of feminist approaches, and promoting long-lasting change. Secondly, counselors must examine and critique their theoretical assumptions, practice strategies, and professional culture (McDowell, 2002). Just as clients present with various intersections, counselors also have varying intersections of identity, which inform their clinical practice. Thirdly, the role of counselor is given a certain amount of "power and privilege." Levy & Sidel (2006) state that it is the responsibility of the counselor to give a "voice to those in the margins" (p. 273). Levy et al. encourages the use of conceptual models to foster understanding, awareness, and recruitment of diverse groups. Through the inclusion of all voices, intersectional feminist theories allow representation of even the "extreme or negative cases," as these too are part of the descriptive whole. Through the inclusion of diverse groups, a counselor is able to further enhance clinical competence and evaluate the effectiveness of a model. Lastly, in accordance with feminist perspective, Levy et al. (2006) calls on counselors to look for opportunities to provide community outreach, further dismantling oppressive systems.

<div align="center">**Theoretical Framework**</div>

In addition to the researchers' lens, a theoretical framework will guide the research study. Feminist, social justice, and multicultural approaches work to reduce areas causing distress, but take a different route: they focus on ameliorating the oppressive systems that affect mental wellness. This involves directing attention to the complexity of culture, as well as a broad range of issues related to gender, race, socioeconomic status, sexual/affectional orientation, power relations, sociopolitical factors, injustices, and various forms of cultural oppression when working with clients (Vera & Speight, 2003). Privilege in the U.S. is often contextualized by the white, male, heterosexual, middle-class populations (McIntosh, 2000). It is due to the awareness of the sociopolitical influencers that

impact clients, the researcher incorporates a feminist intersectional lens to inform this study using multicultural theoretical framework.

Multicultural Counseling Theory

Multiculturalism is often referred to as the fourth wave of counseling (Pederson, 1991). Multicultural Counseling Theory (MCT) emerged during the mid-20th century as a response to the oppressive systems and discrimination that was occurring (Brady-Amoon, 2011). The multicultural counseling movement of the 1960's focused on bringing increased awareness to counselor educators on a client's "racial, ethnic, cultural backgrounds, and worldviews" could have on mental wellness (Brady-Amoon, 2011, p. 139). As the field continued to advance, considerations such as "gender, ability status, class and socioeconomic status, religious and spiritual identity, and other forms of social identity" were included to better understand a client's overall mental wellbeing (Brady-Amoon, 2011, p. 140). The multicultural movement later provided the MCC (Arrendondo et. al, 1996) which provided guidelines for the profession with inclusion of multicultural principles into practice.

It is important to also acknowledge social justice counseling when contextualizing MCT, as it has been recognized as the fifth wave of counseling. Social justice counseling was introduced by Lewis, Lewis, & Dworkin (1971) to address the systemic issues that were impactful to clients. Ratts (2009) states that social justice is the, "belief that social advocacy is a necessary step to address issues of equity for those who have been marginalized in society" (Ratts, 2009, p. 160). Social justice perspectives require that issues surrounding privilege and power are addressed; it is only through acknowledgment of these systems and barriers, that clients are able to resolve their issues (Ratts, 2011).

Six Theoretical Assumptions of MCT

Sue, Ivey & Pederson (1996) proposed six major theoretical assumptions that inform MCT and serve as foundational guiding principles for the framework. The first is that every theoretical

framework is a product of its cultural mindset in which it was created. To expand, the researchers

stated that this influence was neither good nor bad, however it is important to consider the lens in

which a framework was conceptualized. MCT counselors recognize based on this assumption that

there are many ways in which a client can heal, and that including the client's worldviews are essential

for this process. Secondly, MCT asserts that consideration must be given to the individual, familial,

and cultural contexts of a client's life (Crethar, Rivera, & Nash, 2008; Sue et. al., 1996). Thirdly, both

counselor and client attitudes are strongly influenced by where they are in their own cultural identity

development. Cultural identity development many be apparent in behaviors, thoughts, and feelings

related to self and others. The fourth assumption builds from the first, in that it assumes there is no

universally appropriate approach or intervention for clients. This assumption is closely related to

feminist and social justice influences, which challenges counselors to implement interventions that are

most impactful for the client based on their worldview, as regardless of the counselor's preferred

theoretical orientation (Crethar, et al., 2008; Sue et al., 1996). The fifth assumption highlights that

traditional one-on-one counseling is not the only way in which clients can make progress. Therefore,

MCT counselors must be open to implementing a wide range of helping roles, including those of

consultation and advocacy. The sixth and final assumption attempts to have MCT counselors provide

intervention that does not solely focus on the traditional areas of behavior modification, exploration of

unresolved problems, or self-actualization. Rather, it challenges counselors to consider "clients'

awareness of the impact that cultural, economic, educational, political, and social factors all have on

human development" (Crethar, et al., 2008; p.). This is impactful as it promotes "psychological

liberation" which allows clients to self-actualize themselves in context of the systematic barriers that

may be impacting overall well-being (Comstock, Hammer, Strentzsch, Cannon, Parsons, & Salazar,

2008).

Principles of MCT align closely with that of a feminist and intersectional lens. Further, the approaches that multicultural, feminist, and social justice counselors utilize have significant philosophical overlap, and are closely related. Goodman, Liang, Helms, Latta, Sparks, & Weintraub (2004) state that, "(a) ongoing self-examination, (b) sharing power, (c) giving voice, (d) facilitating consciousness raising, (e) building on strengths, and (f) leaving clients with the tools for social change" are essential characteristics of MCT (Goodman et al., 2004; p.798). Characteristics such as self-examination and consciousness-raising are more clearly defined in the professional literature as MCC that derived from the AMCD proposed core conditions of culturally competent practice. It is apparent that characteristics of sharing power, giving voice, building on strengths, and empowering for social change are all reminiscent of feminist and intersectional influences. The multicultural counselor works to promote social, political, and environmental changes that will positively benefit the client. Additionally, multicultural counselors much like feminist and social justice counselors, strive for an egalitarian relationship with clients, ensuring a clear understanding of power differentials that may impact the therapeutic working alliance. Multicultural theory counselors have awareness of the broad range of injustices that may be impacting client's mental health and psychological well-being (Crethar, et al., 2008).

For this study, the lens of a feminist intersectional researcher informs the incorporation of the MCT framework. As an individual's identities are often fluid, and are often shaped by the sociopolitical contexts in which a person has lived, it is important for researchers to give consideration to how these constructs impact well-being and influence their perception of the world. Additionally, MCT provides a theoretical framework that aligns with a feminist intersectional lens, by providing areas of focus that support the individual consideration of a client's lived experience.

Review of the Literature

The ACA *Code of Ethics* (2014), call counselors to practice within the "boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience (ACA, 2014, p. 8). For counselors, this requires a level of multicultural competency when working with culturally diverse clients. To establish MCC when working with clients, counselors must have awareness and insight into themselves as cultural beings, as well as understanding the power differentials that influence institutional and systemic oppression. It is through this awareness that a counselor can truly meet the needs of each client, while working to dismantle the very systems that perpetuate oppression. Through the recognition of the intersections that oppress clients, counselors can create systemic change that promotes the amelioration of mental illness.

The professional literature over the past several decades has begun evolving to give increased awareness to the integration of multiculturally competent practices within the counseling profession. In 1991, the AMCD approved an initial document that sparked recognition for a needed integration of multicultural perspectives within the counseling field. The AACD was later approached in 1992 to include multicultural standards, which were to be implemented within the professional identity (Sue, 1992;b). It is important to note that the early literature surrounding MCC, did not give consideration to various intersections of identity, specifically lesbian, gay, or transgender identities (Ratts, et al., 2016). It was the work of Pope (1995) that created awareness within the profession to include other salient identities to provide a holistic conceptualization of a person (Pope, 1995; Ratts, et al., 2016). Nearly 25 years later, the AMCD moved to revise the initial multicultural counseling competencies with the task of including a more "inclusive and broader understanding of culture and diversity that encompasses the intersection of identities" and to "better understand the expanding role of counselors to include individual counseling and social justice advocacy" (Ratts et al., 2016; p.29). The ACA also included

these competencies within the *Code of Ethics* (2014) which calls all counselors to implement practices that will avoid harm or imposing personal values upon clients (A.4.a). Additionally, the code deems it the professional responsibility of counselors to

> "practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Whereas multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population" (ACA, 2014, C.2.a).

The code further states that counselors are required to monitor their own treatment effectiveness (C.2.d), give consideration to cultural sensitivity (E.5.b), and to recognize societal constructs on a micro and macro level that directly impact biases towards minoritized populations which influence diagnosis (E.5.c). In 2015, the CACREP which establishes educational standards for counselors-in-training and its accredited institutions, released its revised requirements that specify a component of all coursework must recognize areas of multiculturalism and diversity. This inclusion has a section of coursework outlining requirements for teaching cultural and social diversity, with a specific section dedicated to multicultural competencies.

While the integration of professional standards outlined by organizations such as ACA and CACREP are helpful in establishing profession expectations, research suggests that multicultural education provided in stand-alone college courses may not be sufficient to make impactful change on student perspectives over an extended period of time (Garmon, 2004; McDonald, 2005; Sleeter, 1995; Winitzky & Barlow, 1998). Dodd (2015) suggests that many students approach multicultural courses expecting to be trained in specific interventions related to diverse populations, as opposed to

challenging their own beliefs and gaining awareness as a cultural being. Further, students may then experience resistance when the focus is less about specific interventions related to a particular population, and more focused on challenging their belief systems. Beyond the confines of the courses that cover MCC content, we cannot be certain how this knowledge translates into actual skills in the field upon graduating.

Multicultural Counseling Competence (MCC) Defined

Multicultural counseling competence as defined in Chapter One, was initially acknowledged by the profession in the AMCD's MCCs, and through subsequent research (Arredondo et al., 1996; Sue, Bernier, Durran, Feinberg, Pederson, Smith, & Vazquez-Nuttall, 1982; Sue et al., 1992a, 1992b). Researchers have offered factors to objectively define MCCs to include awareness/attitudes/or beliefs, knowledge, and skills (De-Andre, Daniels, & Heck, 1991; Sodowsky, et al., 1994). The three domains of competence (awareness, knowledge, and skill), closely followed the tenets outlined in Sue et al.'s (1982) three-factor model of cross-cultural counseling (Kim, Cartwright, Asay, & D'Andrea, 2003). In the revisions proposed to the AMCD in 2015, the Multicultural and Social Justice Counseling Competencies (MSJCC): Guidelines for the Counseling Profession, a fourth domain of action was added to operationalize MCC (Ratts et al., 2016). The AMCD defined 3 main competencies for which a counselor must adhere in order to provide MCC: 1) counselor awareness of own cultural values and biases, 2) counselor awareness of the client's worldview, and 3) culturally appropriate intervention strategies (Arredondo et al., 1996).

Awareness and Beliefs

The domain of attitude calls counselors to explore their own attitudes and beliefs, recognizing themselves as cultural beings, and develop self-awareness. This domain requires that counselors recognize their own cultural heritage and upbringing, while also recognizing the influences based on

their upbringing that may influence their own biases. The attitude domain also asks counselors to recognize their own limitations related to MCC and have awareness of their lack of expertise. Culturally competent counselors who have awareness in this domain also recognize their own emotional reactions to culturally different peoples, and are able to contrast their own beliefs or attitudes to serve clients in a nonjudgmental way (Arredondo et al., 1996). Finally, counselors who have mastered the beliefs and awareness domain, are able to have a mutual respect for clients who are culturally different and do not attempt to engage in cultural appropriation. Ratts et al., (2016) simplifies to state that, "counselors must possess certain attitudes and beliefs to commit to practicing counseling and advocacy from a multicultural and social justice framework" (Ratts et al., 2016; p.38). It is important to note that Arredondo (1996) later revised "awareness" to be "attitudes", however in MCC literature the two terms are often used interchangeably (Arredondo, et al., 1996).

Knowledge

The second MCC domain of knowledge requires that counselors possess specific knowledge of their own cultural heritage as well as that of their client (Arredondo et al., 1996). Culturally competent counselors who have mastered the knowledge domain recognize how oppression, discrimination, and stereotyping impact themselves as well as clients (Arredondo et al., 1996). Counselors also must recognize the influence of sociopolitical factors and possess knowledge about their social impacts of others, particularly within the counseling relationship. Finally, counselors must have knowledge about the ways in which systematic oppression to include biases in assessment and diagnostic measures, influence mental health treatment received by minoritized populations. Ratts et al., (2016) surmises that counselors must "possess knowledge of relevant multicultural and social justice theories and constructs which is necessary to guide multicultural and social justice competence (Ratts et al., 2016; p. 38).

Skills

In the final of skill, counselors have navigated through the domains of attitude and knowledge, and focus on seeking consultation, education, training, or referring to more qualified sources. Counselors in this domain have embraced the attitude and knowledge tenets, and through their own self-awareness continue to seek a "non-racist identity" (Arredondo et al., 1996). At this level of MCC, counselors are actively reviewing relevant research as it pertains to their clients and cultural competency. Counselors also interact with culturally diverse people outside of the counselor-client relationship. The final competencies within the skill domain include: 1) use of culturally appropriate verbal and non-verbal responses, 2) able to distinguish between mental health issues and impacts of systematic oppression and/or racism, 3) collaborate with community practitioners such as ministers or healers that may be of cultural significance to clients, 4) use the preferred language of a client, and 5) have received training and hold expertise in assessment instruments, recognizing cultural limitations , 6) work to eliminate biases in evaluations and interventions, and 7) educate clients on counselor-client relationship eliminating power differentials (Arredondo et al., 1996). Finally, Ratts et al., (2016) states, "multicultural and social justice–informed attitudes, beliefs, and knowledge provide the background for counselors to develop cultural and change-fostering, skill-based interventions" (Ratts et al., 2016; p. 38).

Action

The fourth and final domain based upon the most recent revisions proposed by the MSJCC (2015) is action. It is in this domain, that awareness, knowledge, and skill (AKS) are operationalized into action (Ratts et al., 2016). Various researchers have suggested that incorporation of an action phase is essential when operationalizing a skill (Arredondo et al., 1996; Ivey, Ivey, & Zalaquett, 2010; Nassar-McMillan, 2014). Therefore, it is within the action domain that AKS "creates the maximum

influence of counseling intervention by operationalizing the MSJCC-based AKS" (Ratts et al., 2016; p. 38).

Multicultural and Social Justice Counseling Competencies (MSJCC) Implications

The revisions that the MSJCC have contributed provide a more expansive understanding of MCC as it relates to recognizing intersections of identity. The MSJCC call for counselors to not only examine their own cultural attitudes and beliefs, but also to recognize power dynamics of both the privileged and marginalized counselor, which impact their lived experiences (Ratts et al., 2016). This same focus is present in the knowledge domain, however it is stressed that even counselor communication style must be considered, with regards to how it is influenced by their marginalized or privileged status. In the skills domain, counselors are able to critically and analytically compare and contrast their own privileged and marginalized statuses, to those of other individuals (Ratts et al., 2016). In the action domain, counselors are proactive in learning about themselves, and immersing to better understand the impacts of oppression, power, and privilege. Overall, the MSJCC revisions allow counselors to have a more attuned understanding of client's experiences, as they are giving consideration to all of the intersections of identity, outside of the original ones proposed by the AMCD. It is through the inclusion of the action domain that the attitudes, knowledge, skills, action (AKSA) model for multicultural and social justice counseling can occur.

MCC in Counselors

As stated before, multiculturally competent counselors must be able to incorporate the AKSA domains to provide culturally competent counseling to clients. There have been many studies in the professional literature that evaluate counselor MCC (D'Andrea & Heckman, 2008). Atkinson (1983) conducted a content analysis of current studies that assessed counselors' MCC (Burrell & Rayder, 1971; Ewing, 1974; Grantham, 1973; Jones, 1978). Of these studies, the researchers assessed for

client satisfaction and perceived helpfulness when working with ethnically or racially similar counselors (D'Andrea & Heckman, 2008). Atkinson (1983) concluded that there were not statistically significant findings during this content analysis to suggest a conclusive outcome as to whether race/ethnicity was significant factors in predicting MCC (D'Andrea & Heckman, 2008). Similar to many of the earlier studies of MCC that evaluated the relationship of racial/ethnic similarities or dissimilarities between counselor/client and satisfaction of the counseling relationship, more recent studies have shown a relationship between counselor gender and ethnic identity (D'Andrea & Heckman, 2008).

While many studies have been inconclusive, in suggesting that race/ethnicity are not factors in MCC, some researchers have found that there may be a correlation (Chao, 2013). Constantine, Warren, & Miville (2005) conducted a study with 50 counseling psychology white doctoral students to compare student's level of racial identity awareness related to case conceptualization and MCC. The Cross-Cultural Counseling Inventory—Revised (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991), and the White Racial Identity Attitude Scale (WRIAS; Helms, 1990) were used to measure both ethnic identity awareness and case conceptualization to predict counselor MCC. The researchers found a correlation between positive ethnic identity and higher perceived MCC among counselors.

Ottavi, Pope-Davis, & Dings (1994) studied 128 white counseling graduate students who participated in a study to assess white counselor identity development and self-reported MCC. The researchers found that those counselors with stronger ethnic identity development, also had greater predictive relationships for MCC. This study was later replicated by Middleton, Stadler, Simpson, Guo, Brown, Crow, & Lazarte (2005), again supporting previous findings that racial/ethnic identity was related to perceived MCC.

In Chao & Nath (2011), the researcher suggested that gender is often a variable that is not accounted for in multicultural counseling research. The variable of gender is important to capture as it relates to MCC, as researchers such a Kabacoff, Marwit, and Orlofsky (1985) have suggested that counselors who may possess less egalitarian views of gender, may be more likely to accept stereotypes. Chao (2008) suggested that gender was significantly associated with aspects of MCC, specifically the knowledge and awareness domains.

Chao & Nath (2011) examined MCC training as it related to ethnic identity and gender roles. The study consisted of 313 participants, and used the following instruments: (a) demographic survey, (b) Sex-Role Equalitarianism Scale (SRES; King & King, 1993), (c) Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1991), (d) Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Rieger, Barrett, Sparks, Sanchez, & Magids, 1996), and (e) Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992). The study found that gender and ethnic identity accounted for 24% variance in counselor MCC. This research suggested the importance of counselor's awareness surrounding their own gender roles and racial/ethnic identity to be culturally competent (Chao & Nath, 2011). Therefore, due to the supporting research for including racial/ethnic identity and gender in measuring MCC (Chao & Nath, 2011; Chao, 2013; Constantine et al., 2005; Middleton et al., 2005; Otavi et al., 1994) the counselor characteristics of race/ethnicity and gender will be examined in the proposed study.

D'Andrea & Heckman (2008) used a deductive approach using computer searches to review MCC literature from 1967-2007. Of this content analysis, 211 articles were identified as MCC outcome studies; however with further refinement of the search criterion, 53 studies were selected for assessing MCC outcomes (D'Andrea & Heckman, 2008).   The researchers noted at the time of this analysis, the substantially low number of research studies examining MCC may impact counselor's

ability to adhere to the ACA *Code of Ethics* (2005) due to the requirement of providing multiculturally competent treatment and not having studies to inform empirically proven interventions (D'Andrea & Heckman, 2008). Areas of concern with regards to the MCC literature found in D'Andrea & Heckman's (2008) analysis included small sample sizes and posing external validity threats related to generalizability of the current studies. Finally, the researchers made the following recommendations of expansion of MCC literature: 1) address the problem of limited resources, 2) random sampling and increased sample sizes, 3) measures of racial/ethnic identity development as independent variables, 4) MCC should be measured as an independent variable, 5) consider combining qualitative and quantitative research when possible, 6) acknowledge the multidimensionality of multicultural counseling, and 7) consider alternative helping strategies (D'Andrea & Heckman, 2008).

These recommendations are significant as they inform the current research study and theoretical framework. MCC is assessed as a dependent variable in research question one, with practice setting as an independent variable; while D'Andrea and Heckman (2008) suggest using MCC as an independent variable. For the purposes of this study, MCC was reviewed as a dependent variable as the research questions are focused on understanding counselor perceptions of MCC based upon practice setting, as opposed to measuring skill. In research question three MCC is studied as a dependent variable, with counselor race/ethnicity, practice setting, and gender identity are independent variables. These variables align with the recommendations from D'Andrea & Heckman (2008) as it will further address MCC in rural communities with limited resources, and addresses racial/ethnic and gender identity as independent variables.

Multicultural Counseling Competence in Counselors-in-Training

Counselors-in-training (CITs) are of particular focus in the literature, as counselor development and competencies are fundamental components of counselor education programs.

Throughout the literature review, the current research related to examining MCC relied on studies looking at CITs. Chao and Nath (2011) suggests that CITs should: 1) receive training surrounding MCC in the very first semester of coursework to introduce students immediately to MCC, 2) CITs should be provided with evidenced-based material on effective MCC, 3) supervisors must be available to provide one-on-one support to provide space for cultural identity development, 4) mentoring can occur from more seasoned graduate students to provide examples of strong MCC, 5) CITs should be trained to conduct holistic case conceptualizations and/or assessment of clients, and 6) training should be provided throughout the year and CITs progress related to MCC should be evaluated (Chao & Nath, 2011). Through inclusion of the practices outlined by Chao and Nath (2011), counselor education programs could better prepare CITs to provide MCC as it would be introduced early in counselor identity development.

Anuar, Jaladin, & Aga (2016) conducted a study with 60 CIT's in which a training program was developed to assess MCC before and after instruction (Anuar, et al., 2016). The theoretical foundation was informed by the three MCC dimensions of attitudes, knowledge, and skills (Sue et al., 1992). The module began by increasing CIT's awareness of their own culture and progressed through the characters and dimensions of the 3x3 framework posed by Sue et al. (1992). The first section provided knowledge about other cultures, the second examined of current beliefs and attitudes, and the final section provided skills training (Anuar et al., 2016). The study took 30 CITs as a control group, and the remaining 30 CIT's as a treatment group; each group was given a pre-test to measure MCC before the treatment group received the training modules three-times over a 30 day period (Anuar et al., 2016). The Multicultural Awareness Knowledge Skills Survey-Counselor Edition- Revised (MAKSS-CE-R) was used to measure MCC for pre and post test data (Anuar et al., 2016). Results of this study showed that in all three variables there was an increase in the means among the treatment group of awareness

(2.76; 3.25), knowledge (2.30; 3.06), and skill (2.32; 3.15), suggesting improved counselor MCC with training that specifically addressed all three domains of MCC (Anuar et. al., 2016). The control groups did not experience the same level of increased MCC across variables, and in some instances, the mean score decreased: awareness (2.76; 2.58), knowledge (2.29; 2.33), and skills (2.32; 2.39) (Anuar et al., 2016). This study was significant as it supports that MCC can be developed further by specific training using Sue et al. (1992) domains of awareness, knowledge, and skills; further, it suggests that the MAKSS-CE-R is a reliable measure for assessing MCC among counselors.

Cartwright, Daniels, & Zhang (2008) conducted a study with 31 counselor education students to examine self-reported MCC using the MAKSS-CE-R over a period of time; the MAKSS-CE-R was administered at the beginning and the end of the semester to assess counselors self-reported MCC (Cartwright et al., 2008). Additionally, the students were asked to submit a video-recorded role play in which a client presented as frustrated since the instructors of the program had presented theories that were not culturally relevant to the populations she would serve (Cartwright et al., 2008). An observer used the Multicultural Counseling Assessment Survey Form I (MCAS; D'Andrea et.al, 1991) to rate aspects of the counselors MCC using a 4-point Likert scale; higher scores on the MCAS represent greater MCC (Cartwright et al., 2008). Scores from the MAKSS-CE-R were compared from the start and end of the semester, using repeated measures t-tests to describe the differences between self-report and the independent observer ratings (Cartwright et al., 2008). Videotapes were scored by faculty to assess for observed MCC. The findings of this study were significant in informing the gap of perceived MCC and observed skill : self-report scores for Awareness (M = 55.87, SD = 7.97), Knowledge (M = 49.63, SD = 5.71), and Skills (M = 43.80, SD = 7.56) were significantly higher than the independent observer ratings for Awareness (M = 32.56, SD = 10.26), Knowledge (M = 29.22, SD = 6.57), and Skills (M = 33.22, SD = 8.79) (Cartwright et al., 2008).

This study is crucial in examining counselors' self-perceived MCC when comparing to observation by others, as the data demonstrates that there was a clear gap in the counselors' perceived knowledge and level of skill. The MAKSS-CE-R may be helpful in research measuring counselor's perceptions of MCC as it relates to awareness and knowledge. For this study, the researcher examined counselors' self-perceived multicultural counseling competency (MCC) between counselors working in rural, suburban, and urban communities, and therefore the MAKSS-CE-R could be useful in understanding counselor's perceptions.

Multicultural Counseling Competence in Professional Counselors

Holcomb-McCoy & Meyers (1999) conducted a study that examined MCC in 500 professional counselors using a stratified sample, through a survey using the Multicultural Counseling Competence and Training Survey (MCCTS) (Holcomb-McCoy & Meyers, 1999). In this study, Holcomb-McCoy & Myers suggest that professional counselors may perceive themselves as less prepared to work with diverse populations, based upon the findings that counselors perceived themselves to have greater awareness and knowledge as opposed to skill (Holcomb-McCoy & Myers, 1999). This study and the findings were closely related to more recent research replicated by Barden et al., (2017), with exception that in the more recent study, researchers examined knowledge and skill as one factor, suggesting that the two are intricately related and cannot be separated (Barden et al., 2017; Ratts, 2011). Barden and colleagues (2017) surveyed 171 professional counselors, selecting a diverse sample from the Counselor Education and Supervision Network Listserv (CESNET). This study further supported Holcomb-McCoy and Meyers (1999) findings that counselors perceived themselves more competent with the awareness and less competent in the area of knowledge (Barden et al., 2017). Additionally, this suggests that counselors are more knowledgeable about their own culture and worldviews, than those of their clients (Barden et al., 2017). The research of Holcomb-McCoy & Meyers (1999) as well as

Barden et al. (2017) is important to consider in context of the current research study, as it supports the need for better understanding of the domains of awareness, knowledge, and skill, which were measured using the MAKSS-CE-R.

Chao (2013) presented a study that was conducted to determine if multicultural training in school counselors was a predictor of MCC. The study also aimed to measure if race/ethnicity is a factor influencing MCC training to include color-blind racial attitudes (Chao, 2013). In the study, 259 school counselors from the American School Counselor Association were surveyed, using several measures that assessed for cultural identities (Chao, 2013). The study found that race/ethnicity had a significant interaction with predicting MCC as it relates to multicultural training (Chao, 2013). This was significant as it suggests that for counselors with higher levels of multicultural training, white and racial/ethnic counselors demonstrated similar MCC; however, for lower levels of multicultural training, racial/ethnic counselors demonstrated higher levels of MCC when compared to white counselors (Chao, 2013). The study further controlled for race/ethnicity and the interaction with multicultural training, racial/ethnic identity was found to "moderate the association of race/ethnicity and MCC" (Chao, 2013, p. 147). This is important as it suggests that school counselors bring "their own racial identity into counseling" which further supports the need to better understand MCC (Chao, 2013; p.147).

Radifah (2011) noted that 79.2% of 401 counselors in this study reported receiving MCC training throughout their training programs. However, 54% of those same counselors reported not receiving MCC training within the past 5 years, suggesting that many counselors do not receive ongoing training to continue improving their MCC (Radifah, 2011). This is problematic as the literature has previously suggested that there is variation in MCC training due to lack of standardization of accreditation bodies such as CACREP. Therefore, if counselors are receiving various levels of MCC

training during their masters programs, the data from Radifah (2011) is further startling as over half of

professional counselors may not continue ongoing training to further develop MCC. This has

significant impact on ensuring that counselors develop MCC, and that clients receive culturally

competent care.

With many studies focusing on the MCC of counselors-in-training and MCC training strategies,

there remains a significant gap in the literature concerning the self-perceived MCC of practicing

counselors in the field. The literature can be expanded to better understand how counselor MCC is

perceived by professional counselors, since as Radifah (2011) notes that ongoing training and

development of cultural competency is not something that was evident in over half of counselors

surveyed. Therefore, it is important to further explore counselors' perceptions of MCC related to the

study's identified factors of race/ethnicity, gender identity, and practice setting.

MCC Instruments

Assessing for MCC is increasingly problematic within the field of counseling, as there are

limited measures to assess for skill (see Table 1). The most common measures for MCC are self-

report, and there are limited tools to accurately measure skill.

Table 1

Multicultural Counseling Competency Measures

Title (Abbreviation; Authors, Date)	Self-Report	Items	Reliability
Multicultural Awareness/Knowledge/Skills Survey (MAKSS; D'Andrea, Daniels, & Heck, 1991)	Yes	60	.75- .96
Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994)	Yes	40	.65-.88
Multicultural Counseling Awareness Scale—Form B (MCAS-B; Ponterotto et al., 1996)	Yes	45	.83-.91

Cross-Cultural Counseling Inventory—Revised (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991)	Yes	20	.88-.92
Multicultural Counseling Self-Efficacy Racial Diversity Form (MCSE-RD; Sheu & Lent, 2007)	Yes	37	.77-.98
Multicultural Counseling Competence & Training Survey-Revised (MCCTS-R; Barden & Greene, 2015)	Yes	32	.43-.95

Additionally, many tools may not be measuring what was intended. The lack of clarity surrounding how to objectively define MCCs suggests that the varying self-report scales may in fact be measuring differing perceptions of competency (Constantine & Ladany, 2000).

Constantine et al. (2000) conducted a study with 135 bachelors, masters, and doctoral level counselors, examining four MCC measures to better understand the relationship between the measures. Researchers used the (a) Multicultural Awareness/Knowledge/Skills Survey (MAKSS; D'Andrea, Daniels, & Heck, 1991), (b) Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994) (c) Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Rieger, Gretchen, Utsey, & Austin, 1999) and the Cross-Cultural Counseling Inventory—Revised (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991). Findings suggested three-of- the-four measures were influenced by social desirability (MAKSS, MCI, and CCCI-R) however, the MCKAS seemed to be the least influenced by social desirability (Constantine et al., 2000). Additionally, even when controlling for social desirability, the results were not significant for measuring MCC case conceptualization ability for any of the instruments, suggesting that the measures did not appear to assess that aspect of MCC (Constantine et al., 2000).Constantine et al., (2000) further noted that many multicultural competence scales may in fact be measuring perceptions of MCC, as opposed to actual MCC. This is important as it suggests the potential for issues related to construct validity in the

measurements that the profession has used to measure MCC. In the current study, this is discussed as a limitation in the current availability of assessments of MCC. As the research currently offers limited measures for evaluating MCC that do not include self-report scales, such as the MAKSS-CE-R, it will be important for future research to expand upon development of measures that do not rely upon self-report measures and allow for measurement of counselor skill as it pertains to MCC.

Rural, Suburban, and Urban Communities

Geographic location is an important area of interest to the current study, particularly as it relates to counselors' MCC. There is limited research in the professional literature related to understanding the work of counselors in various geographic locations. Further, there is no current research to date in understanding counselor MCC for counselors practicing in rural, urban, and suburban communities.

Rural is defined for this study as geographical area or community that has a density of 15 to 50 people per square mile, and total town populations of 2500 or less. Suburban is defined as a type of geographical area or urban community, and includes a population of 2500-50,000 (U.S. Census Bureau, 2011). Urban is defined as a geographical area or community with populations of 50,000 or more people (U.S. Census Bureau, 2011).

Breen & Drew (2012) acknowledge that previous literature has focused on preparing counselors who work in rural communities to understand the unique cultural attributes of those areas; however, the authors further posit that counselors themselves may not be prepared for rural practice. Cook & VanCleaf (2000) studied preservice teachers multicultural preparedness in urban school settings; the researchers found that first year teachers who had student teaching experiences in urban communities also felt more prepared when working with more diverse students in urban settings (Cook & VanCleaf, 2000). Teasley, Baffour, & Tyson (2005) studied school-based social workers, to assess their level of self-perceived cultural competence when practicing in more urban schools, specifically schools in

which the student population was 50% or more African American (Teasley et al., 2005). The

researchers used the Cultural Competence Self-Assessment Questionnaire (CCSAQ; Mason, 1995),

incorporating the adaptive measure for social workers (Teasley et al., 2005). The measure includes

subscales that assess for (a) community knowledge (dynamics, racial composition, socioeconomic

status, etc.), (b) resources and linkages (access, availability, etc.) and (c) service delivery (appropriate

interventions, cultural strengths, etc.) (Teasley et al., 2005). The researchers found social workers who

reported more experience, also reported greater self-perceived cultural competence; total years of

services, was positively correlated with the subscales of resources and linkages, and service delivery

(Teasley et al., 2005). Additionally, the level of social work licensure, intermediate or advanced, was

also significantly correlated with perceived culturally competent practice (Teasley et al., 2005).

Most of the counseling professional literature focuses on opinions or ethical challenges, but few

studies specifically give focus to how these counselors are trained to work within rural communities.

Breen & Drew (2012) performed a basic interpretive qualitative study with 20 counselors, conducting

interviews to fully explore counselor responses. The participants consisted of 11 school counselors and

nine community-based counselors (Breen & Drew, 2012). From the Breen & Drew, (2012) study

emerged unique characteristics that rural counselors face to include community: "poverty, lower levels

of education, limited career opportunities, long travel distances, lack of resources, lack of diversity, and

alcoholism" (Breen & Drew, 2012, p. 4). Additional predominant value themes were present among

counselors in rural communities such as "culture, trust, family, school, and lack of services" (Breen &

Drew, 2012, p. 4). Rural counselors defined each community as having its own culture, with unique

strengths and challenges.

As a counselor in a rural community, there are many positive attributes such as having a slower

pace or more leisurely time. Additionally, there may be availability for funding or grants to assist in

tuition reimbursement, with the hope of securing more practitioners in rural communities (HRSA, 2017). However, the pay for counselors in rural areas is low, there are limited options for professional development/consult, and the balance between ethical considerations and day-to-day life can create emotional fatigue (Breen & Drew, 2012). Lauren Paulson, LPC a researcher on rural communities, notes that counselors in rural communities often feel responsible to be role models for their clients, even when they are not working, due to the smallness of the community (Rollins, 2010).

Counselor perceived self-efficacy in rural communities can create additional challenges due to the multiple roles counselors are expected to fulfill. Because mental health professionals and resources are scarce, counselors in rural settings must often be knowledgeable about providing a broad variety of services (Breen & Drew, 2012). This could place counselors in the position of providing traditional counseling while also being a resource for other areas of need such as linking with financial supports through the Department of Social Services. Relationships with counselors after termination may be further complicated in rural communities. Counselors are likely to continue to see terminated clients in social settings, or may even be contacted for ongoing needs (Breen & Drew, 2012). Among other challenges, ongoing supervision and consultation is limited for counselors in rural areas (Barth, Wildfire, & Green, 2006; Herlihy & Corey, 2006). As many counselors may be the only practitioner in an area, there may be limited opportunities for professional consult.

Breen & Drew (2012) suggested that counselor educators be explicit in talking about rural communities during training programs, as the issues are not always as obvious until practitioners are in the field. Additionally, students should receive training on how to fulfill many roles that may not be directly related to that of a counselor, but that will likely be areas of need in rural communities, such as linking with community resources. Students should also have an awareness of how to seek supervision

and continuing education outside of their practice settings, as this may not be available in rural communities (Breen & Drew, 2012).

The professional literature includes minimal research on providing culturally competent care to clients in rural communities, particularly in areas that are characterized by a relatively homogenous population. This is increasingly important as the professional *Code of Ethics* (ACA, 2014) provides clear expectations and parameters for the profession related to cultural competence. Further, as cultural diversity is not always something that is readily visible, it is imperative for counselors practicing in rural communities that may appear homogeneous, to receive specific training on practicing in culturally competent and sensitive ways.

Summary

This chapter provides an overview of the current literature available related to professional organization's inclusion of multicultural counseling competencies, considerations for practicing in rural communities, and MCT as the theoretical framework that guided the study. Based upon the literature review, there are significant gaps in knowledge surrounding counselor's competency related to skill acquisition when serving diverse populations, specifically in rural communities. In rural communities, counselors may have lower self- perceived MCC related to working with diverse people as there is limited exposure or presumably recognition of issues outside of the homogenous peoples of that particular area. Further, once practicing in rural communities, counselors receive less supervision and have fewer opportunities for professional consultation or continuing education, which further increases the knowledge/skill gap.

Additional research is needed to better understand the self-perceived competency of counselors working in rural communities compared to those practicing in more urban settings. This competency should be quantified to include measures of skill and action, which was explored by asking counselors'

about their work with diverse clients. Counselor characteristics such as gender and ethnicity were also examined, as these have been demonstrated by previous research as relevant to MCC (Chao & Nath, 2011(a), Chao, 2013(b); Constantine & Gushue 2003; D'Andrea & Heckman 2008).

CHAPTER 3

METHODOLOGY

This chapter outlines the research procedures and methods implemented to determine if there

are differences between counselors' self-perceived multicultural counseling competency (MCC) when

considering practice locations in rural, suburban, and urban communities. The purpose of the study and

research problem will be reviewed, followed by the study's research questions. A comprehensive

overview will be provided for sample selection and instrumentation utilized throughout the study.

Finally, the data collection process, data analyses, and conclusion of the study will be described.

The purpose of this study was to examine counselors' self-perceived multicultural counseling

competency (MCC) between counselors working in rural, suburban, and urban communities. A

feminist intersectional framework was used as a conceptual base to inform the research process. It is

through the feminist intersectional lens, lending particular focus to intersectionality, that attention can

be given to the political positionality acknowledging both perspectives of oppression and privilege.

These considerations influence counselor identity development as well as impact client outcomes

(Crethar & Winterowd, 2012). The framework of intersectionality invites "researchers to examine

categories of identity, difference, and disadvantage with a new lens" (Cole, 2009, p. 1).

The goal of this research study was to better understand self-perceived MCC of counselors

working in rural, suburban, and urban communities within Virginia. There is limited research on how

practice settings inform counselors' MCC, and no current research that compares the self-perceived

MCC of counselors in rural, suburban, and suburban settings. While the United States Census Bureau

suggests urbanization will continue, it is not the sole purpose of counselors to be all-knowing about

every culture when working with diverse identities. Rather, the foundational guiding principles of

counselors' professional identities calls for a willingness to learn, engage in consultation, and seek

training; therefore, more knowledge is needed about how counselors in communities with limited exposure to diverse identities perceive their abilities to competently work with diverse clients (ACA, 2014).

Participants for this study included registered members in the Virginia Counselors Association, Virginia School Counselors Association, and the Virginia Department of Health Professionals. The participants were administered an electronic survey including a demographic survey and a MCC assessment. MCC was measured using the MAKSS-CE-R (D'Andrea, Daniels, & Heck, 1991; Kim, Cartwright., Asay, and D'Andrea, 2003). The demographic survey collected information related to counselors' backgrounds, identities, relevant training, and experiences. This chapter outlines research questions, research design, sample selection, instrumentation, validity and reliability, data collection procedures, limitations to methodology, and data analysis.

Research Questions

The study of MCC was guided by the following research questions:

1. What are the differences in counselors' self-perceived MCC based on their practice location in rural, suburban, or urban communities?

2. What are the differences in counselors' self-perceived MCC based on area of origin (e.g. hometown or other location of significant influence) in rural, suburban, and urban communities?

3. Does a counselor's a) practice location, b) area of origin, c) gender identity, d) race/ethnicity, and e) number of racially/ethnically different clients served in the past year *predict* self-perceived MCC?

This chapter describes the methods used throughout this study to include: participant selection, research design, instrumentation, survey procedures, and data collection. A description of the data analysis procedures is also provided.

Research Design

A quantitative design was selected for this study due to the method's applicability for "identification of problems that influence outcomes", attention for generalizability from a sample to a population, and preference as a research method when collecting quantitative data using an instrument (Creswell, 2013, p. 4). Creswell further defines quantitative research as the study among variables, which allows for numbered data to be reviewed and analyzed. This study utilized survey research, which provides numeric information about a trend, attitude, or opinion of a population (Creswell, 2013). Lastly, the approach in this study is largely informed using deductive logic, guided from hypotheses, which is characteristic of quantitative research (Creswell, 2013).

Sample Selection

In order to be included in this study, participants had to meet certain selection criteria. The research sample consists of LPCs, school counselors, and residents in counseling practicing in Virginia. Virginia was selected for the sample as it has great diversity in terms of rural, suburban, and urban locations, with the northern Virginia DC metropolitan area being one of the most diverse regions in the United States (Morello, 2012). The sample participants provide mental health counseling in a variety of settings to include community, private and for-profit sectors, managed care organizations, k-12 schools, and academic universities. All participants were selected using convenience sampling from registered members in the Virginia Counseling Association, Virginia School Counselors Association, and the Virginia Department of Health Professionals.

Selection Criteria

All elected participants had a minimum of a master's degree in the field of counseling. Some participants held additional certifications and doctoral degrees. The criteria for participation in the study: (1) Participants must hold a master's degree in a counseling field, and (2) must be actively working with clients in a therapeutic relationship. The primary criterion was to be a professional counselor in the state of Virginia. This criterion is important as it requires a minimum of a master's level degree, which excludes counselors-in-training. The counseling field includes the following disciplines: counselor education, counseling psychology, clinical counseling, counseling and human services, marriage and family counseling, mental health counseling, substance abuse counseling, and school counseling. As the licensure standards vary across the United States for professional counselors, it was imperative to solicit participants from a state in which the requirements were uniform, as variations in counselor education training programs may account for counselor's perceived cultural competencies. Additionally, students who identified as counselors in-training were ineligible for the study, as the focus of this research was on practitioners in the field. Counselors serving in administrative roles who were only supervising professional counselors were ineligible for this study, as the focus of the research was on understanding perceived multicultural competency between counselors working in rural, suburban, and urban communities when serving diverse clients.

The sample for this study was obtained by reviewing participants' information obtained through the Virginia Counseling Association, Virginia School Counselor Association, and Virginia Department of Health Professionals, as the researchers is a professional member of the organizations. Participant names were collected using public member directories. Upon reviewing the names listed in the directories, for members who did not include email or contact information, a google search was performed in attempts to establish contact. It is important to note that the Virginia Counseling Association and Virginia School Counselor Association allows for student members, who may not yet

possess a master's degree. Therefore, participants in the study were further screened for meeting the criterion of holding a master's degree in a counselor education related field through the demographic survey, and excluded from the study if they did not meet the criterion. Each participant was screened using the skip logic criterion in Qualtrics; requirements were: (1) participants were required to be actively working with clients in a counselor-client relationship, and (2) any participants who were currently working in supervisory-only capacities were ineligible for the study. Participants were excluded from the sample if a) they were not actively working with clients, or b) were in solely supervisory/administrative roles within the counseling profession.

Power analysis for a priori ANOVA was conducted in G*Power to determine a sufficient sample size using an alpha of .05, a power of .95, a medium effect size (d=.15) F (3.03), and two-tail (Cohen, 2013). Based on the aforementioned assumptions, the desired sample size is 252. Power analysis for a multiple regression with four predictors was conducted in G*Power to determine a sufficient sample size using an alpha of 0.05, a power of 0.95, and a medium effect size (d=.15) F (2.44). Therefore, a sample size of 129 was desired.

Data Collection Procedures

The researcher requested member names provided through membership directories. Included in the participant information were the participant names of professional counselors, employment addresses, telephone numbers, email addresses and professional affiliations. Participants were sent an email invitation, with information pertaining to the study, and a link for completing the survey. Participants were notified that if 250 surveys are completed, a donation of $150 will be made to the Association for Multicultural Counseling and Development, to promote ongoing MCC research initiatives. The survey was administered using Qualtrics and was anticipated to take approximately 15 minutes to complete.

All research protocols were submitted, reviewed, and approved to the Virginia Tech Institutional Review Board (IRB). Upon IRB approval, the researcher emailed information to the selected participants. The researcher entered all survey data into Qualtrics, to include: the MAKSS-CE-R and demographic survey. Email reminders with the Qualtrics link survey were sent to encourage greater participation. The study was available for 30 days, and the researcher sent reminder emails on a bi-weekly basis (total of two), notifying participants of days remaining to participate in the study. Please see Appendix E for email notification to participants and Appendix F to review IRB approval.

Instrumentation

The current study used a survey design accompanied with the MAKSS-CE-R and a demographic survey to examine counselors' self-perceived multicultural competency between counselors working in rural, suburban, and urban communities. The information obtained from the study provides more research to better understand the self-perceived competency of counselors working in rural communities compared to those practicing in more urban settings. This competency was quantified to include measures of skill and action, which was explored by asking counselors' about their work with diverse clients

Demographic Survey

The demographic survey collected information related to counselors' identities and other demographic variables of interest (age, gender identity, race/ethnicity, years in field, etc.). Specific questions were included to collect information about professional setting (community mental health, school, profit/nonprofit) and geographical location. It is important to note that as race/ethnicity was used as an independent variable for multiple regression in research question 3, to provide rationale for the grouping. Based upon a 2015 study in which the U.S. Census Bureau contacted 1.2 million households, the study experimented with two ways of asking about race and ethnicity. In the first, race

and ethnicity were combined, and respondents could select one or multiple categories (U.S.Census

Bureau, 2015). In the second way, respondents were asked about race and ethnicity separately. The

results found that respondents reported more accurately when selecting a demographic when given the

combined option of race and ethnicity, as compared to when provided with separate categories of race

and ethnicity (U.S. Census Bureau, 2015). While there are challenges with comparing combined

demographics of race and ethnicity to previous research, a combined racial/ethnic category is provided

in the demographic survey, as it appears to be more congruent with the direction of the field in

inquiring about racial/ethnic identity using a culturally informed approach. The Demographic Survey

is located in Appendix A.

Multicultural Awareness, Knowledge, and Skills Survey-Counselor Edition-Revised (MAKSS-

CE-R)

MCC for this study was obtained from the MAKSS-CE-R. The MAKSS-CE-R was selected as

it offers subscales to measure awareness, knowledge, and skill that is reflective of the MCT model.

Additionally, permission to use the measure was obtained via email by Dr. Bryan Kim, in appendix C.

The MAKSS-CE-R (D'Andrea, Daniels, & Heck, 1991; Kim, Cartwright, Asay, and D'Andrea,

2003) was developed to assess counselor's effectiveness when working with culturally diverse clients.

The survey has been used in teaching, social work, and for counselors. In the current research study,

the MAKSS-CE-R was administered to measure counselor's perceived MCC, considering all three

domains of awareness, knowledge, and skills, related to their work with clients.

The MAKSS-CE was one of the first instruments based upon the three domains of competence

(awareness, knowledge, and skill), which closely followed the tenets outlined in Sue et al.'s (1982)

model of cross-cultural counseling (Kim et al., 2003). It consisted of 60 total items, which were evenly

distributed across three subscales consisting of 20 questions each. The measure was first revised using

confirmatory factor analyses specific to internal reliability and criterion-related validity measures to address the length of time that a counselor had worked with racial minorities (Kim et al., 2003). In the second study the psychometrics were revised, and the questions were limited to 33 questions, condensed from the original 60 question set.

The final MAKSS-CE-R 33 items self-assessment is divided into 3 subscales: 10 items provide information about counselor Awareness-R, 13 items provide information about counselor Knowledge-R, and 10 items provide a measure of multicultural counseling Skills-R. The assessment ranks responses using a 4-point Likert scales: 1- *Strongly Disagree* to 4 - *Strongly Agree*; 1 - *Very Limited* to 4 - *Very Aware*; and, 1 - *Very Limited* to 4 - *Very Good*. Higher scores on the total instrument and on the individual subscales indicate higher self-reported competency. The MAKSS-CE-R is located in Appendix B.

Awareness Subscale

The awareness subscale measures counselor's attitudes or beliefs about cultural diversity. It is calculated by adding participant responses, 1- *Strongly Disagree, 2-Disagree, 3-Agree, and 4- Strongly Agree,* using reverse score items 1, 2, 3, 4, 6, 8, and 9. After adding the scores, the sum of the scores from these items plus the scores from items 5, 7, and 10 provide an awareness subscale score. Sample questions from this subscale include: a) In counseling, clients from different ethnic/cultural backgrounds should be given the same treatment that White mainstream clients receive, and b) The criteria of self-awareness, self-fulfillment, and self-discovery are important measures in most counseling sessions. Further examples of the awareness subscale can be reviewed in Appendix B.

Knowledge Subscale

The knowledge subscale assesses a counselor's knowledge about their own culture, as well as their understanding of other's worldviews. Questions in this section are rated from, 1 - *Very Limited* to

4 - *Very Aware*; and, 1 - *Very Limited* to 4 - *Very Good.* To determine a subscale total, items 11-23 are added. The participant is asked, "at the present time, how would you rate your understanding of the following terms: ethnicity, culture, prejudice, racism, etc." Additional examples of the knowledge subscale can be reviewed in Appendix B.

Skill Subscale

The final subscale of skill is determined by assessing the counselors overall competence related to delivering culturally appropriate intervention and incorporation of the awareness and knowledge domains into practice. The subscale total is determined by summing items 24-33, with 1 - *Very Limited* to 4 - *Very Aware*; and, 1 - *Very Limited* to 4 - *Very Good* as the respondent options. A few sample questions from the skill subscale include: a) How well would you rate your ability to accurately assess the mental health needs of persons who come from very poor socioeconomic backgrounds, and b) How would you rate your ability to accurately assess the mental health needs of women? Additional examples of the skills subscale can be referenced in Appendix B.

In previous studies, the MAKSS-CE-R has been used as an instrument to measure MCC among counselors. In Anuar et al., (2016), the researchers administered the MAKSS-CE-R prior to implementing multicultural competency training. The MAKSS-CE-R, was again administered after completing the training to assess for increase in counselor MCC (Anuaret al., 2016). Similarly, Carwright et al. (2008) conducted a study which assessed for changes in MCC throughout the course of a semester with graduate students. Further information regarding these studies, can be found in the literature review in Chapter 2, (p.33-34).

MAKSS-CE-R – Reliability and Validity

Reliability measures indicated coefficient alphas of .71 for the 10-item awareness-R, .85 for the 13-item knowledge-R, and .87 for the 10 Skills-R domains with the full scale of .82 (Kim et al., 2003;

Hays, 2008). Construct validity was validated across similar multicultural competence measures

(MCKAS). Criterion-related validity was supported by comparing participants who had taken at least

one multicultural course and those who had not (Kim et al., 2003). A multivariate analysis of variance

was conducted with multicultural counseling coursework as the independent variable, and the three

subscales of knowledge, awareness, and skill as the dependent variables; the results yielded significant

multivariate effect in all domains except skills F (1, 307) = 1.53, p = .218; additionally, those

participants who had completed a minimum of one multicultural counseling course, also scored higher

on the MAKSS-CE-R (Kim et al., 2003).

Variable Selection

Variable selection for this study was driven by the items on demographics survey created by the

researcher and the MAKSS-CE-R. Demographic survey items were used to study results of the

MAKSS-CE R. Table 2 summarizes five items from the Demographics survey that were used as

demographics in this study.

Table 2

Demographic Survey Variables

Variable	Demographic Question
Practice location	What is your current practice setting? (1) rural, (2) suburban, (3) urban, (4) unsure
Area of origin	What type of community do you identify as your hometown? (1) rural, (2) suburban, (3) urban, (4) unsure
Gender identity	What gender identity do you most identify with? (1)female, (2) male, (3) transgender female, (4) transgender male, (5) gender expansive/fluid/non-conforming, (6) not listed, (7) prefer not to answer
Race/ethnicity	How do you describe yourself? (1) Asian, (2) Black, (3) Native Hawaiian or Pacific Islander,

	(4) Hispanic/Latino/or Spanish origin, (5) American Indian or Alaska Native, (6) White, (7) Multiethnic, (8) Choose not to respond
Approximate number of racially/ethnically different clients/students	Approximate number of past and current clients/students who were racially/ethnically different than you: (1) >5%, (2) 6-10%, (3) 11-20%, (4) 21-30%, (5)31-50%, (6) more than 50%

For example, one item on the survey asked participants, "What gender identity do you most identify with?" The response options were: female, male, transgender female, transgender male, gender expansive/fluid/non-conforming, not listed, and prefer not to answer. The researcher also reviewed each item on the MAKSS-CE-R to determine which items and subscales could be considered for this study. In some cases the response options for certain survey items required recoding to ensure accurate interpretation of the data. Therefore, in addition to the description of demographic items, Table 1 also includes an explanation of how response options were recoded, if recoding was necessary. The demographic survey which contains all variables measured is included in Appendix A.

Data Analysis

The data analysis for this study involved three steps: cleaning, recoding, and analyzing the data. The data analysis procedures for the study included descriptive statistics, analysis of variance (ANOVA, and linear regression. Descriptive statistics allow for analysis that help describe data sets, but that do not provide information about correlation or causation of a phenomenon (Howell, 2012). Measures such as central tendency or comparing the spread can be obtained through descriptive statistics. ANOVAs allow for inferences to be made about a data set as it compares the difference between two or more means (Howell, 2012). The researcher used SPSS, the Statistical Packages for the Social Sciences version 24 to analyze all collected data (IBM Corp, 2016).

Cleaning the Data

The initial step was cleaning the data. As part of the first step missing variables were accounted for. Responses that were incomplete were coded as "no response" to allow for ongoing analysis of the answered questions. All participants were anonymous, and therefore the study did not require any removal of identifying information. Additionally, the majority of all responses were multiple choices in both the demographic survey and MAKSS-CE-R. However, measures of mean, median, and mode were reviewed when evaluating questions 4 and 5 in the demographic survey, and also for the subscale and total MAKSS-CE-R score. Therefore, attention was given to significant outliers that were in the extremes of the distribution to determine if the data was skewed from remaining in the data set; for outliers in which the data was skewed, outliers were removed (Hellerstein, 2008).

Analyzing the Data

Data analysis was conducted to address the study's research questions. In the first research question, ANOVAs were used to compare the scores between counselors' MAKSS-CE-R total score and subscale scores of attitude, knowledge, and skill across the three geographic practice locations: rural, suburban, and urban communities. Subscales of the MAKSS-CE-R were included to examine differences between counselors' knowledge, awareness, and skill between the three types of practice locations. Power analysis for an a priori ANOVA was conducted in G*Power to determine a sufficient sample size using an alpha of .05, a power of .95, a medium effect size (d=.15) F (3.03), and two-tail (Cohen, 2013). Based on the aforementioned assumptions, the desired sample size was 252.

To address research question 2, ANOVA was used to identify relationships between a counselors' geographical area of origin (rural, suburban, urban) and MCC. Subscales of the MAKSS-CE-R were included to examine differences between counselors' knowledge, awareness, and skill between the three types of areas of origin. The priori power analysis for research question one is also

applicable for the ANOVA in research question two, demonstrating a desired sample size of 252.
(Refer to the above power analysis.)

The research suggests that ongoing learning must occur to continue building MCC (Radifah, 2011). The research also states that counselors practicing in rural areas may experience fewer opportunities for training, professional isolation, and limited supervision (Barth, Wildfire, & Green, 2006; Breen & Drew, 2012; Glasoff, Corey, & Herlihy, 2006). The dependent variable of MCC was compared to counselor's geographical area of origin, to determine if differences exist with awareness, knowledge, and skill.

To examine the counselor area of origin as it relates to MCC, the survey respondents were sorted into groups (rural, suburban, and urban). The mean score of MCC was then calculated for each group. ANOVA's were calculated to compare mean scores between the groups. If the results of the ANOVA revealed that there was a statistically significant difference in MCC ($p < .05$) between rural, suburban, and urban groups, then area of origin would later be included in multiple regression analysis. If the results of the one-way ANOVA test revealed that there was a significant difference ($p < .05$) between the mean scores, post hoc tests were conducted to determine where the differences in the mean scores occurred. If any pairs had a statistically significant relationship to MCC ($p < .05$), the statistically significant groups were then entered into a linear regression model. The same process was followed related to standard statistical assumptions of normality and homogeneity as defined with research question one.

To address research question 3, the researcher conducted a multiple regression, using the total summation of the MAKSS-CE-R (MCC) as the dependent variable, to compare five independent variables of a) practice location, b) area of origin, c) gender identity, d) counselor race/ethnicity, and e) number of racially/ethnically different clients served in past year. The independent variables used in

the regression analysis were obtained from the demographic survey items 8, 9, 11, and 12 (See

Appendix A). Area of origin was assessed by an item asking for counselors' description of the area in

which they grew up. Power analysis for a multiple regression with four predictors was conducted

in G*Power to determine a sufficient sample size using an alpha of 0.05, a power of 0.95, and a

medium effect size (d=.15) F (2.44). Therefore, a minimum sample size of 129 was used.

Multiple regression is the most appropriate test as it is commonly used for predictive analyses

(Preacher, Curan, & Bauer, 2006). The strength of the effect for multiple independent variables (a)

practice location, b) area of origin, c) gender identity, d) counselor race/ethnicity, and e) number of

racially/ethnically different clients served in past) are being compared to the dependent variable (MCC)

to determine causal factors.

 To examine the independent variables of a) counselor practice location, b) area of origin, c)

gender identity, d) counselor race/ethnicity, and e) number of racially/ethnically different clients served

in past year, as it correlates with the dependent variable of MCC, the survey respondents mean

MAKSS-CE-R total score was compared to each independent variable. If the results of the multiple

regression revealed that there was a statistically significant difference in MCC ($p < .05$) when

considering each independent variable (a) counselor practice locations, b) area of origin, c) gender

identity, d) counselor race/ethnicity, and e) number of racially/ethnically different clients served in

past), then that variable was kept as a predicting factor of MCC. Lastly, consideration was given to the

amount of variance, since adding independent variables will increase variance in multiple regressions.

Variance was reviewed using R-squared computation to minimize an over-fit model.

 It is important to note that the dependent variable is a scale score created from the total score on

the MAKSS-CE-R. Demographic characteristics that are known to influence multicultural competency

were analyzed to review RQ3. These characteristics included gender (Chao & Nath, 2011; D'Andrea &

Heckman, 2008), race/ethnicity (Chao & Nath, 2011; Chao,2013; Constantine & Gushue, 2003;

D'Andrea & Heckman, 2008) and MCC training (Anuar et al., 2016; Barden et al., 2017; Cartwright et

al., 2008; Chao & Nath, 2011; Holcomb-McCoy & Meyers, 1999).

To examine the role of gender as it relates to MCC, survey respondents were sorted into two

groups (male and female). The mean score on MCC for each group was then calculated. Then an

ANOVA to compare mean scores between the groups was conducted. An ANOVA is the appropriate

statistical test to determine if statistically significant differences exist between a continuous dependent

variable (MCC) and a dichotomous independent variable (gender) (Chao & Nath, 2011). If the results

of the ANOVA revealed that there was a statistically significant difference in MCC ($p < .05$) between

males and females, then gender would be included in multiple regression analysis. If the results of the

one-way ANOVA test revealed that there was a significant difference ($p < .05$) between the mean

scores, a post hoc test was completed to determine where the differences in the mean scores occurred.

The standard statistical assumptions of normality and homogeneity were evaluated. Normality

assumes the scores are normally distributed. Normality was assessed using the Shapiro-Wilks test. If

the Shapiro-Wilks test generated a p value that was greater than 0.05 the data were considered normally

distributed. Homogeneity assumes both groups have equal error variances. This assumption was

assessed using the Levene's test for the Equality of Error Variances. If the Levene's test generated a p

value that was greater than 0.05 the data were considered homogeneous. The same steps were followed

to test for statistical significance of study by race (white and non-white), gender identity (cisgender

male, cisgender female, or transgender/gender expansive), etc. The sample was divided into groups,

group mean scores were calculated for each group, and ANOVA was conducted to compare mean

scores ($p < .05$).

Summary

This chapter has provided an overview of the method for the current study. To participate in the study, participants were required to be actively working with clients in a counselor-client relationship, and any participants who were currently working in supervisory-only capacities were ineligible for the study. Participants were contacted by email to participate in the study. Information was provided about purpose and criterion of the study; an electronic link to complete an informational packet on Qualtrics was provided.

The survey packet included a demographic informational survey and the MAKSS-CE-R. The demographic informational survey collected information relevant to counselor's identities, practice settings, and experience. The MAKSS-CE-R (D'Andrea, Daniels, & Heck, 1991; Kim, Cartwright, Asay, and D'Andrea, 2003) is a 33-item survey that assesses a counselors' self-perceived awareness, knowledge, and skill with MCC.

ANOVAs were used to compare counselors in rural, suburban, and urban practice settings and MCC using the subscales of the MAKSS-CE-R. ANOVAs were also used to identify any relationship for counselors' area of origin (rural, suburban, or urban) and self-perceived MCC. A multiple regression analysis was performed to compare information obtained from the MAKSS-CE-R and independent variables including counselor's a) practice setting, b) area of origin, c) gender identity, d) race/ethnicity, and e) number of racially/ethnically diverse clients worked with in the past year, to better understand self-perceived MCC.

Chapter Four presents the results of the study for each of the three research questions. Chapter Five provides a discussion of the results, as well as implications for counselors, counselor educators, and supervisors. Implications regarding MCC for counselors serving clients in rural settings were given particular focus.

CHAPTER 4

RESULTS

The purpose of this study was to examine counselors' self-perceived multicultural counseling competency (MCC) between counselors working in rural, suburban, and urban communities. This chapter will provide the results from the study's research questions:

1. What are the differences in counselors' self-perceived MCC based on their practice location in rural, suburban, or urban communities?

2. What are the differences in counselors' self-perceived MCC based on area of origin (e.g. hometown or other location of significant influence) in rural, suburban, and urban communities?

3. Does a counselors' a) practice location, b) area of origin, c) gender identity, d) race/ethnicity, and e) number of racially/ethnically different clients served in the past year *predict* self-perceived MCC?

In this chapter, the researcher describes the sample then reports the results of the data analysis. Results are reported by research question.

Demographic Characteristics of Participants

Following the process outlined in Chapter Three, a total sample size of $N = 2,184$ was obtained. The sample for this study was obtained using membership directories from two professional counseling organizations of which the researcher is a member, the Virginia School Counseling Association and the Virginia Counselors Association. A total of 2,184 emails were sent to individuals with email addresses from the membership directories. Eighty email messages were returned back due to invalid addresses. The researcher received emails from two participants who declined to complete the survey because they

no longer met the criteria. One reminder email was sent to the initial subject pool two weeks apart.

After 30 days, the survey link was deactivated to prevent any additional responses.

The initial email invitation resulted in a total of 233 responses. A second reminder email was sent, and resulted in an additional nine respondents. The initial sample included a total of 242 respondents. Participants were excluded if they did not complete at least 98% of the survey, which was necessary to collect data to answer all three research questions. The criterion of 98% was established as this was the percentage of information required in the survey to answer all of the variables used in the analyses; any participants who did not complete 98% of the survey were removed from the sample. Of the eligible sample ($n = 2,184$), 242 started the survey for a response rate of 11%; however, only 166 participant responses are used in the analysis because they completed the items associated with the researcher's three research questions.

Participants answered all of the items on the MAKSS-CE-R instrument to accurately determine a total MCC score. In this study, 56 participants were removed because they stopped responding after completing the demographic portion. While these participant responses were excluded for this study, they may be used for future research.

The researcher included participants who did not respond to certain demographic items (i.e., age and year graduated) because these are not central to the present study. Examples of questions that were most commonly unanswered or were answered using vague responses were related to age, year graduated, and CACREP accreditation of master's or doctoral program. As an example, participants entered responses such as "50+" or left blank.

Additionally, many items in the survey provided open text boxes or allowed multiple responses in order to gather as much demographic information as possible. In one example, participants were asked to list all current licenses held. This demographic item was of interest to the researcher to

explore whether MCC skill is related to having more licenses held by the professional. However, the nature of these open-ended questions became problematic for analysis because some participant responses were inconsistent. Participants were asked in Item 15 of the demographic survey, "In the past year, approximately how many clients/students have you worked with who were racially/ethnically different than you?" This field was left as an open response, which resulted in participants providing both categorical (e.g. "10-20") and continuous (e.g. "18") variable data.

Participants also reported serving a wide number of clients who were racially/ethnically different from themselves (between 1 and 1600), oftentimes based on professional setting. A total of 132 participants responded to the question using numeric data. There were three participants who used a less than symbol (<) with a number (e.g. <10). Another four participants responded using a range such as 10-20. Thirteen participants responded with an approximate number followed by a plus sign (e.g. 100+). Five participants responded with percentages (such as "10%" and "50%"). Since participants were not asked how many total clients were served over the past year, there was no way for the researcher to make meaning of responses that contained percentages. Such cases were not included in the analysis. An additional 14 participants did not answer the question.

The information provided in Item 15 was crucial to answer research question 3. The researcher cleaned the data to utilize as many participant responses as possible for analysis. The researcher used a process of grouping individual responses to create response ranges. Participant responses that were given in categorical values were grouped with the corresponding recoded variable. Table 3 displays examples of participant responses and their recoded values.

Table 3

Demographic Survey Item 15: Recoded Values

Example Participant Responses	Recoded Variable
(a) None, >5	(1) >5
(b) <5, 6, 6+,6-10	(2) 6-10
(c) <10, 10+, 11, 11-20	(3) 11-20
(d) <20, 20+, 21, 21-40	(4) 21-40
(e) <40, 40+, 41, 41-60	(5) 41-60
(f) <60, 60+, 61, 61-100	(6) 61-100
(g) <101, 101+, 102, 101-250	(7) 101-250
(h) <250, 250+, 251, 251-500	(8) 251-500
(h) <500, 500+, 501, 501-2,000	(9) 501-2,000

Some participants skipped or did not respond to certain demographic questions. Examples of skipped items were related to the year of graduation ($n=7$), and age ($n=3$). As these variables were not required to answer the researcher's three questions related to this study, participants were not removed from the sample. Additional demographic information was collected that will not be used for the analysis of this study, but may be used in future research.

Description of the Sample

There were 242 initial respondents in this research sample. Of the 242 respondents, 13 did not actively work as a professional counselor with clients/students in a therapeutic relationship. Four respondents did not hold a minimum of a master's degree in a counseling related field. A total of 59 respondents completed between 2-31% of the survey, making their responses ineligible, as there were

not enough data points to address all three of the research study's questions. The final sample included

166 participants for the study.

The sample included Virginia professional counselors who possess a minimum of a master's

degree from the counseling field discipline, and are actively working with clients/students. The

majority of the sample identified as professional school counselors (60%). Licensed professional

counselors (LPC) made up 31.32% of the sample, and residents in counseling comprised 9% of the

sample. There were a total of 35 professionals who identified as a National Board Certified Counselor

(NBCC) and 31 participants held additional trainings and/or certifications. The sample had participants

who had graduated from their master's program between 1967 and 2018; of the sample, 29% graduated

from 2000-2010, and 47% graduated from 2011 to present. The participants indicated that 71%

graduated from a CACREP accredited master's program, and 7% graduated from a CACREP

accredited doctoral program.

The sample consisted of participants 22 years of age to 74 years of age. The gender identities

reported were female (n=86.14%), male (n=13.25%), and transgender male (.60%). The racial/ethnic

make-up of the study consisted of 3 Asian (1%), 26 Black (15%), 5 Hispanic (3%), 2 American Indian

(1%), 132 White (80%), and 1 Multi-ethnic participant.   No participants identified as Native Hawaiian

or Pacific Islander. The demographic characteristics of the sample are represented in Table 4.

Table 4

Demographic Characteristics of the Sample ($N = 166$)

Characteristic	n	%N
Gender Identity		
Men	22	13.25
Women	143	86.14
Transgender	1	.60

Race
White	132	80
Black	26	15
Hispanic	5	3
Asian	3	1
American Indian	2	1
Multi-ethnic	1	.6

Counselor Type
School Counselor	100	60
LPC	52	31.32
Other	14	8.68

CACREP
Master's Program	115	71
Doctoral Program	12	7

Practice Settings
Community-Based	39	26.89
In-patient	4	2.8
School	89	61.4
University counselor	4	2.8
University faculty	3	2.1
Other	6	4.15

Area of Origin
Rural	54	32.5
Suburban	78	47
Urban	34	20.5

Practice Location
Rural	54	32.5
Suburban	64	38.6
Urban	48	28.9

Professional counselors in the sample worked in a variety of settings to include: 39 community-based, four inpatient counselors, 89 school counselors, four university counselors, three university faculty, and six counselors who responded "Other." A primary area of focus of this study was counselor area of origin. Counselors were asked to identify the type of community where the majority

of time was spent growing up (i.e. hometown or other location of significant influence). The sample consisted of 54 counselors who identified their hometown as a rural community, 78 as a suburban community, and 34 as an urban community. Additionally, another area of focus was the counselor's current practice location where clients were served. Of the participants, 54 worked in a rural community, 64 in a suburban community, and 48 in an urban community. The demographics for counselors' area of origin and counselors' practice location are represented in Table 4.

The final demographic of interest related to the study examined how many clients a counselor had served within the past year that identified as racially or ethnically different than the counselor. The participants' responses are shown in Table 5.

Table 5

Racially/Ethnically Different Clients

Number of Clients	Participant Responses
(1) >5	12
(2) 6-10	7
(3) 11-20	18
(4) 21-40	21
(5) 41-60	16
(6) 61-100	26
(7) 101-250	29
(8) 251-500	18
(9) 501-2,000	2

Results of the Data Analysis

The data were analyzed to respond to the research questions central to this study. The analysis is based largely on responses to the Multicultural Awareness Knowledge Skills Survey Counselor Edition-Revised (MAKSS-CE-R) and the demographic survey. Higher total scores on the instrument and the individual subscales indicate higher self-reported MCC competency. For this study, the total MAKSS-CE-R score is used as the measure of MCC, along with the demographic survey. The total score of the MAKSS-CE-R was used to describe counselors' perceived awareness, knowledge, and skill when working with culturally diverse clients. The subscales of awareness, knowledge, and skill provide insight to the counselor's perceptions of ability related to specific domains.

The range within the subscales and total scores had noted spread within the data. This is important to consider as the spread in the participant scores varied, suggesting the mean values may not be representative of all participants. The MCC range, mean, and standard deviations for the total and subscales are shown in Table 6.

Table 6

MAKSS-CE-R Subscales and Total Score

MCC	Range	Mean (total; item)	Std. Dev
Knowledge	23-52	38.22; 3.19	6.39
Awareness	27-40	34.40; 3.44	3.37
Skill	19-40	29.61; 2.96	4.77
Total Scores	77-130	102.24; 3.2	12.44

As shown in Table 6, mean scores in some domains in this study were rated higher by participants than other studies in which the MAKSS-CE-R was used. In Anuar et al., (2016), the mean scores were used to pre and post intervention and were as follows: awareness (2.76, 3.25), knowledge (2.30; 3.06), and skill (2.32, 3.15). In this study, mean scores for awareness (3.44) and skill (2.96) were lower than the post- test score in Anuar et al., (2016). In Cartwright et al. (2008), counselors' self-perceived MCC and faculty observed MCC were compared using the MAKSS-CE-R. The counselor self-report scores were: awareness (M=55.87, SD=7.97), knowledge (M=49.63, SD=5.71), and skill (M=43.80, SD 7.56). This was significantly higher than the rating from faculty which were: awareness (M=32.56; SD=10.26), knowledge (M=29.22, SD=6.57), and skill (M=33.22, SD=8.79) (Cartwright et al., 2008). Interestingly in this study, the participants did not rate themselves as highly as the counselors in the Cartwright et al. (2008) study, but also not as low as the faculty did for the domains of both awareness and knowledge.

The first research question examined the extent to which practice location influences the MCC score. A one-way between subjects ANOVA was conducted to compare the effect of practice location on MCC for counselors in rural, suburban and urban communities. There was not a significant effect of the independent variable of practice location on the dependent variable of MCC at the $p < .05$ level for the three conditions ($F(2, 164) = .367, p > .05$). Additionally, the subscales of awareness [$F(2, 164) = .925, p => .05$], knowledge ($F(2,164) = .284, p > .05$), and skills ($F(2, 164) = .141, p > .05$) did not show significant interactions. Therefore, it was determined that counselor's practice location did not have a significant interaction with counselors' self- perceived MCC in this study.

Table 7

Counselor Practice Location ANOVA results using MAKSS-CE-R as criterion

Practice Location	Sum of Squares	*df*	Mean Square	*F*	Sig
Knowledge	23.453	2	11.727	.284	.753
Awareness	11.229	2	5.614	.925	.399
Skill	6.483	2	3.241	.141	.869

The researcher used a similar method to answer the second research question which addresses differences based on the counselor's area of origin. Again, the total MAKSS-CE-R score was used to examine counselor's perceived MCC. A one-way between subjects ANOVA was conducted to compare the effect of MCC on counselor's identified hometown of rural, suburban, or urban community. Again, there was not a significant effect of the independent variable of hometown on the dependent variable of MCC at the $p < .05$ level for the three conditions [$F(2,164) = .132$, $p = .877$]. Additionally, the subscales of awareness were [$F(2,164) = 1.013$, $p > .05$]; knowledge [$F(2,164) = .238$, $p > .05$]; and skills [$F(2,164) = .704$, $p > .05$]. Therefore, it was determined that no significant interaction was present between counselor's identified hometown and self-perceived MCC in this study.

Table 8

Counselor Area of Origin ANOVA results using MAKSS-CE-R as criterion

Area of Origin	Sum of Squares	*df*	Mean Square	*F*	Sig
Knowledge	19.615	2	9.807	.238	.789
Awareness	12.295	2	6.147	1.013	.365
Skill	32.170	2	16.085	.704	.496

For the final analysis, the researcher examined whether the variables of counselor's a) practice location, b) area of origin, c) gender identity, d) race/ethnicity and e) number of racially/ethnically different clients served in the past year could predict MAKSS-CE-R scores. Correlational and multiple regression analyses were calculated to predict the dependent variable of MCC with the independent variables of practice location (IV_1), area of origin (IV_2), gender (IV_3), race/ethnicity (IV_4), and racially/ethnically different clients served (IV_5). A multiple regression was conducted examining if counselor race /ethnicity was a predictor of counselor self-perceived MCC; findings suggest that counselor race/ethnicity accounted for 9.4% of the variance in counselor self-perceived MCC (R^2 =.094), which was significant, $F (5,140) =366.725, p < .05$). The independent variable of counselor race/ethnicity was the only significant predictor of MCC at the .003 level.

Table 9

Summary of Multiple Regression Analysis for Demographic Variables Predicting MCC ($N = X$)

| | Model 1 | | | |
Variable	*B*	*SE B*	*β*	Sig
(Constant)	102.838	5.822		.000
Practice Location	1.018	1.134	.077	.371
Area of Origin	-1.486	1.092	-.115	.176
Race	-2.365	.792	-.242	.003
Gender	-1.763	2.481	-.057	.478
DiffClients	-.012	.007	-.142	.085
R^2		.094		
F for change in R^2		2.900		

p<.05

Summary

This chapter included results from the participants for the MAKSS-CE-R, in a study examining perceived MCC among professional counselors in various practice settings and types of communities. Demographics of the respondents are included. Results suggest that counselors who practice in rural, suburban, and urban communities perceive their MCC comparably when working with culturally diverse clients. Based on the variation of responses in the demographic information, it is likely participants possess varying levels of competence, however as regression was not used for RQ1, the researcher was unable to determine if a relationship existed between practice location and how competent counselors perceive themselves to be. Results also revealed that there was no significant difference in counselors self-perceived MCC based on their area of origin/hometown (i.e. rural, suburban, or urban). Lastly, the demographic variables of practice location, counselor area of origin,

gender identity, and the amount of clients served who were racially/ethnically different did not predict a correlation with MCC. However, counselor's racial/ethnic identity did show significance for predicting MCC when working with culturally diverse clients at the $p < .05$ level. This finding further supports previous research validating counselor ethnicity as a predicting factor for MCC (Chao & Nath, 2011(a), Chao, 2013(b); Constantine & Gushue 2003; D'Andrea & Heckman 2008).

CHAPTER 5

DISCUSSION

This chapter provides discussion and implications about the results of the study. An overview

of the study and information about the significance of the topic is provided. Results of the research

questions are reviewed, discussion of the results is offered, and implications for professional

counselors, counselor educators, and supervisors are considered. Limitations of the study are described

along with recommendations for future research.

Overview of Results

The United States Current Population Report (2015) as well as other research (Colby & Ortman,

2015), suggest that by the year 2044 more than half of Americans will identify as belonging to a

minority group. This report identifies a significant increase in racial and ethnic diversity within the

U. S., which will be accompanied with various intersections of identity as society becomes more

diverse and expansive. The ongoing shift in national demographics has important implications for the

counseling field.

Professional counselors are governed by professional and educational organizations such as the

American Counseling Association (ACA) and the Council for Accreditation of Counseling and other

Related Educational Programs (CACREP), in addition to other federal and state bodies, regulating

ethical service delivery to clients. The ACA calls for professional counselors to possess, "cultural and

diversity awareness and knowledge about self and others, and how this awareness and knowledge are

applied effectively in practice with clients and client groups" (*ACA Code of Ethics*, 2014, p. 20). The

ACA Code of Ethics call for counselors to possess multicultural counseling competence (MCC), a set of

skills that is integrated into counselor training programs and is a requirement of continuing education

for licensed professionals. The rapid shift of the demographic make-up of the U. S. population, paired

with the increased awareness surrounding inclusion of multicultural competence within the profession, has sparked a renewed focus of examining counselor readiness and ability to serve diverse clients.

Currently, across the United States, there are varying licensure standards for professional counselors. At the time of this study, there is active research and advocacy occurring from the American Counseling Association (ACA), CACREP, and the Department of Defense (DoD) to standardize requirements in order to promote licensure portability and with specific focus on strengthening professional identity (Lawson, 2016). Due to the lack of standardization across counselor education programs and professional licensure, there are inevitable variations in the way programs prepare counselors-in-training (CIT), which result in variations in service delivery to clients when they become independent practicing professionals. This issue becomes further complex when counselors' practice locations (rural, suburban, and urban) are considered.

Rural communities often have less access to resources and limited interactions with culturally diverse peoples (Breen & Drew, 2012; Rollins, 2010). Therefore, counselors who practice in more rural or even some suburban areas may be less routinely exposed to diversity, when compared to counselors who practice in urban areas where the population make-up is more diverse. Rural counselors may also be more likely to experience "professional isolation" with regards to supervision, seeking training, and case consultation (Barth, Wildfire, & Green, 2006; Breen & Drew, 2012; Herlihy & Corey, 2006). Further, when considering exposure to various diverse populations, counselors in rural communities may have limited, if any, exposure to cultures that are different than their own. This is particularly troublesome as counselor education programs may vary in the way MCC curriculum is integrated. Counselors who return to communities that seems to be culturally homogenous post-graduation leaves counselors with limited understanding of MCC beyond textbook knowledge.

The purpose of this study was to examine counselors' self-perceived multicultural competency between counselors working in rural, suburban, and urban communities. The researcher examined whether a relationship existed between counselors' self-perceived MCC and practice location including rural, suburban, or urban communities. The study also examined if a relationship existed between counselors' self-perceived MCC and their area of origin (e.g. hometown or other location of significant influence) in rural, suburban, and urban communities. Lastly, the researcher examined if the variables of counselors' a) practice location, b) area of origin, c) gender identity, d) race/ethnicity, e) and number of racially/ethnically different clients served in the past year were predictors of counselors' self-perceived MCC.

Key Finding Research Question #1

Counselors were asked to identify the practice locations of rural, suburban, or urban in which they currently worked. A one-way between subjects ANOVA was conducted to compare the effect of practice location on MCC for counselors in rural, suburban and urban communities. The results suggested that there was no significant effect for counselors MCC regardless of practice location. This information is important for the field, as it suggests practice location may not have a relationship with counselors' self-perceived MCC. It is also noted in the research that in more rural communities, professional counselors have fewer opportunities for ongoing supervision, consultation, training, etc. (Breen & Drew, 2012); therefore, it should be noted that while counselors may not perceive their own MCC differently across practice location the supporting research suggests that there may be some challenges for ongoing professional development of counselors, which may therein increase biases.

Based upon the results of the study, there are additional considerations if indeed practice location is not related to counselor self-perceived MCC. Research by Breen & Drew (2012) discussed the challenges counselors experience in rural communities such as dual relationships and other research

has highlighted challenges for ongoing consult and supervision (Barth, Wildfire, & Green, 2006; Herlihy & Corey, 2006). Additional opportunities for professional consult or supervision could look like counselors reaching out to colleagues for support for client experiences they may not have had exposure previously, or even to process a challenging case. While these barriers may exist in rural communities, there were no statistical differences in self-perceived MCC for counselors in rural communities compared to those in suburban or urban communities. With this knowledge, there may be opportunities for counselors in rural communities, to employ innovative technology to continue supporting MCC development.   If practice location in rural, suburban, or urban communities does not significantly impact counselors' self-perceived MCC, then long-distance consulting, supervision, and/or professional development may be sufficient in supporting MCC.

Another consideration from the results of counselor practice location, is perhaps counselors have begun to embrace the ACA *Code of Ethics* (2014) related to working with culturally diverse populations, regardless of the cultural landscape of practice location. Many of the areas outlined in the *ACA Code of Ethics* address topics that intersect with sociopolitical issues that impact not only clients but also counselor beliefs and attitudes. While it may seem the ACA *Code of Ethics* (2014) would be sufficient for professionals to incorporate into their practice, these are merely best-practice recommendations and it is challenging to assess counselor adherence. Ultimately, counselors must be informed of the federal and state laws for their practice location as they can only be sanctioned on these violations. Therefore, the ACA *Code of Ethics* is intended as a guide for professional counselors. Unless a counselor is found to be in violation of federal or state laws, outside of reporting ethical violations to state licensure boards, there is minimal recourse for lack of adherence. Based on the findings of this study, if counselor practice location is not a barrier for self-perceived MCC, then it might also suggest that while federal and state laws may supersede the ACA *Code of Ethics* (2014),

many of the guidelines could be a strong enough influencer for counselors to incorporate MCC without mandates from state or federal oversight.

Key Finding Research Question #2

The results from this study suggest that there are no significant differences in counselors' self-perceived MCC based on area of origin (e.g. hometown or other location of significant influence) in rural, suburban, and urban communities. Previous research by Breen & Drew (2012) acknowledge the profession's need to prepare counselors who work in rural communities to understand the unique cultural attributes of those areas; however, the authors further suggest that counselors themselves may not be prepared for rural practice. In light of the suggestions from Breen & Drew (2012), it is interesting that the current study found no significant relationship between counselor area of origin (e.g. hometown or other location of significant influence) and self-perceived MCC. One would hope that this key finding may be an indicator that counselors are engaging in introspective training throughout their development, allowing self-exploration and gaining heightened awareness of their own cultural biases. From this finding, one might surmise that counselors are engaging in similar levels of cultural introspection regardless of their area of origin. Further it is possible that training programs, which ideally provide ample opportunities for self-reflection, are having a lasting impact regardless of the influence of a counselor's area of origin.

Key Finding Research Question # 3

Multiple regression analyses were calculated to predict the dependent variable of MCC with the independent variables of counselor's a) practice location, b) area of origin, c) gender, d) race/ethnicity, and e) racially/ethnically different clients served. The study found that the only significant factor in predicting counselor self-perceived MCC was counselor race/ethnicity. There may be several factors to consider with this result.

First, regarding counselor race/ethnicity, it is plausible that counselors who identify as part of a minoritized racial/ethnic identity may have shared lived experience with other diverse peoples and thus may have greater understanding. The power of the shared experience with others may provide stronger therapeutic working alliances and allow for greater insight to understand the client's experiences (Chao & Nath, 2011; Chao, 2013; Constantine et al., 2005; Middleton et al., 2005; Otavi et al., 1994). Additionally, it is possible that because of lived experience, counselors with culturally diverse backgrounds may have greater capacity for empathy for the experiences of their clients. As these counselors may have shared life experiences, they may also better understand the cultural stigmas and forms of institutional "isms" (racism, sexism, able-bodism, etc.) that are barriers for the client. Additionally, counselors who are also members of a minoritized population may better understand non-traditional communities of support such as neighborhoods, churches etc. that a counselor who does not have those experiences may not consider. This shared lived experience could create not only better understanding, but possibly increased level of MCC as well.

Another consideration worth mentioning is the variable of participant gender. In this study, gender was not predictive of counselor MCC as in other studies (Chao, 2008; Chao & Nath, 2011). This study included participants with gender identities reported as female ($n = x$, 86.14%), male ($n = y$, 13.25%), and transgender male ($n = 1$, 0.6%). The majority of participants listed themselves as cisgender females, which may impact the representation of the sample. From a feminist intersectional framework, this breakdown in counselor population may be representative of the counseling profession; however the voice of the minority may be lost by the volume of the majority. It is possible that using a study using qualitative methods to better understand the experiences of counselors who do not identify as cisgender females, would provide additional findings related to gender.

Additional Findings

When considering levels of counselor education and professional experience, it is important to highlight that the majority of the participants practice as school counselors (60%). It is unclear to the researcher if counselors' self-perceived MCC could be higher based on practice setting for school counselors compared to counselors in a community setting. It is possible that school counselors are likely to work with a more diverse student population than community-based practitioners simply based on the larger case sizes of average 250-500 cases that school counselors carry during an academic year. The exposure to increased cultural diversity could be attributed to the statistically increased diversity in the demographic make-up, which is most likely to be accounted for in the children demographic. This was explained in the United States Current Population Report (2015) which highlights that by the year 2044 more than half of Americans will identify in a minority group.

Another consideration for the study is related to the subscales of the MAKSS-CE-R of awareness, knowledge, and skill. Research supports that counselors tend to perceive themselves as having greater competence in the domains of awareness and knowledge when working with diverse people compared to competence in skills (Arredondo et al., 1996; Barden et. al 2015, 2017; Holcomb-McCoy et. al, 1999; Malott & Schaefle, 2015; Ratts, 2011; Sue et al., 1992a, 1992b). This study yielded similar results when measuring counselors' self-perceived MCC, which included subscale scores of Awareness ($M=34.40$, $SD=3.37$), Knowledge ($M=38.22$, $SD=6.39$), and Skill ($M=29.61$, $SD=4.77$).

It may be possible that counselors naturally rate themselves as more competent with domains such as awareness and knowledge as these are areas most commonly focused on in training programs. Counselor education programs that are accredited by CACREP are required to infuse MCC topics into coursework. However, it is less certain how counselor education programs are infusing MCC skill into their curriculum. This may be further compounded for skills such as MCC since it is more difficult to

objectively measure. Therefore, it is possible that the reason the skill domain is often rated as lower by counselors is related to programs not offering focus on skill attainment during training programs, and licensure supervisors not having objective measures to assess for skill.

Counselors may be able to effectively increase MCC awareness and knowledge through training, whereas the development of MCC skills occurs over time as they gain experience, regardless of exposure to people from culturally diverse backgrounds.

Implications

There are various implications throughout this study that inform future research, training, and considerations for counselor educators, counselor supervisors, and practitioners. As a profession, counseling is in the midst of a substantial transformation, with growing support for the infusion of social justice into work with clients (ACA, 2014; Ratts, 2009, Ratts et al., 2016). This transformation is a professional calling to include social justice perspectives in counseling theories, classroom instruction, supervision, in work with clients, and training/professional development. Ratts (2009) states "a social justice counseling approach uses social justice advocacy and activism as a means to address inequitable social, political, and economic conditions that impede on the academic, career, and personal/social development of individuals, families, and communities. The belief is that social justice advocacy is a necessary step to address issues of equity for those who have been marginalized in society." Therefore, building upon Ratts (2009), one may make the connection that social justice is intricately intertwined with MCC as counselors must first be multiculturally competent to become social justice advocates.

MCC has been studied throughout the professional literature. Much like the MAKSS research suggests, counselors commonly have greater self-perceived competence in the areas of knowledge and awareness than in the area of skill; yet there is still work to be done related to understanding counselor

MCC to address the social justice component as Ratts (2009; Ratts et al., 2016) describes. As this study was conducted using the perspective of multicultural counseling theory (MCT) with a feminist intersectional lens, it is imperative to address opportunities for social justice related to counselors' self-perceived MCC when working with diverse clients.

It appears that professional counselors perceive themselves as having awareness and knowledge for MCC, with a need to further develop skills for MCC. Considering this, the concept of deliberate practice offers some possibilities (Ericsson et al., 1993; Ericsson, 2006; Krampe & Ericsson, 1996). Deliberate practice is described as "the individualized training activities specially designed by a coach or teacher to improve specific aspects of an individual's performance through repetition and successive refinement" (Ericsson & Lehmann, 1996, pp. 278–279). The use of deliberate practice challenges the notion that the longer something is done, a person can obtain mastery; rather it stresses that through the use of repetition, modeling, coaching, and performance feedback a person can obtain a skill. The art of deliberate practice is studied across professional disciplines to include sports, medicine, chess (Ericsson & Pool, 2016), and is also gaining traction within mental health disciplines (Miller, Hubble, Chow, & Seidel, 2013; Duncan, Miller, & Hubble, 2007). More specifically, deliberate practice studies suggest it is an effective intervention to improve client outcomes, supervision, and training (e.g., Chow et al., 2015; Rousmaniere, Goodyear, Miller, & Wampold, 2017; Tracey, Wampold, Lichtenberg, & Goodyear, 2014).

Deliberate practice is an important consideration when reviewing self-perceived MCC in counselors. In this study, the participants responded in a similar trend as other research studies, rating themselves as better prepared with the domains of awareness and knowledge for MCC, rather than skill. This is an important finding as it suggests counselor education programs and entities responsible for state and/or organizational licensure are preparing professional counselors to feel equipped with

awareness and knowledge when working with diverse populations. However, as discussed in the literature review, currently counselor preparation with regard to MCC may vary state to state because there is no parity for training or licensure among licensed professional counselors across the United States. Therefore, counselors receive a variation of preparation related to MCC, and outside of the ACA *Code of Ethics* (2014), there are no entities to truly measure or ensure counselor competence to serve diverse clients. It then becomes the professional responsibility of counselors to not only seek opportunities to further develop MCC skill, but to also engage in ongoing professional development such as deliberate practice to master the skills required.

Research

This study focused on professional counselors who were actively working with clients. The information gathered was from the perspective of the counselor using the MAKSS-CE-R, which is a self-report measure of MCC. Currently, there is no research that compares counselors' self-perceived MCC to clients' perceptions of the counselor's MCC. The literature and results from this study suggest that counselors perceive themselves as having greater MCC knowledge and awareness than MCC skill. It is plausible that respondents in this study rated their own MCC levels as higher than their client may have rated them. Additional research is needed to examine counselor's self-reported MCC and the client's perception of counselor MCC.

Training

Currently, the standards for CACREP-accredited programs require students to engage in curricula that focus on tenets of multicultural competence –theoretical models, cultural identity development, and social justice advocacy (CACREP, 2016). Likewise, the *ACA Code of Ethics* (2014) outlines requirements for the counseling profession related to cultural diversity competency. Research suggests training programs and professional development experiences often provide opportunities for

increasing cultural awareness both of the counselor and that of the client, but less focus has been given

to skill development (Garten, 2015; Hill, 2013). Lastly, counselor education programs are currently not

standardized, making it nearly impossible to ensure counselors-in-training receive the same level or

amount of MCC training.

Standardized training is needed across counselor education programs. The profession has

identified standards that are effective in addressing counselor awareness and knowledge of MCC

topics; however, targeted training for skill development is needed (Anuar et. al, 2016). Therefore, the

same standards should be implemented for licensed professionals to continue measuring all domains of

MCC, but particularly skill development as part of continuing education.

Counselor Educators

Counselor educators aim to offer meaningful classroom instruction opportunities that are

encouraging safe environments to process personally challenging topics and confront any cultural

biases held by counselors-in-training. However, more is needed to continue building student MCC

outside of increasing self-awareness and providing textbook knowledge. Research on deliberate

practice offers a promising alternative. Counselor educators could offer feedback using strategies such

as deliberate practice with a specific focus on CITs skill related to working with cultural diversity.

Additionally, counselor educators could use of evidenced based tools to provide counselor trainees with

feedback and limit the use of subjective measures to evaluate students, which may be susceptible to

instructor biases. Inclusion of standardized and measurable tools for feedback paired with creating

opportunities for students to receive feedback from clients specifically about their MCC, could

significantly improve CITs' skill levels.

Supervisors

Supervision is an essential component of counselor's ongoing development, both as a novice counselor and as a seasoned licensed professional. Therefore, it is imperative for supervisors to include not only process oriented interventions related to MCC, but to also observe and evaluate their supervisees' skill levels. Clinical supervisors should aim to provide feedback not only about the counselor's MCC skill, but also elicit feedback from the supervisee about their own skill related to MCC within the supervisory working relationship. This could be impactful for the supervisory working alliance, as the supervisor may also have preconceived biases related to their own MCC. Incorporation of this deliberate practice strategy could create parallel process for CIT for how to demonstrate the same MCC with their clients.

Counselors

Counselors have a significant responsibility to their clients to provide culturally competent services. The findings of this study suggest that neither practice location nor counselor area of origin (e.g. hometown) is predictive of counselor's self-perceived MCC. This is a key finding for counselors as it suggests that while the research indicates counselors in more rural communities experience phenomena such as professional isolation, fewer opportunities for professional development, and limited ability to seek consult (Breen & Drew, 2012), these experiences do not predict a counselor's self-perceived competence when working with diverse clients. This is significant as it suggests that perhaps education obtained via technology, attending live trainings, or even the information absorbed while completing one's master's degree could have enough of an impact to support counselors' MCC when they come from rural areas or practice in rural locations.

However, it is important for counselors and CITs to seek professional development opportunities to build competency in all three domains of MCC (knowledge, awareness, and skill). It is also important for counselors to recognize that MCC is fluid and ever-evolving; counselors must not

assume that amount of time in the field is commensurate with skill attainment for MCC. Rather, counselors should be constantly evaluating their own MCC by checking their own biases, attending ongoing professional development opportunities specific to topics of cultural diversity, and seeking regular feedback from clients on their cultural competence and efficacy using multiple measures (e.g. client satisfaction surveys, informal dialogue, peer consult, ongoing supervision, etc.).

Another key take-away for counselors is related to race/ethnicity. The results from this study were similar to other studies (Chao & Nath, 2011; 2013; Constantine et al., 2005; Middleton et al., 2005; Otavi et al., 1994), suggesting that counselor race/ethnicity predicts higher levels of self-perceived MCC. Therefore, it is important for practitioners to have this awareness when working with clients, as it could have implications for the therapeutic working alliance. As explicated previously, counselors may be more understanding or even have greater capacity for empathy, based on sharing similar life experiences related to identifying as part of a minoritized group.

Limitations

This study relied on self-report data from counselors in Virginia, using contacts obtained through professional data bases. There are inherent fallacies such as social desirability effects and lack of awareness with participant self-report surveys, which must be considered. It is also plausible to consider that most of the participants could have already been counselors with high MCC, as counselors with lower self-perceived MCC may not avail themselves to participate in studies such as these, since it is such a significant requirement of the profession. Completing surveys for studies that are evaluating MCC when a counselor may already perceive their own MCC as low could create additional emotional strain and therefore, a respondent may have avoided participation. Additionally, it is important to note that due to the format of Qualtrics and the questions used in the survey, some respondents did not answer questions in a consistent format. The researcher had to recode several

variables in attempts to best understand the data, which may have limited the analyses. Additionally, for the research questions inquiring about rural, suburban, and urban communities, participants were not asked to name the specific location; therefore, the practice setting and area of origin information was based on the respondent's perspective, which could have created some discrepancy based on perception. For example, there are some communities that are fairly isolated and may be perceived as rural, but based on the U. S. Census Bureau's definition of rural by population, the area may be classified as suburban.

Professional counselors who participated in this study indicated that there was no significant difference in practice setting or area of origin, in counselors self-perceived MCC. Additionally, it is important to acknowledge that the study was based only on the responses of Virginia counselors, and therefore may not be generalizable to other states based on various considerations such as policy, number of in-state CACREP programs, licensure requirements, etc. However, the study did support counselors perceived themselves as having more MCC related to topics of awareness and knowledge when working with diverse populations, and indicated less perceived MCC with actual skill. This study focused on counselor's self-report of their own MCC when working with diverse clients. One of the most significant limitations is that the study did not allow for any client ratings related to counselor MCC. Therefore, counselors in this study may have perceived themselves as possessing MCC although they had minimal training and/or exposure to diverse populations. Additionally, even with significant training or exposure, clients still may not perceive a counselor as displaying MCC in the way that the ACA *Code of Ethics* (2014) calls upon counselors to provide.

Conclusion

The researcher of this study examined counselors' self-perceived MCC when working with culturally diverse clients. The purpose of this study was to examine counselors' self-perceived MCC

among counselors working in rural, suburban, and urban communities. There were no statistically significant differences between counselors' self-perceived MCC based upon practice location of rural, suburban, or urban community. Counselors also did not indicate significant variation of MCC based on their area of origin (e.g. hometown or other location of significant influence) in rural, suburban, and urban communities. Lastly, counselor race/ethnicity was predictive of counselors' self-perceived MCC.

The results of this study are helpful in contributing to the professional literature surrounding counselor MCC; however, additional research is needed. As the United States census continues to be more diverse and expansive, the field of counselor education must develop evidenced-based tools for measuring MCC, outside of self-report. Even though self-reported knowledge and awareness show a positive trend in MCC, counselors continue to report lower levels of self-perceived skill competency. Additional training focused on MCC skill competencies should be considered for CITs and professional counselors. Finally, in future studies of MCC, it would be beneficial to develop ways to assess clients' perceptions of counselor MCC. This knowledge would yield important insights that could be incorporated into counselor education programs as well as continuing education and training in counseling settings.

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Appendix A

PROFESSIONAL COUNSELORS SELF-PERCEIVED MULTICULTURAL COUNSELING COMPETENCY

Q54 This survey is intended to gather information on the educational needs of professional counselors, and is designed for counselors practicing in the state of Virginia. The data gathered from this survey will be used to contribute to the professional literature by identifying training and/or knowledge gaps surrounding issues of cultural diversity. Information will be protected through standards set by the Virginia Tech Institutional Review Board requirements. The survey includes 47 questions and should take 15 minutes to complete. If the study receives 250 responses, a donation will be made to the Association of Multicultural Counseling and Development in the amount of $150. Please contact the researcher with questions at *cjames1@vt.edu*.
  By clicking "yes" below, you consent to participate in this study.

○ Yes, I consent to participate in the research study (1)

○ No, I do not consent to participate in the research study (2)

Skip To: Q51 If This survey is intended to gather information on the educational needs of professional counselors... = No, I do not consent to participate in the research study

---

Page Break ——

Q50 **This survey is designed to obtain information on the educational needs of counselors.**

In the following section, you will find a demographic survey. The survey is confidential and anonymous. Please answer each of the questions, selecting the most accurate choice. The survey should take 15 minutes for completion. Thank you for your participation!

Page Break

Q1 Do you work as a professional counselor, in any setting, and actively work with clients/students in a therapeutic relationship?

○ Yes (1)

○ No (2)

Q2 What is your age?

_____

Q3 Please select your highest level of education:

○ Master's degree in a counseling field (counselor education, counseling psychology, marriage and family counseling, substance abuse counseling, clinical counseling, or mental health counseling) (1)

○ Doctoral degree in a counseling field (counselor education, counseling psychology, marriage and family counseling, substance abuse counseling, clinical counseling, or mental health counseling) (2)

○ Other (3) _____

Q4 What year did you complete your master's level training?
_____

Q5 Please indicate the CACREP-accreditation status of your graduate program(s) Check all that apply:

☐ Master's program was CACREP-accredited (1)

☐ Master's program was not CACREP-accredited (2)

☐ I am unsure of the accreditation status of my graduate master's program (3)

☐ Doctoral program was CACREP-accredited (4)

☐ Doctoral program was not CACREP-accredited (5)

☐ I am unsure of the accreditation status of my graduate doctoral program (6)

Q6 What is your current licensure and certification status (select all that apply):

☐ Licensed Professional Counselor (LPC) (1)

☐ LPC-in-residence (working toward LPC licensure in VA) (2)

☐ Professional School Counselor (3)

☐ National Board Certified Counselor (NBCC) (4)

☐ Licensed Substance Abuse Treatment Practitioner (LSAT-P) (5)

☐ Licensed Marriage and Family Therapist (LMFT) (6)

☐ Describe any additional licensure, certifications, and/or specializations (7)

_____

Q7 What is your current practice setting? Select all that apply:

☐ Community (agency, community services board, private practice, etc.) (1)

☐ Inpatient Treatment (hospital, residential, group home, etc.) (2)

☐ K-12 school (3)

☐ University/College counseling and/or student services (4)

☐ University/College faculty member in counseling field (6)

☐ Other (5) _____

Q8 What type of community do you work in? (if unsure, select your best estimate)

○ Rural (geographical areas or communities that have a density of 15 to 50 people per square mile, and total town populations of 2500 or less) (1)

○ Suburban (type of urban community, and includes a population of 2500-50,000) (2)

○ Urban (geographical area or community with populations of 50,000 or more people) (3)

Q9 In what type of community did you spend the majority of your time growing up? (e.g. hometown or other location of influence) (If unsure, select your best estimate.)

○ Rural (geographical areas or communities that have a density of 15 to 50 people per square mile, and total town populations of 2500 or less) (1)

○ Suburban (type of urban community, and includes a population of 2500-50,000) (2)

○ Urban (geographical area or community with populations of 50,000 or more people) (3)

Q10 How would you describe yourself? Select as many as apply:

☐ Asian (including: Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, etc.) (1)

☐ Black (including: African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.) (2)

☐ Native Hawaiian or Pacific Islander (including: Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.) (3)

☐ Hispanic/Latino/or Spanish origin (including: Mexican, Mexican American, Puerto Rican, Cuban, Salvadoran, Columbian, etc.) (4)

☐ American Indian or Alaska Native (including: Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, etc.) (5)

☐ White (including: German, Irish, English, Italian, Lebanese, Egyptian, etc) (6)

☐ Multi-ethnic or multiracial (7)

☐ Choose not to respond (8)

Q11 What gender identity do you most identify with?

○ Woman (1)

○ Man (2)

○ Transgender woman (3)

○ Transgender man (4)

○ Gender Expansive/Fluid/Non-Conforming (5)

○ Not Listed (6)

○ Prefer not to answer (7)

Q12 What is your current employment status? Check as many as apply:

☐ Employed full time (40 or more hours per week) (1)

☐ Employed part time (up to 39 hours per week) (2)

☐ Student (3)

☐ Retired (4)

☐ Self-employed (5)

Q13 Approximately how many years of experience have you had working with clients/students who were racially/ethnically different from you?

_____

Q14 In the past year, approximately how many clients/students have you worked with who were racially/ethnically different than you?

_____

Page Break

Below you will find a list of statements and/or questions related to a variety of issues in the field of multicultural counseling. Please read each statement/question carefully. From the available choices, circle the one that best fits your reaction to each statement/question. Thank you for your participation!

Q15 Promoting a client's sense of psychological independence is usually a safe goal to strive for in most counseling situations.

○ Strongly Disagree (1)

○ Disagree (2)

○ Agree (3)

○ Strongly Agree (4)

Q16 Even in multicultural counseling situations, basic implicit concepts such as "fairness" and "health", are not difficult to understand.

○ Strongly Disagree (1)

○ Disagree (2)

○ Agree (3)

○ Strongly Agree (4)

Q17 How would you react to the following statement? In general, counseling services should be directed toward assisting clients to adjust to stressful environmental situations.

○ Strongly Disagree (1)

○ Disagree (2)

○ Agree (3)

○ Strongly Agree (4)

Q18 While a person's natural support system (i.e., family, friends, etc.) plays an important role during a period of personal crisis, formal counseling services tend to result in more constructive outcomes

○ Strongly Disagree (1)

○ Disagree (2)

○ Agree (3)

○ Strongly Agree (4)

Q19 The human service professions, especially counseling and clinical psychology, have failed to meet the mental health needs of ethnic minorities.

○ Strongly Disagree (1)

○ Disagree (2)

○ Agree (3)

○ Strongly Agree (4)

Q20 The effectiveness and legitimacy of the counseling profession would be enhanced if counselors consciously supported universal definitions of normality.

○ Strongly Disagree (1)

○ Disagree (2)

○ Agree (3)

○ Strongly Agree (4)

Q21 Racial and ethnic persons are under-represented in clinical and counseling psychology.

○ Strongly Disagree (1)

○ Disagree (2)

○ Agree (3)

○ Strongly Agree (4)

Q22 In counseling, clients from different ethnic/cultural backgrounds should be given the same treatment that White mainstream clients receive.

○ Strongly Disagree (1)

○ Disagree (2)

○ Agree (3)

○ Strongly Agree (4)

Q23 The criteria of self-awareness, self-fulfillment, and self-discovery are important measures in most counseling sessions.

○ Strongly Disagree (1)

○ Disagree (2)

○ Agree (3)

○ Strongly Agree (4)

Q24 The difficulty with the concept of "integration" is its implicit bias in favor of the dominant culture.

○ Strongly Disagree (1)

○ Disagree (2)

○ Agree (3)

○ Strongly Agree (4)

Q25 At the present time, how would you rate your understanding of the following term: **ETHNICITY**

○ Very Limited (1)

○ Limited (2)

○ Good (3)

○ Very Good (4)

Q26 At the present time, how would you rate your understanding of the following term: **CULTURE**

○ Very Limited (1)

○ Limited (2)

○ Good (3)

○ Very Good (4)

Q27 At the present time, how would you rate your understanding of the following term:
MULTICULTURAL

○ Very Limited (1)

○ Limited (2)

○ Good (3)

○ Very Good (4)

Q28 At the present time, how would you rate your understanding of the following term: **PREJUDICE**

○ Very Limited (1)

○ Limited (2)

○ Good (3)

○ Very Good (4)

Q29 At the present time, how would you rate your understanding of the following term: **RACISM**

○ Very Limited (1)

○ Limited (2)

○ Good (3)

○ Very Good (4)

Q30 At the present time, how would you rate your understanding of the following term:
TRANSCULTURAL

○ Very Limited (1)

○ Limited (2)

○ Good (3)

○ Very Good (4)

Q31 At the present time, how would you rate your understanding of the following term: **PLURALISM**

○ Very Limited (1)

○ Limited (2)

○ Good (3)

○ Very Good (4)

Q32 At the present time, how would you rate your understanding of the following term:
MAINSTREAMING

    ○ Very Limited (1)

    ○ Limited (2)

    ○ Good (3)

    ○ Very Good (4)

Q33 At the present time, how would you rate your understanding of the following term: **CULTURAL ENCAPSULATION**

    ○ Very Limited (1)

    ○ Limited (2)

    ○ Good (3)

    ○ Very Good (4)

Q34 At the present time, how would you rate your understanding of the following term: **CONTACT HYPOTHESIS**

    ○ Very Limited (1)

    ○ Limited (2)

    ○ Good (3)

    ○ Very Good (4)

Q35 At this point in your life, how would you rate your understanding of the impact of the way you think and act when interacting with persons of different cultural backgrounds?

○ Very Limited (1)

○ Limited (2)

○ Fairly Aware (3)

○ Very Aware (4)

Q36 At this time in your life, how would you rate yourself in terms of understanding how your cultural background has influenced the way you think and act?

○ Very Limited (1)

○ Limited (2)

○ Fairly Aware (3)

○ Very Aware (4)

Q37 How well do you think you could distinguish "intentional" from "accidental" communication signals in a multicultural counseling situation?

○ Very Limited (1)

○ Limited (2)

○ Good (3)

○ Very Good (4)

Q38 How would you rate your ability to effectively consult with another mental health professional concerning the mental health needs of a client whose cultural background is significantly different from your own?

○ Very Limited (1)

○ Limited (2)

○ Good (3)

○ Very Good (4)

Q39 How well would you rate your ability to accurately assess the mental health needs of lesbian women?

○ Very Limited (1)

○ Limited (2)

○ Good (3)

○ Very Good (4)

Q40 How well would you rate your ability to accurately assess the mental health needs of older adults?

○ Very Limited (1)

○ Limited (2)

○ Good (3)

○ Very Good (4)

Q41 How well would you rate your ability to accurately assess the mental health needs of gay men?

○ Very Limited (1)

○ Limited (2)

○ Good (3)

○ Very Good (4)

Q42 How well would you rate your ability to accurately assess the mental health needs of persons who come from very poor socioeconomic backgrounds?

○ Very Limited (1)

○ Limited (2)

○ Good (3)

○ Very Good (4)

Q43 How would you rate your ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons from different cultural/racial/ethnic backgrounds?

○ Very Limited (1)

○ Limited (2)

○ Good (3)

○ Very Good (4)

Q44 How would you rate your ability to accurately assess the mental health needs of men?

○ Very Limited (1)

○ Limited (2)

○ Good (3)

○ Very Good (4)

Q45 How well would you rate your ability to accurately assess the mental health needs of individuals with disabilities?

○ Very Limited (1)

○ Limited (2)

○ Good (3)

○ Very Good (4)

Q46 How would you rate your ability to effectively secure information and resources to better serve culturally different clients?

○ Very Limited (1)

○ Limited (2)

○ Good (3)

○ Very Good (4)

Q47 How would you rate your ability to accurately assess the mental health needs of women?

○ Very Limited (1)

○ Limited (2)

○ Good (3)

○ Very Good (4)

Page Break

Q51

You have successfully completed the survey. If the study receives 250 responses, a donation will be made to the Association of Multicultural Counseling and Development in the amount of $150.

If you have any additional questions, please send an email to: cjames1@vt.edu.

Thank you for your participation!

End of Block: Default Question Block

Appendix B

Multicultural Awareness, Knowledge, and Skills Survey – Counselor Edition - Revised (MAKSS-CE-R)

Bryan S. K. Kim
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Before the MAKSS-CE-R is copied or distributed, permission must be obtained from one of these authors:

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Multicultural Awareness, Knowledge, and Skills Survey – Counselor Edition – REVISED

This survey is designed to obtain information on the educational needs of counselors.

Below you will find a list of statements and/or questions related to a variety of issues in the field of multicultural counseling. Please read each statement/question carefully. From the available choices, circle the one that best fits your reaction to each statement/question. Thank you for your participation.

1.

1.   Promoting a client's sense of psychological independence is usually a safe goal to strive for in most counseling situations.

Strongly Disagree Disagree Agree Strongly Agree

2.   Even in multicultural counseling situations, basic implicit concepts such as "fairness" and "health", are not difficult to understand.

Strongly Disagree Disagree Agree Strongly Agree

3.   How would you react to the following statement? In general, counseling services should be directed toward assisting clients to adjust to stressful environmental situations.

Strongly Disagree Disagree Agree Strongly Agree

4.   While a person's natural support system (i.e., family, friends, etc.) plays an important role during a period of personal crisis, formal counseling services tend to result in more constructive outcomes.

Strongly Disagree Disagree Agree Strongly Agree

5.   The human service professions, especially counseling and clinical psychology, have failed to meet the mental health needs of ethnic minorities.

Strongly Disagree Disagree Agree Strongly Agree

6.   The effectiveness and legitimacy of the counseling profession would be enhanced if counselors consciously supported universal definitions of normality.

Strongly Disagree Disagree Agree Strongly Agree

7.   Racial and ethnic persons are under-represented in clinical and counseling psychology.

Strongly Disagree Disagree Agree Strongly Agree

8.   In counseling, clients from different ethnic/cultural backgrounds should be given the same treatment that White mainstream clients receive.

Strongly Disagree Disagree Agree Strongly Agree

9.   The criteria of self-awareness, self-fulfillment, and self-discovery are important measures in most counseling sessions.

Strongly Disagree Disagree Agree Strongly Agree

10. The difficulty with the concept of "integration" is its implicit bias in favor of the dominant culture.

Strongly Disagree Disagree Agree Strongly Agree

At the present time, how would you rate your understanding of the following terms:

11. "Ethnicity"

Very Limited   Limited   Good   Very Good

12. "Culture"

Very Limited   Limited   Good   Very Good

13. "Multicultural"

Very Limited   Limited   Good   Very Good

14. "Prejudice"

Very Limited   Limited   Good   Very Good

15. "Racism"

Very Limited   Limited   Good   Very Good

16. "Transcultural"

Very Limited   Limited   Good   Very Good

17. "Pluralism"

Very Limited   Limited   Good   Very Good

18. "Mainstreaming"

Very Limited   Limited   Good   Very Good

19. "Cultural Encapsulation"

Very Limited   Limited   Good   Very Good

20. "Contact Hypothesis"

Very Limited   Limited   Good   Very Good

21. At this point in your life, how would you rate your understanding of the impact of the way you think and act when interacting with persons of different cultural backgrounds?

Very Limited   Limited   Fairly Aware   Very Aware

22. At this time in your life, how would you rate yourself in terms of understanding how your cultural background has influenced the way you think and act?

Very Limited   Limited   Fairly Aware   Very Aware

23. How well do you think you could distinguish "intentional" from "accidental" communication signals in a multicultural counseling situation?

Very Limited   Limited   Good   Very Good

24. How would you rate your ability to effectively consult with another mental health professional concerning the mental health needs of a client whose cultural background is significantly different from your own?

Very Limited   Limited   Good   Very Good

25. How well would you rate your ability to accurately assess the mental health needs of lesbian women?

Very Limited   Limited   Good   Very Good

26. How well would you rate your ability to accurately assess the mental health needs of older adults?

Very Limited   Limited   Good   Very Good

27. How well would you rate your ability to accurately assess the mental health needs of gay men?

Very Limited   Limited   Good   Very Good

28. How well would you rate your ability to accurately assess the mental health needs of persons who come from very poor socioeconomic backgrounds?

Very Limited   Limited   Good   Very Good

29. How would you rate your ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons from different cultural/racial/ethnic backgrounds?

Very Limited   Limited   Good   Very Good

30. How would you rate your ability to accurately assess the mental health needs of men?

Very Limited   Limited   Good   Very Good

31. How well would you rate your ability to accurately assess the mental health needs of individuals with disabilities?

Very Limited   Limited   Good   Very Good

32. How would you rate your ability to effectively secure information and resources to better serve culturally different clients?

Very Limited   Limited   Good   Very Good

33. How would you rate your ability to accurately assess the mental health needs of women?

Very Limited   Limited   Good   Very Good

SCORING INSTRUCTIONS

For the <u>Awareness Scale</u>: Reverse score items 1, 2, 3, 4, 6, 8, and 9. Then, sum the scores from these items plus the scores from items 5, 7, and 10.

For the <u>Knowledge Scale</u>: Sum the scores for items 11 to 23.

For the <u>Skills Scale</u>: Sum the scores for items 24 to 33

For the <u>Total Scale</u>: Sum all of the reverse scored items and the rest of the items.

Appendix C

VIRGINIA TECH.   **Challen Mabry <cjames1@vt.edu>**

MAKSS-CE-R

6 messages

Challen Mabry <cjames1@vt.edu>   Sat, Sep 9, 2017 at 10:59 AM
To: bkim@education.ucsb.edu

Hello!

I am a doctoral candidate at Virginia Tech in the department of Counselor Education. I am conducting dissertation research on counselors perceived multicultural competency when working with culturally similar and dissimilar clients, in rural and urban practice settings. I would like to use the MAKSS-CE-R as a measurement tool. Would it be possible to obtain a copy and permissions to use the measure in this study?

I greatly appreciate your time and consideration.
Warm Regards,

Challen Mabry
Virginia Tech

Challen Mabry <cjames1@vt.edu>   Sat, Sep 9, 2017 at 11:06 AM
To: bryankim@hawaii.edu

[Quoted text hidden]

Bryan S. K. Kim, Ph.D. <bryankim@hawaii.edu>   Mon, Sep 11, 2017 at 4:30 PM
To: Challen Mabry <cjames1@vt.edu>

Hello Challen:

Thank you for your interest in the MAKSS-CE-R. Attached is the scale and its scoring instructions. You are welcome to use the measure in your dissertation. Good luck with your study!

Bryan Kim

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Bryan S. K. Kim, Ph.D.
Professor of Psychology
Director of MA Program in Counseling Psychology
(Specialization: Clinical Mental Health Counseling)
Department of Psychology
University of Hawai'i at Hilo
200 W. Kawili Street
Hilo, Hawai'i 96720-4091
Tel: 808-932-7090
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http://www2.hawaii.edu/~bryankim

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Editor, "Asian American Journal of Psychology"
Associate Editor, "Measurement & Evaluation in Counseling & Development"
Fellow, American Psychological Association (Divisions 17, 29, & 45)
Fellow, Asian American Psychological Association
Fellow, International Academy of Intercultural Research
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Appendix D

Email Invitation

Hello,

I am reaching out to you about an exciting research study for which you have been identified as a qualifying participant. You have been identified as a professional counselor in the Commonwealth of Virginia who meets one or more of these criteria: 1) holds a minimum of a 2-year master's degree in counseling field, 2) are an active member of the Virginia Counselors Association, 3) are an active member of the Virginia School Counselors Association, and/or 4) are a licensed professional counselor through the Virginia Department of Health Professions.

The current research study is focused on professional counselors in Virginia and their level of comfort with working with diverse peoples across geographic settings. Within the next 7 business days, you will receive an email invitation to participate in this study.

The data gathered from the survey is anonymous and confidential. All protocols for the study have been reviewed and approved by the Virginia Tech Institutional Review Board (IRB #___). All participants will receive an electronic informed consent at the start of the online survey; if a participant would like a written copy of the informed consent, the researcher will provide via email after receiving a request. After collecting survey data, I hope to contribute to the professional literature by identifying training or knowledge gaps surrounding issues of cultural diversity when working with diverse clients.

If the study receives 250 responses, a donation will be made to the Association of Multicultural Counseling and Development in the amount of $150. I hope you will consider contributing to this research study. Please feel free to contact me via email with any additional questions you may have.

Sincerely,

Challen Mabry