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Association Between Multicultural Counseling Graduate Training and Mental Health Professionals' Self-Perceived Effectiveness

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Abstract

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Janessa L. Henry

MS, Walden University, 2011

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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General Psychology

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Abstract

Special training is often needed for counseling professionals to meet the unique cultural needs of their clients. Previous researchers have suggested that larger samples of professional counselors are needed to better understand the presence of these multicultural skills and noted a dearth of research regarding the effects of training in multicultural counseling following graduation and among practitioners. Following the theory of multicultural counseling and therapy (MTCT), the research questions were tested by using descriptive statistics, *t*-tests, and multiple linear regression to address the study of multicultural knowledge and multicultural awareness among counseling professionals who did and did not receive formal training in multicultural competencies based on various demographics, including race/ethnicity, age, gender, and education of mental health professionals. The researcher used the Multicultural Counseling Knowledge and Awareness Scale to measure the dependent variable of multi-cultural counseling skill of 47 American Counseling Association members through the Survey Monkey platform. The results of the multiple linear regression analyses showed that participants who had received multicultural training did not differ in multicultural awareness or knowledge from those who had not received multicultural training, while controlling for age, and gender. However, education of the counselor individually or in linear combination did impact multicultural knowledge. The findings indicate that a positive social change in the field of mental health and psychology can be achieved by encouraging mental health institutions to ensure that the service providers are culturally competent, and that multicultural training should be incorporated in the curricula for students pursuing the career.

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Dedication

To my husband Edward and my daughter Adrinia, without whom this dissertation would have not been completed. I love you always and forever.

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I would like to thank the following people, without whom I would not have been able to complete this dissertation or make it through my Ph.D.

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Chapter 1: Introduction

Mental health professionals require qualifications aside from knowledge of how to address mental health concerns. According to Smith et al. (2013), "People who are motivated and confident in their ability to use their knowledge and skills are more likely to be active participants in maintaining and improving health" (p. 1). Smith et al. also mentioned that mental healthcare providers play important roles in cultural competence development, especially when they interact with culturally diverse patients, communities, and families. Cultural competence is already being integrated with medical students to ensure that they are able to provide quality service for all patients. Researchers have recommended an integration of cultural competence education and mental health training to mental health professionals (Jeffreys & Dogan, 2013).

The purpose of this survey research study was to investigate the perceptions of counselors on mental health competency between mental health professionals who did and did not receive formal training in multicultural competencies in their degree programs and post-graduation as part of continuing education. Another purpose of this study was to compare the multicultural counseling skills based on the demographics of the mental health professionals. Researchers have studied factors such as gender, race, and participation in relation to multiculturalism (Bellini, 2002). In the current study, the researcher delved into the impact of the different factors on the cultural competency of the mental health professionals. The researcher considered the gender of the mental health professionals in terms of whether this variable is a significant factor influencing the professionals' perceptions of cultural competency. Further, the researcher analyzed

the education levels of the mental health professionals to determine the contribution of multicultural educational experience to the performance of mental health professionals.

The researcher aimed to promote positive social change in the field of mental health and psychology by encouraging mental health institutions to make sure that the service providers are culturally competent to deal with culturally diverse clients and patients. Due to the diversity of factors that the researcher examined in this study, the different variables may be considered by the policymakers such as hospital and university officers when seeking to improve the cultural competency of mental health professionals. With this expectation, it is likely that patients and clients would be more satisfied with the mental health services that they receive. The remainder of Chapter 1 includes the Introduction, Background, Problem Statement, Purpose of the Study, Research Questions and Hypotheses, Theoretical Framework for the Study, Nature of the Study, Definitions, Assumptions, Scope and Delimitations, Limitations, Significance, and Summary.

Background

Cultural diversity is highly prevalent in modern American society. The U.S. Census Bureau (2010) has projected that racial and ethnic minorities will become the majority and will outnumber the White majority by 2042—8 years earlier than the Bureau originally projected. The Bureau also projected that by 2050, minorities will represent 54 percent of the United States population, in comparison to 34 percent population today (Penny, 2010). In 2005, the American Association for Counseling and Development (AACD) and the American Psychological Association (APA) became

serious about providing more training to deal with racial, ethnic, and cultural issues in educational settings (APA, 2009).

Eighty-nine percent of all APA- and non-APA-accredited counseling psychology programs provided only one multicultural training course (Newell et al., 2010). The American Counseling Association proposed that the different trainings of counselors must include development of multicultural skills and this must be a full-course training (Malott, 2010). In order to understand the culture of other races, mental health professionals must be trained to understand the self, and explore all areas to improve their treatment of clients and patients (Malott, 2010). Chao and Nath (2011) posited that it was important for mental health professionals to display multicultural cultural expertise in order to help clients of all races and ethnicities. This expertise requires knowledge of multicultural issues at all levels of the spectrum, including personal and societal levels.

It was revealed a need to find programs within a school curriculum that trained counselors and psychologists effectively. Chao and Nath (2011) stated the need to identify which programs within a school curriculum can adequately train counselors and psychologists. Multicultural cultural curricula has a growing concern to expose counselors and psychologists to lived experiences pertaining to racial and cultural issues (Chao & Nath, 2011; Newell et al., 2010; Sehgal et al., 2011). Newell et al. (2010) focused on school psychology training programs, finding that schools are required to provide multicultural training to school psychologists because of the growing multicultural setting in most schools. Trainers, however, have reported challenges in properly incorporating multicultural content into the curricula (Newell et al., 2010).

Support for multicultural training was found to be significant to the self-efficacy of mental health professionals (Sheu et al., 2012). The vested interests of the mental health professionals in multicultural counseling mediated the effects of cross-racial client contacts and perceptions of multicultural training environments on the intention of performing multicultural counseling in the future because of the recognized benefits of the phenomenon. Sheu et al. (2012) mentioned that outcome expectations were predictive of the interests associated with multicultural counseling and choice of goals. Implications for multicultural skills training and directions for future research were also highlighted in this study (Sheu et al., 2012). These authors' suggestions on the improvement of multiculturalism in mental health included training on language services. One idea is that practitioners in the mental health profession should be offered training on how to render services without the language barriers. This is in addition to having ready access to data on the special needs of patients pertaining to language and communication skills of the mental health professionals (National Committee for Quality Assurance [NCQA], 2010). Cultural responsiveness would also promote multiculturalism in the field of mental health (NCQA, 2010). Hospitals and clinics would then provide access on information regarding the race of patients so that mental health professionals are able to provide culturally appropriate care and to address the shortcomings when necessary (NCQA, 2010). These hospitals and clinics should be assured that the data regarding the race of the patients will be treated with confidentiality.

The medical education system has been aware that cultural competence carries with it some important moral underpinnings (Paasche-Orlow, 2004). According to

Paasche-Orlow (2004), the essential principles of cultural competence are acknowledgement of the importance of culture in people's lives, respect for cultural differences and minimization of any negative consequences of cultural differences. It is perceived that healthcare done with cultural competence would promote justice and patient autonomy (Paasche-Orlow, 2004). Thus, the deeper understanding of how patients need quality care is included in the responsibilities of a responsible medical professional (Paasche-Orlow, 2004). Further, Paasche-Orlow (2004) suggested that "Learning about disparities in health outcomes should institute a cascade of events to determine the barriers experienced by patients and the types of accommodation needed to ameliorate the health burden due to cultural difference" (p. 348).

The gap in the literature that the researcher sought to fill through this study was the examination of the effects of training in multicultural counseling skills in school and post-graduation and the multicultural perceptions of the counselors. Several researchers studying effective counseling (Berger et al., 2014; Pope-Davis & Ottavi, 1994; Reynolds & Rivera, 2012) have focused on the importance of demographic variables with multicultural counseling skills and how it can improve their counseling. The focus of these research studies has been on different demographic variables, including the relationships between ethnicity and multicultural counseling competency (Berger et al., 2014; Pope-Davis & Ottavi, 1994); between psychological factors, attitudes, and multicultural competence (Reynolds & Rivera, 2012); and between demographic, experiential, and training variables in relation to multicultural counseling competencies (Bellini, 2002). The purpose of the current survey research was to investigate the

perceptions of counselors of multicultural counseling between mental health professionals who did and did not receive formal training in multicultural competencies in their degree programs as well as post-graduate programs and compare the multicultural counseling skills based on the demographics of age, sex, and education of mental health professionals. Specifically, the gap lay in the lack of study regarding the effects of training in multicultural counseling in school and post-graduation (NCQA, 2010). The researcher used the Theory of Multicultural Counseling and Therapy (TMCT; Sue et al., 1996) as a framework to support the main proposition of the study because this theory addresses the effectiveness of multicultural training. TMCT supports the influence of the age, sex, and education variables in relation to the responses of the participants regarding having gotten training in multicultural counseling.

The researcher aimed to investigate the effectiveness in multicultural counseling between counseling professionals who did and did not receive formal training in multicultural competencies in their degree programs as well as post-graduation. The researcher also compared the participants' multicultural counseling skills based on their demographic factors of age, gender, and education. The study represents an important contribution to the body of counseling literature, as it provides information on how multicultural competencies factor in the effectiveness of multicultural counseling. These findings may assist counseling administrators and persons involved in counseling in evaluating whether training in multicultural competencies should be a requirement for all counseling programs.

Problem Statement

There have been a number of studies, which have investigated the effectiveness of graduate courses and practice in enhancing the (mainly self-perceived) levels of multicultural counseling competence (MCC) among graduate students (Chao & Nath, 2011; Chao et al., 2011; Newell et al., 2010; Sehgal et al., 2011). In the review of literature conducted, only two researchers—Bellini (2002) and Dodson (2013)—considered the multicultural counseling skills of counseling professionals. In this study, the framework was the theory of multicultural counseling and therapy (Chao & Nath, 2011; Newell et al., 2010; Sehgal et al., 2011). Multicultural counseling approaches focus on the counseling relationship that includes strategies and clinical techniques to help address the needs of clients (Hanna & Cardona, 2013). The researcher aims to address this gap by investigating the effectiveness of multicultural counseling between counseling professionals who did and did not receive formal training in multicultural competencies in their degree programs as well as post-graduation, as well as comparing the participants' multicultural counseling skills based on the demographic variables of age, gender, and education.

Purpose of the Study

The purpose of this quantitative study was to investigate the effectiveness in multicultural counseling between counseling professionals who did and did not receive formal training in multicultural competencies in their degree programs and post-graduation, as well as to compare the participants' multicultural counseling skills based on the demographic variables of age, sex, and education. The independent variables that

the researcher considered for this study was exposure to multicultural training in one's graduate program, multicultural training received post-graduation, and the demographic factors of age, gender, and education. The diversity and range of the factors that the researcher examined in this study allowed a comprehensive examination of the field of mental health. The dependent variable was multicultural cultural counseling skill.

Research Questions and Hypotheses

This primary research question for this study was: What are the differences in the effectiveness in multicultural counseling between mental health professionals who did and did not receive training in multicultural competencies in their degree programs and post-graduation, controlling for age, gender, and education? The specific research questions and hypotheses are as follows.

Research Question 1

What is the relationship between multicultural training received and multicultural counseling skills awareness of mental health professionals (measured through Multicultural Counseling Knowledge and Awareness Scale) who received and did not receive multicultural counseling training in the completion of graduate program?

H_{01}: There is no significant difference in the awareness of mental health professionals who received or did not receive multicultural counseling training.

H_{a1}: There is a significant difference in the awareness of mental health professionals who received or did not receive multicultural counseling training.

Research Question 2

What is the relationship between multicultural training received and multicultural counseling skills knowledge of mental health professionals (measured through Multicultural Counseling Knowledge and Awareness Scale) who received and did not receive multicultural counseling training in the completion of graduate program?

H_{02}: There is no significant difference in the knowledge of mental health professionals who received or did not receive multicultural counseling training.

H_{a2}: There is a significant difference in the knowledge of mental health professionals who received or did not receive multicultural counseling training.

Research Question 3

Do the multicultural training received and the age of the counselor individually or in linear combination predict the counselor's mental health awareness?

H_{03}: Multicultural counseling training and age of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' awareness

H_{a3}: Multicultural counseling training and age of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' awareness

Research Question 4

Do the multicultural training received and the age of the counselor individually or in linear combination predict the counselor's mental health knowledge?

H_{04}: Multicultural counseling training and age of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' knowledge

H_{a4}: Multicultural counseling training and age of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' knowledge

Research Question 5

Does the multicultural training received and the education of the counselor individually or in linear combination predict the counselor's mental health awareness?

H_{05}: Multicultural counseling training and education of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' awareness.

H_{a5}: Multicultural counseling training and education of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' awareness.

Research Question 6

Do the multicultural training received and the education of the counselor individually or in linear combination predict the counselor's mental health knowledge?

H_{06}: Multicultural counseling training and education of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' knowledge.

H_{a6}: Multicultural counseling training and education of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' knowledge.

Research Question 7

Does the multicultural training received and the gender of the counselor individually or in linear combination predict the counselor's mental health awareness?

H_{07}: Multicultural counseling training and gender of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' awareness.

H_{a7}: Multicultural counseling training and gender of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' awareness.

Research Question 8

Do the multicultural training received and the gender of the counselor individually or in linear combination predict the counselor's mental health knowledge?

H_{08}: Multicultural counseling training and gender of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' knowledge.

H_{a8}: Multicultural counseling training and gender of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' knowledge.

Theoretical Framework for the Study

The theoretical framework for this study was the theory of multicultural counseling and therapy of Sue et al. (1996). The TMCT provides a bases for the basic understanding of the differences between clients and mental health professionals. TMCT recognizes that family and cultural factors affect one's worldview. The researcher will provide a more detailed explanation of this theory in Chapter 2. According to Sue et al. (1996), many existing theories of counseling have been validated in reference to White middle-class males and are deficient in their applicability to people with different cultural characteristics. This theory emphasizes that the sex and gender of mental health professionals can affect their performance in rendering service to the patients and clients seeking mental health assistance. The TMCT provides a more broadly applicable approach for mental health professionals to achieve an understanding of acculturation, alternative worldviews, the dangers of stereotyping, and the need to exhibit respect for clients' culture (Sue et al., 1996).

The TMCT is related to the research question on the relationship between multicultural training received and multicultural counseling skills of mental health professionals and the purpose of this study because the theory promotes multiculturalism. The researcher has noted that cultural competency can be attributed to several demographic factors, such as age, gender, and education. The researcher examined these factors in the current study using the theoretical framework to establish conclusive findings that can help the future decisions of policy makers. The researcher highlighted this relationship because multiculturalism is important in the field of mental health. In the

current study, the researcher differentiated the effects of multicultural training from the absence of this training. In a way, TMCT may also be used in the study if the results show that multicultural training does not have any effect on the results of the study.

According to Jones-Smith (2011), the TMCT theory is one of five emerging theories of multicultural counseling that go beyond the conventional Western framework of multiculturalism that defined the concept in terms of race/ethnicity and oppression. The basic propositions and foundations of this theory are tackled in the following discussion. First, TMCT is a meta-theory of counseling and psychotherapy. Both counselor and client identities are formed and embedded in multiple levels of experiences (i.e., individual, group, and universal) and contexts (i.e., individual, family, and cultural milieus). Second, the totality and interrelationships of experiences and contexts must be the focus of treatment. Development of cultural identity is a major determinant of counselor and client attitudes toward the self, others of the same group, others of a different group, and the dominant group. These attitudes are strongly influenced not only by cultural variables but also by the dynamics of a dominant-subordinate relationship among culturally different groups. The effectiveness of TMCT is most likely enhanced when the counselor uses modalities and defines goals consistent with the client's life experiences and cultural values. TMCT stresses the importance of multiple helping roles developed by many culturally different groups and societies. Besides the one-on-one encounter aimed at remediation in the individual, these roles often involve larger social units, systems intervention, and prevention. The liberation of consciousness is a basic goal of TMCT, which emphasizes the importance of expanding personal, family, group,

and organization consciousness of the place of self-in-relation, family-in relation, and organization-in-relation. This emphasis results in therapy that not only is ultimately contextual in orientation but also draws on traditional methods of healing from many cultures.

Nature of the Study

The study was based on the survey research method. During data analysis, the researcher performed multiple regression analysis to examine whether the exposure to multicultural training in a graduate program is related to the variables under examination in this study. The researcher also conducted t-tests. The variables were the responses of the participants regarding their training and the demographic variables of age, gender, and education. The researcher selected the sample from the directory of counselors on the American Counseling Association website. The researcher collected data via a Survey Monkey online survey process. The independent variables included exposure to multicultural training in a graduate program, multicultural training received post-graduation, and the demographic factors of age, gender, and education. The dependent variable was multicultural counseling skill. After collecting the data, the researcher used SPSS to calculate descriptive statistics and inferential statistics to address the research questions posed for this study. The researcher calculated multiple linear regression statistics for each pair of variables under consideration. The first regression model explains the impact of independent variables while controlling demographic variables on awareness of multicultural counseling. Similarly, the second regression model explains

the impact of independent variables while controlling demographic variables on Knowledge of multicultural counseling.

Definition of Terms

Age: In this study, age referred to the biological age of the participants, which the researcher measured in the following ranges: 18-25, 26-35, 36-45, 46-55, and 56 and above.

Culture: Culture describes a cumulative deposit of the experiences, beliefs, knowledge, attitudes, values, meanings, hierarchies, religion, roles, spatial relations, notions of time, concepts of the universe, and material objects and possessions acquired by a group of people. The scope of a culture is a community which could include several generations and encompass different territories and ages (Texas A&M University, 2014).

Cultural competence: This is a set of congruent behaviors, attitudes, and policies that come together in an agency, system, or among professionals, which enables those professionals to work effectively in multicultural situations. Cultural competence is also related to the use and comprehension of knowledge regarding certain practices and how to act on the differences in the attitudes and beliefs of people from different cultures (National Association of School Psychologists, 2014).

Education: Education is the process or action of educating or being educated in an institution such as a school, college, or university (Merriam-Webster, n.d.-a). This also refers to graduate training received in counseling, marriage and family, psychology, and social work.

Mental health: Mental health can be defined as the state of wellbeing wherein every person is able to attain the realization of his or her potential and possess the ability to deal with the normal stresses that life has to offer. Mental health is related to the capability of making a contribution to the community (World Health Organization, 2013).

Mental health professionals: This includes professionals who offer services for the purpose of rendering assistance for the betterment of an individual's mental health. Mental health professionals also research the field of mental health. A mental health professional can either be a psychiatrist or a psychologist (Berger, 2014).

Multicultural counseling skills: This describes the process of approaching the counseling process from the context of the personal culture of the client (Hanna & Cardona, 2013).

Multicultural training: This defines training that prepares psychologists to counsel people from different cultural/racial backgrounds (Hanna & Cardona, 2013).

Sex: Sex is a categorical variable that is measured as either male or female (Merriam-Webster, n.d.-b).

Assumptions

Assumptions are self-evident truths. In a quantitative study, it may be assumed that participants be highly qualified in the study in the field of mental health. The researcher assumed that the participants would answer truthfully and accurately to the interview questions based on their personal experience, and that the participants would respond honestly and to the best of their individual abilities. The most basic assumption

of this study was regarding the growing need to have a multicultural approach to address the dynamic situation found in the field of mental health and counseling. The researcher assumed that multicultural counseling is already a known phenomenon among mental health professionals, and that the question is limited to answering whether or not this phenomenon is indeed helpful to the profession. The researcher assumed that multicultural training and multicultural counseling skills are necessary to equip counselors with a higher level of service for the patients. Further, the researcher assumed that demographics would have significant impact in the determination of whether or not age, sex, and education affect the multicultural counseling skills of mental health professionals. The researcher assumed that the counselors and mental health professionals who were selected from the American Counseling website would be willing to participate in the study.

Scope and Delimitations

Delimitations are limitations on the research design imposed deliberately by the researcher. Delimitations in a social sciences study would be such things as the specific setting where a study took place, or in a scientific study, the number of repetitions. One delimitation of this study was that the participants only included mental health professionals that had been accessed and who positively responded to the invitation to participate. There are several factors that set the stage for the boundaries of the study. The study only included mental health professionals who are part of the American Counseling website. The sample did not include mental health professionals who do not have their names on the website. Internal validity includes the factors related to the

chosen methodology of the study. Regarding the internal validity of the study, the researcher chose to use the official website to ensure that as many psychologists and mental health professionals as possible were contacted for the survey. External validity includes the factors that are not limited to the methodology of the study. The external validity of the study is related to the theory of multicultural counseling. The researcher addressed the effects of formal training in mental health in the academic setting to the performance of mental health professionals. The external validity was delimited because the researcher focused on mental health professionals, and not the other professionals who work in the field of health or medicine. As the information was derived from volunteers who were not compensated for the project, the respondents did not receive any incentive after participating. Due to the lack of incentive, the participants may not have taken enough time and effort to answer the questions related to the study. The results of the study may not be applicable to all mental health professionals in the United States because not all counselors have been able to answer the questions raised in this study by being participants and part of the sample.

Limitations

A limitation to the study is that information is self-reported, while participants' responses may accurately reflect the details of their programs, they may overestimate or underestimate their own multicultural competence. Some participants may not want to reveal the status of their lack of sufficient training to improve multicultural competence and counseling skills. External validity relates to the factors external to the methodology of the study. The external validity of the study can be related to the generalizability of the

results. The results of the study were generated only from transcript of Survey Monkey, which is an online application. Because of this method, there was less personal interaction between the participants and the researcher. Due to less interaction, the researcher may not have the effect on familiarity. The answers to the survey were based on a set of questions already prepared for the survey. In contrast, internal validity includes the factors limited to the methodology of the study. Because the researcher performed the analysis through the use of the SPSS software, the interpretations may have been influenced by the bias and prejudice of the researcher when SPSS or any neutral software is not used. To avoid this, the researcher consulted existing literature on the topic to support the interpretations made. Validity and reliability may be ensured by staying as objective as possible. The construct validity of the study states that the multicultural training formally received by the mental health professionals suffice as training to improve their cultural competence. Further, because of the quantitative method, the participants did not have the opportunity to elaborate or explain on the inclusions or presence of the training and how training has improved their multicultural counseling skills. The researcher addressed these limitations by describing the possible limitations in the results and findings of the study. The researcher also addressed the limitations by taking them into account during the interpretation and analysis of data.

Significance

Through this study, mental health professionals who maintain a license can help make social change and can impact society sharing the basic principles of life, honesty, trust, fairness, respect, and responsibility because of the awareness of the different

cultures that they may encounter every day. Socially, the findings of this study may bring about change by making mental health professionals more adaptive to the needs of their society. Mental health professionals will be more equipped in dealing with patients from different cultural background and provide an approach and service that is more appropriate to the culture of the patient. The researcher expects these positive impacts because these will be developed through multicultural competence. The mental health professionals that must maintain licensure will benefit from this study because if the training that they receive during graduate school includes multicultural skill development, then their professional skills that have been developed since graduation and licensure will already include those important skills.

Academic integrity has a major connection to professional practice, professional excellence, and academic excellence. The multicultural concepts and the curriculum recommended will help psychology school administrators by serving as a guide on how to incorporate multicultural concepts in their respective curricula. The impact of training on the skill of the mental health professionals will be improved by professional training and will be related to the improved performance in the field of rendering psychological services, as the researcher hoped a positive correlation between the two.

Summary

The purpose of this quantitative survey study was to investigate the effectiveness in multicultural counseling between mental health professionals who did and did not receive formal training in multicultural competencies in their degree programs as well as post-graduation and compare the multicultural counseling skills based on the

demographics such as the age and gender of mental health professionals. Chapter 1 included the Introduction, Background, Problem Statement, Purpose of the Study, Research Questions and Hypotheses, Theoretical Framework for the Study, Nature of the Study, Definitions, Assumptions, Scope and Delimitations, Limitations, Significance and Summary. In Chapter 2, the researcher discusses the body of related literature to this study. The literature review includes the Literature Search Strategy, Theoretical Foundation, Literature Review Related to Variables and/or Concepts, and Summary.

Chapter 2: Literature Review

The purpose of this study was to investigate the multicultural counseling skill discrepancy between mental health professionals who did and did not receive formal training in multicultural competencies in their degree programs. The researcher also compared the participants' multicultural counseling skills based on the demographic variables of age, gender, and education, as well as continuing education multicultural training. In line with this, Chapter 2 contains a detailed literature review aligned with the purpose of the study. The researcher divided the literature review into four parts. In the first part, the researcher discusses psychology and mental health. In the second part, the researcher discusses the role of mental health professionals. In the third section, the researcher illustrates the impact of discrimination in mental health. The fourth section involves a discussion of the theory of multicultural counseling and therapy. In the last part of the review, the researcher explains the significance of multiculturalism and competence in mental health. The researcher concludes the chapter with a summary.

Literature Search Strategy

To support the claims in the problem statement of the study and provide basis for the purpose and research questions, the researcher performed a literary search using different journals and databases. The databases the researcher used to search for relevant literature included EBSCOHost, ProQuest, PsychArticles, JSTOR, and ScienceDirect. The keywords used for the search were: "multicultural competency," "mental health practitioners," "mental health professionals," "counseling," "counselors," "psychology

trainings," "multicultural counseling and therapy," "cultural diversity," and "multiculturalism."

Psychology and Mental Health

Despite the proven value of mental health, the term has no single definition. Mental health refers to comprehensive physical, mental, and social welfare, and goes beyond the mere absence of disease (Doherty et al., 2008). Psychological distress is associated with problems with the mental health conditions. According to Barlow and Durand (2005), psychological distress can be viewed as an emotional condition that may involve a negative view of the self, of the environment, and of others. Psychological distress can be characterized by subjective states including worry, unreasonable tension, and unexplained irritation (Barlow & Durand, 2005).

Psychology and mental health play an important role for the function of a human being. According to the Australian Psychological Society (APS, 2013), the mental disorder term describes "a range of clinically diagnosable disorders that significantly impact on a person's emotions, thoughts, social skills and decision-making" (p. 1). Mental health patients need the participation of proactive mental health services (Panayiotopoulos et al., 2013). Panayiotopoulos et al. (2013) found that mental health professionals should be able to address the needs of patients and make them feel good, as "mentally ill individuals may experience uncomfortable social interactions, limited social networks, a deprived quality of life, low self-esteem, depressive symptoms, and loss of revenue due to inability of finding appropriate work" (p. 31). Scholars have studied psychology and mental health, concluding that structural discriminations exist against

patients with mental health issues. Structural discrimination in rendering mental health services should be avoided by ensuring that facilities stigmatized diseases such as schizophrenia are not located in isolated settings with dangerous neighborhoods because of the negative connotations of the disease (Panayiotopoulos et al., 2013).

Psychiatric services ensure that the mental health conditions of patients are addressed. Psychiatric services have been deinstitutionalized and more adequate services provided since the 1950s in most of the developed world (Brunero et al., 2012). The purpose of the phenomenon was to mainstream mental health services, wherein services may be integrated to improve comprehensive care to people with mental illness (Brunero et al., 2012). Various patients would need the assistance of mental health services when prompted with mental health issues that need addressing. Brunero et al. (2012) cited the two groups of patients requiring mental health services as the following:

> (a) patients with an existing diagnosis of mental illness who have physical conditions requiring general hospital care; and (b) patients who have physical health conditions who go on to develop signs and symptoms of mental illness or mental distress. (p. 429)

Mental health is not an exact science, and not every mental disease would have a precise solution that mental health professionals can resort to (McLaren, 2010). As a result, innovations within the field of mental health are continually needed. McLaren mentioned that the perception of mental health is an art versus a science, as the specific skill in curing mental health patients is not yet available. A number of medical professionals would opt to practice in another branch of medicine other than mental

health (Stuhlmiller, 2006). Stuhlmiller (2006) noticed that mental health is not usually pursued by most medical professionals because there is lack of immediate gratification in delivering mental healthcare when compared with physical healthcare.

With the advancement of medicine and technology, changes in how mental health disorders are perceived are noticeable (Freeman et al., 2002). Mental health or psychiatric disorders are conceptualized as health conditions that are on a par with other disease categories (Freeman et al., 2002). Treatments for mental health conditions have been recognized and discovered by mental health professionals. The treatment for psychological disorders ranges from weight-control programs to behavioral therapy (Freeman et al., 2002). In the medical field, mental health services have played integral roles in research, public health initiatives, and policies in public health (Freeman et al., 2002). Aside from treatment to mental disorders, primary prevention is already being considered by mental health professionals (Freeman et al., 2002). Prevention would lessen the number of mental health patients who need treatment.

Mental health is a significant field for every person. Good mental health is an essential factor for people of all ages, including children (National Association of School Psychologists, 2006). In fact, the National Mental Health and Education Center (2006) mentioned that children who achieve better academically are raised with supportive socio-emotional and mental health support. With the proven positive effects of good mental health to other areas, people are becoming more concerned with the value of mental health. The promotion of mental health can start with schools and universities, as "school-based mental health services range from prevention and skills development to

intervention and evaluation, referral and collaboration, and consultation and counseling" (National Association of School Psychologists, 2006, p. 2).

Mental Health Professionals

Several national and local organizations focus on training mental health professionals, equipping them with the necessary skills to cater to their patients (Gamm et al., 2010). The Ad Hoc Rural Mental Health Provider Work Group provides trainings to mental health professionals (Gamm et al., 2010). Researchers have found a need to provide training on rural-focused experiential training for counselors with focus on cultural competency development (Gamm et al., 2010). Similarly, the American Psychological Association has required the incorporation of counselor trainings to incorporate clinical expertise in the context of patient characteristics, culture, and preferences through evidence-based practice in psychology (Herschell et al., 2010).

According to the American Counseling Association, the continued attainment of multicultural knowledge and skill in counseling is important for counselors (Lee, 2014). The American Counseling Association highlights the need for integrating multicultural, social justice, and feminist approaches, which each acknowledge the influence of privilege, power, and oppression on clients' lives (Burnes et al., 2010). It is important to use the proper language when dealing with multicultural clients or patients (Burnes et al., 2010). Counselors need to develop an awareness of culturally learned assumptions, knowledge of accurate multicultural information, and the acquisition of counseling skills given the increasing diversity of cultures among patients (Lee, 2014).

Mental health professionals play important roles in the development of mental health as a branch in the field of medicine (Slade, 2010). The present dynamics promote increasing the well-being of patients rather than pure treatment of illness (Slade, 2010). Thus, health professionals need to explore new approaches for treating patients (Slade, 2010). For mental health services, the emerging knowledge from positive psychology should be integrated with education and training to all practicing mental health professionals (Slade, 2010).

Mental health professionals may also decide on how to focus the services being offered:

> With respect to focus, psychologists may become involved in the healthcare system at different system levels. Services may target individuals, families, classrooms or schools, work sites, communities or, more broadly, federal and state public policy. Psychologists have long been involved in service delivery at the individual and family level. (Freeman et al., 2002, p. 539)

Mental health professionals are expected to know the medicinal requirements for mental health patients. Aside from medical compliance using the products of science and technology, the satisfaction of psychosocial needs of service users is equally important (Panayiotopoulos et al., 2013). Mental health professionals require other qualifications aside from knowledge of how to cure "people who are motivated and confident in their ability to use their knowledge and skills are more likely to be active participants in maintaining and improving health" (Smith et al., 2013, p. 1). Campinha-Bacote (2003), found that healthcare providers played important roles in cultural competence

development, especially when interacting with culturally diverse patients, communities, and families. Cultural competence is already being taught to medical students to ensure that they can provide quality service for multicultural patients. Cultural competence education needs further integration into the studies required by medical professionals (Jeffreys & Dogan, 2013).

Mental health professionals are instrumental in the success in every treatment of mental health. The APS (n.d.) recognized the importance of mental health professionals in the success of treatment of mental health patients:

> to provide quality health outcomes, clients' preferences and values, clinicians' experience, and the availability of resources also need to be considered in addition to research evidence. Effective evidence-based psychological practice requires more than a mechanistic adherence to well-researched intervention strategies. Psychological practice also relies on clinical expertise in applying empirically supported principles to develop a diagnostic formulation, form a therapeutic alliance and collaboratively plan treatment within a client's socio-cultural context. (p. 6)

The mental health profession is not a homogenous field. It involves several professions that play different roles in addressing the care desired by the patients. Mental health professionals include psychologists who study the way people act, think, feel, and interact (APS, 2013). Psychologists aim to achieve a reduction of distress and enhancement of emotional wellbeing (APS, 2013). Psychologists are specialists and experts in studying human behavior by studying memory, brain, human development, and

learning (APS, 2013). They are instrumental in assisting people who have problems controlling emotions, such as depression and anxiety (APS, 2013). Psychologists make sure that proper treatment is given to patients with psychological problems. Therapies given by psychologists are effective in treating mental health conditions (APS, 2013).

Cultural competence means being able to provide a customized service, keeping in mind the special needs of patients with different cultures. Healthcare professionals provide care for patients originating from cultures with different languages and unique ways of understanding illness and healthcare (Carillo et al., 1999). Because of diversity of the patients that health professionals may encounter, nursing students receive training to provide culturally sensitive and competent care (Harris et al., 2013). Cultural competence education should be supported by the health institutions by providing library resources, relevant book purchases, bulletin boards for transcultural nursing events, and an advanced certificate program in cultural competence (Jeffreys & Dogan, 2013). Medical professionals should prevent discrimination, despite the segregated context that remains present today (Rodenborg & Boisen, 2013). Professionals in human services and education are increasingly expected to exhibit cultural competence (Sperry, 2012). Students still in medical school are expected to have cultural competency. High levels of cultural competence are shown by gestures and high levels of social interest, tolerance, and acceptance (Sperry, 2012).

Theory of Multicultural Counseling and Therapy

In the counseling and guidance field, most practitioners acknowledge that every client has his or her own identity and uniqueness; thus, each individual requires

acceptance and respect in their own way (Jones-Smith, 2011). Theory-based practices taught in training and developed into action theories often reflect the assumption that a particular approach is transferable across a wide range of clients (Ivey et al., 2013). However, Sue et al. (1996) challenged this approach, proposing a multicultural counseling and therapy theory.

TMTC is considered necessary because of the inadequacies of current theories informing current counseling practice (Jones-Smith, 2011; Sue et al., 1996). According to Sue et al., the TMTC has the following propositions relevant to the study:

- Diversification is occurring at such a rapid pace; hence, mental health professionals have higher tendencies of encountering clients or client groups who differ from them racially, culturally, and ethnically.
- Mental-health professionals are not adequately prepared to engage in multicultural practice.
- Current theories of counseling and psychotherapy inadequately describe, explain, predict, and deal with current cultural diversity.
- These inadequacies in theory translate to inadequacies in training concepts that make use of traditional training models.

Based on these propositions, Sue et al. (1996) developed the concept that multiculturalism provides a fourth dimension to the traditional three dimensions of helping orientations: psychodynamic, existential-humanistic, and cognitive. A culture-centric meta-theory is viable. By incorporating multicultural concepts into training, counselors and mental health practitioners can potentially improve the skills set and

perspectives of counselors and mental health professionals (Sue et al., 1996). To facilitate this, the cultural and sociopolitical context of a client's behavior must be understood to perform accurate assessment, interpretation and treatment, while considering cultural awareness and knowledge relevant to the case (Sue et al., 1996). The TMTC highlights the importance of developing multicultural competency, especially among professionals dealing with people from diverse cultural backgrounds, such as counselors and mental health professionals. The development of multicultural competency is best facilitated by incorporating relevant concepts in trainings.

The TMCT is one of five emerging theories of multicultural counseling that go beyond the conventional Western framework of multiculturalism that defined the concept in terms of race/ethnicity and oppression (Jones-Smith, 2011). In the TMTC, counselor and client identities are formed and embedded in multiple levels of experiences (i.e., individual, group, and universal) and contexts (i.e., individual, family, and cultural milieus; Collins & Arthur, 2010). The TMTC implies a non-hierarchical relationship between client and counselor for the counseling encounters to be effective (Jones-Smith, 2011). The effectiveness of the TMCT may most likely be improved when the counselor uses modalities and defines goals consistent with the life experiences and cultural values of the client. The TMCT highlights the need for expanding personal, family, group, and organization consciousness of the place of self-in-relation, family-in relation, and organization-in-relation; thus, resulting in therapy that is contextual in orientation and traditional in methods of counseling or healing for different cultures (Collins & Arthur, 2010; Jones-Smith, 2011).

In relation to this study, the TMTC focuses of the development of multicultural competency among mental health professionals. Moreover, the TMCT was the basis of the research questions that highlights the relationship between multicultural training received and multicultural counseling skills among mental health professionals. Cultural competency is attributable to several factors, including age, gender, and education. The researcher examined these factors in this study using the theoretical framework to establish findings that can help the future decisions of policymakers, such that the TMCT may also be used in the study if the results show that multicultural training do not have any effect to the results of the study.

Multiculturalism and Cultural Competence in Mental Health

Culture has no single definition. According to Lederach (1995), culture is the shared knowledge and schemes created by a set of people for perceiving, interpreting, expressing, and responding to their social realities. Hofstede (1984) believed that culture is the collective programming of the mind, which distinguishes the members of one group from another. Linton (1945) said that culture is the configuration of learned behaviors and results of behaviors whose component elements are shared and transmitted by the members of a particular society.

According to Ethnic Communities Council of Victoria (2006):

> Culture can be described as the interplay of many elements which including behaviors, customs, beliefs, values and institutions. Culture is sometimes described as a lens through which we view the world, meaning that one culture influences their perceptions and interactions in everyday life. A few of the

> dimensions of difference between cultures are apparent when considering different ways of understanding time, hierarchy, health, collectivism and individualism. Importantly though, while culture influences human interactions it must be viewed as dynamic rather than static. That is to say, culture changes over time and members of a particular culture or ethnicity will not always think and act in ways which are consistent with their cultural background. (p. 2)

Culturally diverse populations can be attributed to changing demographic trends (Kratzke & Bertolo, 2013). It is estimated that by 2050, the minority population in the United States will increase to 48%, with Hispanics representing 24.4% of the total population (Kratzke & Bertolo, 2013). The need for cultural competency arises from the continued increase of cultural diversity in the United States as reported by the U.S. Census Bureau (2010), which found that the U.S. population was comprised of 20% minorities, including 13.7% Hispanic, 12.2% African American, and 4.1% Asian/Pacific Islander, American Indian, and Alaskan Native people. It is also predicted that immigration by 2050 would increase the U.S. population from 303 million to 438 million (Passel & Cohn, 2008).

The main goal of cultural competence is the fostering of constructive interactions among members from different cultures (Ethnic Communities Council of Victoria, 2006). Cross (1989) defined cultural competence as the set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross cultural situations. The

observation of cultural competence does not end with a single step. Cultural competence is an ongoing process with the goal of striving towards the main goal (Cross, 1989).

The demographic shift would prove that understanding the cultural beliefs of the immigrant populations is vital to promoting a multicultural health program development (Kratzke & Bertolo, 2013). Horevitz et al. (2013) affirmed the centrality of cultural competence as an important values-based factor of optimal social work practice. According to Kratzke and Bertolo (2013), "It is critical for students to learn how their understanding of cultural differences and their cultural awareness affect providing quality care and health promotion" (p. 107). The Center on an Aging Society (2004) defined cultural competence as

> the ability of providers and organizations to understand and integrate these factors into the delivery and structure of the healthcare system. The goal of culturally competent healthcare services is to provide the highest quality of care to every patient, regardless of race, ethnicity, cultural background English proficiency or literacy. (p. 5)

Because cultural competence is perceived as providing positive effects, it is encouraged in institutions. For example, in institutions for education, counselors must first develop awareness of their own gender roles and ethnic identity to be culturally competent—thus, improving their MCC when dealing with students from diverse cultures (Chao & Nath, 2011). Moreover, Chao et al. (2011) have shown that training on multicultural encounters can significantly enhanced multicultural awareness and MCC, especially for people from the dominant culture or race such as White people. However,

students are said to receive some instruction on cultural awareness, but such instruction may not translate into multicultural competence (Walls, 2009).

According to Hong (1997), becoming culturally competent would prove advantageous because embracing diversity can build one's problem-solving capacity. Accepting different points of view creates more available solutions to problems (Hong, 1997). Mental health professionals must properly exhibit their expertise to help all racial/ethnic clients (Chao & Nath, 2011). Keeping an open mind when dealing with other people from different cultural backgrounds has several advantages. Thus, flexibility and open-mindedness are necessary consequences of cultural competence (Hong, 1997).

Having cultural competence is part of providing care for mental health patients. Today, it is recognized that cultural competence is not an isolated and independent variable of medical care (Center on an Aging Society, 2004). In providing healthcare to mental health patients, the diversity of culture among patients should always be considered. Cultural competence is a vital component in achieving excellence in healthcare (Center on an Aging Society, 2004). Cultural competence in mental health services should start among students, where they enhance their skills as part of the academic preparation (Kratzke & Bertolo, 2013). Sperry (2012) introduced five basic premises of cultural competence:

> (a) Cultural competence reflects a high level of social interest collaboration and mutuality. Practically speaking, it fosters acceptance, cooperation, and tolerance of difference; (b) Cultural competence has four dimensions: cultural knowledge, cultural awareness cultural sensitivity, and cultural action; (c) Cultural

> competence has various levels, ranging from “very low” to “very high”; (d) The overall level of cultural competence is characterized by the degree to which each of the four dimensions is operative; (e) Effective professional work requires at least a “moderate” level of cultural competence and the capacity to demonstrate all four of its components. (pp. 312–312)

In mental health, Leininger (1996), the founder of the theory on transcultural nursing, defined culture as “the learned and transmitted values, beliefs, and practices that provided a critical means to establish culture-care patterns from the people” (p. 36). Cultural competence is rooted on a keen understanding of what culture is, including the implications of why it is important to understand the concept of culture. Cultural competence is a requisite of social work education (Rodenborg & Boisen, 2013).

Recently, the attention of scholars and practitioners has been moved beyond the overviews of minority groups to the inclusion of more social theory (Rodenborg & Boisen, 2013). While culture has several definitions formulated by various scholars, the same is true for cultural competence. Cultural competence has no single definition. Sperry (2012) defined cultural competence as the “capacity to interact effectively with other cultures” (p. 311). Further, the term multicultural competence was first coined by Pedersen (1988) to create a wider scope than cultural competence.

Despite the need to develop MCC among psychology students, research shows that training programs for psychology students in schools, trainers have been said to experience difficulty in adequately including multicultural content into the curriculum; thus, affecting the MCC levels of students (Chao & Nath, 2011; Newell et al., 2010;

Sehgal et al., 2011). The lack of the skill may be harmful for mental health patients. Mental health professionals are therefore obligated to consider patients' ethnicities as a major factor because the lack of cultural competence among healthcare professionals can cause fatal repercussions (Sperry, 2012).

In 2007, New Jersey legislators started requiring physicians to undergo cultural competency training before practicing in the profession (Sperry, 2012). Based on the definition of multicultural competence by Pedersen (1988), awareness, knowledge, and skills are the three components of multicultural competence. Cultural competence has two important aspects. (Sperry, 2012). The first aspect is the acknowledgement of the embedded nature of individuals in organizations or institutions. The second involves the developmental process, where the levels of awareness evolve over an extended period (Sperry, 2012).

The need for cultural competence arises due to language and communication problems. The Center on an Aging Society (2004) noted that language and communication problems may lead to dissatisfaction of patients, poor adherence, and comprehension and lower quality of care. Language and communication problems should be avoided to increase patient satisfaction of the medical services that the patient receives.

To facilitate the development of effective multicultural training, several factors must be considered, especially when training psychology students. Newell et al. (2010) stated that to develop and improve multicultural training in school psychology, guidance is needed regarding the content and structure necessary to adequately develop

multicultural competence. Rust et al. (2013) claimed that to improve MCC, mental health professionals and their respective supervisors must understand their own cultural group memberships and its influences on their evaluation methods toward their trainees. The relationship between the trainees and their mental health professional trainers must also be considered to facilitate proper MCC development (Rust et al., 2013). The effectiveness of these factors has not been considered based on findings between mental health professionals who did and did not receive training in multicultural competencies that have these factors (Newell et al., 2010; Rust et al., 2013).

The use of cultural competence is not limited to the medical and mental health fields. Cultural competence has always been advanced in culturally diverse groups, including people in places where refugees comprise a significant percentage of the population (APA, 2009). The APA (2009) mentioned:

> Clinical services for war-affected refugee populations must reflect cultural competence by offering services that effectively meet the needs of multicultural populations. Inherent in this notion of culturally competent care is the concept of identifying needs and creating clinical services consistent with a population's values, beliefs, and practices. (p. 9)

Suggestions for the improvement of multiculturalism in mental health include language services training. Practitioners in the mental health profession should be offered training on how to render services without the language barriers, in addition to having ready access to data on the special needs of patients pertaining to language and communication (NCQA, 2010). Cultural responsiveness would promote multiculturalism

in the field of mental health (NCQA, 2010). Hospitals and clinics should provide access on information regarding the race of patients to ensure that mental health professionals will be able to provide culturally appropriate care and be able to address shortcomings when necessary (NCQA, 2010).

A culturally competent organization ensures a commitment to the skill throughout the various levels of organizational hierarchy, including the mission statement, philosophy, organizational policies, and advocacy (Ethnic Communities Council of Victoria, 2006). Aside from ensuring compliance at the organizational level, individuals should also comply with cultural competence guidelines. For the individual, the process of cultural competence involves becoming culturally aware, gaining cultural knowledge, and achieving cultural skills (Mays, 2002).

The medical education system has been aware that cultural competence carries with it important moral underpinnings (Paasche-Orlow, 2004). According to Paasche-Orlow (2004), the essential principles of cultural competence are acknowledgement of the importance of culture in people's lives, respect for cultural differences, and minimization of negative consequences of cultural differences. It is perceived that healthcare provided with cultural competence will promote justice and patient autonomy (Paasche-Orlow, 2004). Thus, the deeper understanding of how patients need quality care is included in the responsibilities of a responsible medical professional (Paasche-Orlow, 2004). Further, Paasche-Orlow (2004) suggested that “learning about disparities in health outcomes should institute a cascade of events to determine the barriers experienced by

patients and the types of accommodation needed to ameliorate the health burden due to cultural difference" (p. 348).

Based on existing research, it is known that the medical education system gives importance to cultural competence of psychology students and mental health professionals (Horevitz et al., 2013; Kratzke & Bertolo, 2013; Paasche-Orlow, 2004). Despite the importance of cultural competency in psychology, research suggests that mental health professionals are generally unprepared to address multicultural issues or issues related to cultural diversity (Chao & Nath, 2011; Crook-Lyon et al., 2012). Moreover, empirical studies on the cultural competence of psychology students are lacking in existing research. Hence, this will be the focus of this proposed study, specifically, counseling graduates to support for counseling program graduates.

Discrimination in Mental Health

Discrimination in mental health is caused by several socio-economic factors that characterize the patients. Scholars have admitted that there are health disparities where ethnic and racial minority groups shoulder a disproportionate burden of negative health outcomes (Horevitz et al., 2013). Betancourt et al. (2002) revealed that individuals from minority ethnic and racial groups are likely to develop health problems disproportionately to individuals who come from majority groups. Health disparities are present in almost every medical institution. Medical health professionals must eliminate, if not abolish, health disparities. Health disparities are still present, even after manipulating other variables such as insurance status, age, and socioeconomic status (Betancourt et al., 2002).

Bias in social work has also been noticed. This bias is related to the possible discrimination in mental health. From social psychology, two theories may imply the likelihood of bias in social work: aversive racism and intergroup contact (Rodenborg & Boisen, 2013). Aversive racism focuses on race and ethnic discrimination (Rodenborg & Boisen, 2013). Most discrimination is attributed to ethnic and race roots of the patients.

Surveys have recorded the percentages of discrimination experienced in the field of mental health. Patients with mental health problems experience discrimination, and 87% of individuals with mental health issues have been affected by discrimination and stigma (National Mental Health Development Unit, n.d.). Because of the stigma that mental health patients receive in society, an average of 71% of people with mental health issues have already changed their ways of doing things (National Mental Health Development Unit, n.d.). The negative connotation of mental health problems affects various aspects of an individual's life, including education, community participation, friendships, and other social relationships (National Mental Health Development Unit, n.d.). Most often, mental health patients are not able to live a normal life because of the negative connotations the public attach to them. The discrimination in mental health can be attributed to the negative portrayal in the media pertaining to people with mental illness (National Mental Health Development Unit, n.d.).

Link and Phelan (2001) described stigma as occurring “when elements of labelling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold” (p. 367). Corrigan and Watson (2002) created a model on public stigma wherein the reaction of the public to the people

with mental health problems was analyzed. In addition to stigma, stereotypes have also been in place to define people affected with certain mental health conditions. According to Major and O'Brien (2005), stereotypes include the negative connotations normally associated with members of a certain culture or society. These connotations eventually become the basis for the avoidance of particular groups. To avoid discrimination and stereotypes, mental health literacy should be in place (Major & O'Brien, 2005).

Stigma and discrimination can have serious detrimental effects, including economic and personal consequences (McDaid, 2010). People may have negative attitudes towards patients with mental health problems (McDaid, 2010). Often, negative attitudes are derived not from the public or the media but from mental health professionals, creating an increase in social distance and social exclusion (McDaid, 2010). In addition to institutional issues among mental health service providers, the stigma towards mental health patients can affect policymakers and render them unwilling to invest in mental health institutions (McDaid, 2010).

Even in chronic diseases, ethnic and racial minorities exhibit a higher rate of mortality and morbidity, which can be attributed to greater financial burden (Center on an Aging Society, 2004). The difference is because of the disparity in access to healthcare of different races and ethnicities (Center on an Aging Society, 2004).

In relation to this study, culture or ethnicity is said to be a determinant of discrimination in terms of the healthcare given to individuals, wherein people from minority groups feel more disadvantaged as compared to those from majority groups because of healthcare professionals' lack of understanding the behavior and preferences

of people from minority groups (Horevitz et al., 2013; Rodenborg & Boisen, 2013). The modern era calls for the improvement of a stigmatized realm by "improving social inclusion, becoming social activists who challenge stigma and discrimination, and promoting societal well-being," which needs to be "the norm rather than the exception for mental health professionals in the 21st Century" (Slade, 2010, p. 13). This highlights the need for developing the multicultural competency and skills of these healthcare professionals. To aid mental health patients, discrimination should be decreased, if not abolished.

Importance of Personal Demographics and Multicultural Counseling Skills

In several studies, the researchers focused on the importance of considering the demographic variables and multicultural counseling skills to improve effective counseling of mental health professionals (Berger et al., 2014; Pope-Davis & Ottavi, 1994; Reynolds & Rivera, 2012). Berger et al. (2014) focused on examining therapist characteristics, therapeutic orientations, person-level and agency-level practices and their relationship with cultural competency. Berger et al. (2014) found that ethnic minority therapists were more personally involved in communities of color, more likely to use a cultural framework in clinical practice, and perceived their agencies to be more culturally sensitive as compared to White or Caucasian therapists. Hence, it was not surprising that Berger et al. (2014) found that ethnic minority therapists also reported greater multicultural and better multicultural counseling relationships than White therapists.

In a related study, Pope-Davis and Ottavi (1994) explored the relationship between demographic variables and self-reported multicultural counseling competencies

among therapists or counselors, with specific focus on multicultural awareness, knowledge, skills, and relationships. Using multivariate and univariate analyses, Pope-Davis and Ottavi found that Asian American and Hispanic counselors reported more multicultural knowledge than did White counselors (1994); thus, affirming the results of Berger et al. (2014). Pope-Davis and Ottavi also found that Asian American and Hispanics African American, Asian American, and Hispanic counselors reported more competence in multicultural awareness and relationships than did White counselors (1994). Based on the findings of Berger et al. (2014) and Pope-Davis and Ottavi (1994), ethnicity is a demographic variable that has a significant relationship with the multicultural skills of individuals.

Reynolds and Rivera (2012) explored the role of attitudes and psychological factors that may affect the self-reported multicultural competence of counseling professionals. The results of the study revealed a positive and significant relationship between Cognitive Racial Attitudes (as measured by the Quick Discrimination Index) and self-reported multicultural competence. Cognitive Racial Attitudes measured through the QDI refer to attitudes toward racial minority groups and women (Reynolds & Rivera, 2012). The significant relation that emerged between attitudinal characteristics and self-reported multicultural counseling competence suggests that by focusing on students' attitudes on diversity we may be able to impact the development of multicultural competence (Pope-Davis & Ottavi, 1994; Reynolds & Rivera, 2012).

Dodson (2013) explored the self-perceived multicultural competence of school counselors. Recruiting 41 school counselors from the American School Counselor

Association (ASCA), data gathering was performed through demographic survey and the Multicultural Counseling Knowledge and Awareness Scale (MCKAS). From the analysis, it was found that one (race/ethnicity) out of eight demographic variables demonstrated significance in relation to multicultural competence (Dodson, 2013). In a similar study, Bellini (2002) focused on multicultural counseling competencies for a sample of vocational rehabilitation counselors were examined. One hundred seventy-five counselors completed the Multicultural Counseling Inventory (MCI) and a demographic questionnaire. Demographic, experiential, and training variables were analyzed in relation to counselors' self-reported multicultural counseling competencies. Together these three variable sets explained 33% of the variation in MCI score, and each variable set significantly added to the variation in multicultural competencies. More specifically, gender, race, participation in a graduate class in multicultural counseling, and participation in a greater number of workshops on multicultural issues over the previous five years were found to significantly predict MCI total score (Bellini, 2002). Based on these studies, future research should include using a larger, ethnically diverse sample (Dodson, 2013). Based on the studies, it is recommended that more aspects of multiculturalism, other than race/ethnicity, be further explored. Through this proposed study, the variables of gender, age, and continuing education of mental health professionals were explored.

Multicultural Training

Several studies touched on cultural competency training in the healthcare setting. Training plays an important role in developing cultural competence. Cultural competence

training should factor in developing the communication and practical skills of healthcare professionals to be more culturally competent, increasing awareness of discrimination and inequities that minority groups experience, and providing culturally competent care to individuals (Kingsley, 2001; Kraemer, 2001).

Diallo and McGrath (2013) highlighted that cultural competence programs are of great importance due to the shift in the ethnic groups of patients receiving primary care. Culturally sensitive quality care needs to be provided with this shift. The researchers noted challenges with training healthcare professionals on cultural competency, which is basically the difficulty in measuring and defining cultural competency. Training programs to improve cultural competency is present; however, changes in demographic need consideration, and this is where these trainings programs are unable to keep up (Gallardo & Kaivan, 2000). Traditional perceptions on healthcare need to evolve along with the changing demographic.

In Hanssmann et al. (2010), the researchers focused on the community competency trainings provided to healthcare and social service providers in relation to the healthcare they provide to LGBTs. Participants of the study were healthcare and service providers who attended the community competency trainings. Results showed that training sessions contribute to increasing the competence, clinical and cultural, of healthcare professionals. The participants responded to the trainings positively.

The American Counseling Associations Code of Ethics (2014) has incorporated more information to ensure multicultural competency is achieved. According to Kaplan et al. (2017), 13 ethicists over 3 years collected tons and tons of literature from around

the country and created 2014 American Counseling Association Code of ethics. The ethicist was called the ACA Ethics Revision Task Force. The ACA Ethics Revision Task Force developed the ACA code of Ethics with all of the additional tools needed to ensure multicultural competency is achieved. Kaplan et al (2017) revealed from the additions made for the ACA Code of Ethics provided all the tools for counselors and clients.

Pernell-Arnold et al. (2012) focused on investigating how mental health providers can become more culturally competent. Dougherty (2004) believed that cultural competency training is an approach to reduce the cultural disparities among mental health providers. It is believed that a developmental process through training can improve cultural competence. Pernell-Arnold et al. (2012) implemented 2-day monthly sessions for 10 months. These sessions were divided into developmental and sequential phases to aid in transitions. The data through the logs from participants were used in the study. Results showed a change in the view of the participants of the session due to cultural competence training in those sessions. Ethnocentric views shifted to ethno-relative thinking, where participants accepted the differences in views and adapted to this difference. Pernell-Arnold et al. (2012) posited that the change was not constant, but varied. The process of change in each participant was different, but all had upward progression. This study will add to the research on continuing education in multicultural skills, which will be discussed in chapter 5.

Summary

Based on the review of existing literature, psychology and mental health are significant to the development of a human being (Panayiotopoulos et al., 2013). Researchers have shown that mental health is not an exact science, wherein every mental issue has a prescribed and precise solution that mental health professionals can follow (McLaren, 2010). Innovations within the field of mental health are continually needed, especially with the advancement in technology and the role of multicultural settings in society (Jones-Smith, 2011; McLaren, 2010; Sue et al., 1996).

Mental health professionals tend to encounter more diverse client groups in terms of cultural backgrounds, with the increasing cultural diversity present within a given society (Jones-Smith, 2011; Sue et al., 1996). Increasing cultural diversity in a given population can be attributed to changing demographic trends (Kratzke & Bertolo, 2013). To address this increasing cultural diversity, mental health professionals are expected to be equipped with the necessary knowledge and skill to interact with clients from different cultural backgrounds (Kratzke & Bertolo, 2013; Panayiotopoulos et al., 2013; Smith et al., 2013). Counselors and mental health professionals must undergo training to develop their multicultural skills when dealing with people from different cultural backgrounds (Ivey et al., 2013). These trainings, however, do not fully reflect such concepts that develop multicultural skills and competencies of counselors (Ivey et al., 2013; Sue et al., 1996). In line with this, Sue et al. (1996) developed the TMTC.

The TMTC claims that people are unique, depending on their cultural background, which must be understood to provide proper care and respect (Sue et al.,

1996). The gap established from the literature review is that despite the significance of development of multicultural competency among counselors or mental health professionals to ensure their multicultural effectiveness, literature has not fully explored this phenomenon. TMTC stresses a need to develop multicultural skills among professionals, including counselors and mental health professionals, who interact with people from different cultural backgrounds (Sue et al., 1996), which is the basis for this study's purpose and research questions.

In Chapter 3, The researcher will discuss the details of the research methodology and research design selected to fill the literature gap and answer the research questions of the study. This includes the population and sample size, and procedure for sampling, instrumentation, data collection, and data analysis, as well as ethical considerations.

Chapter 3: Methodology

This survey research study had two purposes. First, the researcher aimed to investigate the multicultural counseling perceptions between mental health professionals who did and did not receive formal training in multicultural competencies in their degree programs as well as post-graduation while a practitioner. The second purpose was to compare the participants' multicultural counseling skills based on the demographics age, gender, and education. The researcher used a quantitative research design to examine both purposes. For this study, the independent variables included exposure to multicultural training in graduate programs and multicultural training in post-graduate programs. The dependent variable was multicultural counseling skill (measured by multicultural knowledge and multicultural awareness) for mental health professionals. The researcher addressed the following research questions and hypotheses:

Research Question 1

What is the relationship between multicultural training received and multicultural counseling skills awareness of mental health professionals (measured through Multicultural Counseling Knowledge and Awareness Scale) who received and did not receive multicultural counseling training in the completion of graduate program?

H_{01}: There is no significant difference in the awareness of mental health professionals who received or did not receive multicultural counseling training

H_{a1}: There is a significant difference in the awareness of mental health professionals who received or did not receive multicultural counseling training

Research Question 2

What is the relationship between multicultural training received and multicultural counseling skills knowledge of mental health professionals (measured through Multicultural Counseling Knowledge and Awareness Scale) who received and did not receive multicultural counseling training in the completion of graduate program?

H_{02}: There is no significant difference in the knowledge of mental health professionals who received or did not receive multicultural counseling training

H_{a2}: There is a significant difference in the knowledge of mental health professionals who received or did not receive multicultural counseling training

Research Question 3

Do the multicultural training received and the age of the counselor individually or in linear combination predict the counselor's mental health awareness?

H_{03}: Multicultural counseling training and age of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' awareness

H_{a3}: Multicultural counseling training and age of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' awareness

Research Question 4

Do the multicultural training received and the age of the counselor individually or in linear combination predict the counselor's mental health knowledge?

H_{04}: Multicultural counseling training and age of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' knowledge

H_{0a4}: Multicultural counseling training and age of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' knowledge

Research Question 5

Does the multicultural training received and the education of the counselor individually or in linear combination predict the counselor's mental health awareness?

H_{05}: Multicultural counseling training and education of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' awareness

H_{a5}: Multicultural counseling training and education of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' awareness

Research Question 6

Do the multicultural training received and the education of the counselor individually or in linear combination predict the counselor's mental health knowledge?

H_{06}: Multicultural counseling training and education of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' knowledge

H_{a6}: Multicultural counseling training and education of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' knowledge

Research Question 7

Do the multicultural training received and the gender of the counselor individually or in linear combination predict the counselor's mental health awareness?

H_{07}: Multicultural counseling training and gender of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' awareness

H_{a7}: Multicultural counseling training and gender of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' awareness

Research Question 8

Does the multicultural training received and the gender of the counselor individually or in linear combination predict the counselor's mental health knowledge?

H_{08}: Multicultural counseling training and gender of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' knowledge

H_{08}: Multicultural counseling training and gender of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' knowledge

Chapter 3 includes the discussion of the methodology of the proposed study. Specifically, this chapter includes details on the research design, population, sample size, sampling plan, the instrumentation or the measures used to measure the study variables, methods for data collection, data analysis, and ethical considerations. Chapter 3 concludes with a summary section.

Research Design

The researcher used a survey-based quantitative research design in this study to determine the differences in the effectiveness in multicultural counseling between mental health professionals who did and did not receive training in multicultural competencies in their degree programs as well as post-graduation while a practitioner using demographic variables of age, sex, and education. The researcher chose a quantitative method for this study because this type of research method is typically used to investigate the relationships between variables (Babbie, 2012). Quantitative methodologies are usually used when attempting to establish relationships and differences between two or more variables measured numerically (Babbie, 2012). The researcher measured the variables for this study quantitatively in order to statistically test them. Quantitative variables must be numerical or be converted to a numerical form through an instrument; therefore, the researcher used a survey instrument to quantitatively measure the study variables. The researcher attempted to identify relationships between variables through quantifying larger amounts of data using a variety of statistical techniques, including regression analysis.

The researcher used the multiple regression analysis quantitative method. This was because the objective of this quantitative study was to determine relationships between variables or the impact of various independent variables to a dependent variable. Correlational studies can only suggest a relationship between two or more variables, not cause-and-effect relationships (Zikmund et al., 2010). The current study was nonexperimental because there were no interventions introduced to the participants.

Population, Sample Size, and Sampling Procedure

The researcher accessed the sample of the study consisting of mental health professionals who agreed to participate. The inclusion criteria included members of the American Counseling Association listed on the American Counseling website. Only those mental health professionals who were in the official website were sampled for this study to ensure that as many psychologists and mental health professionals as possible were contacted for the survey process. The exclusion criteria of the sample include those mental health professionals who do not have their names on the website. The population that the researcher targeted was located in the geographical region of United States. The demographic information of the sampled participants had no restrictions. Specifically, there were no restrictions placed on the age, gender, and education levels of the mental health professionals. A larger ethnically diverse sample was a suggestion from previous research, so this study involved no restrictions on demographics.

A priori power analysis was conducted using the G*power to determine the minimum required number of study participants for this study. The researcher conducted a priori power analysis employing the statistical test of linear multiple regression with

four predictors (i.e., exposure to multicultural training and the demographics of age, gender, and education), using a statistical power of 0.8, the minimum required power for a quantitative study (Faul et al., 2009), a medium effect size (0.15), and a level of significance or alpha level of 0.05. The resulting required minimum sample size for an appropriately powered study computed in the priori analysis was 55 study participants. This was the minimum required sample size for the researcher to achieve a necessary statistical power of 80%. Response rate using G* Power analysis showed a power of 0.80 to be statistically significant for each research hypothesis.

To ensure that the minimum of 55 mental health professionals with different multicultural counseling training statuses were recruited, the researcher employed a purposeful sampling method. The researcher chose this method because the samples of mental health professionals recruited included only those that have contacts or were included in the American Counseling website. Purposeful sampling was used because of the accessibility advantage, higher speed, and lesser costs to sample the study participants (Coy, 2008). A purposeful sampling strategy was used to limit the study to one sample pool—specifically, those American Counseling Association members with names included in the American Counseling website.

Instrumentation

The researcher administered a survey to gather the data needed for numerical analysis. Survey research provides a holistic view of the problem derived from a systematic process of evaluation and produces numerical descriptions about targeted aspects of the population being studied (Creswell, 2009). The researcher chose a survey

for the data collection method due to its cost- and time-efficiency advantages in gathering large amounts of data to analyze (Creswell, 2009). The survey was based on a set of questions already prepared for the research. The creation of a standardized evaluation of the collected data decreased the possibility of the researcher's personal bias influencing the data interpretation.

Demographic Questionnaire

Appendix B summarizes the demographic questionnaire that the researcher used to measure the independent variables of exposure to multicultural training in one's graduate program and the demographics such as age, gender, and education. The researcher measured this demographic information using nominal or ordinal responses by creating groups of categories for each of the study variables.

Multicultural Counseling Knowledge and Awareness Scale

Appendix C summarizes the Multicultural Counseling Knowledge and Awareness Scale, which the researcher used to measure the dependent variable of multi-cultural counseling skill of the mental health professionals. The MCKAS is a 32-item self-report inventory of perceived multicultural counseling knowledge and awareness created by Ponterotto et al. (2002) and is a revision of the earlier Multicultural Counseling Awareness Scale (MCAS). The MCKAS is a two-factor instrument that includes 20 knowledge items and 12 awareness items. The 20 knowledge items are questions 2, 3, 5, 6, 8, 9, 12, 13, 14, 15, 16, 17, 19, 21, 22, 23, 27, 28, 31, and 32. These items are all worded in a positive direction where high scores indicate higher perceived knowledge of multicultural counseling issues. The score range for the knowledge scale ranges from 20

to 140 using aggregate score. The 12 awareness items are questions 1, 4, 7, 10, 11, 18, 20, 24, 25, 26, 29, and 30. Items 1, 4, 7, 10, 11, 18, 20, 24, 25, and 30 are reversed-coded before getting the total score for awareness. After reverse coding, the total score range for the awareness scale ranges from 12 to 84 with higher scores indicating higher awareness of multicultural counseling issues. In terms of reliability and validity of the MCKAS, Cronbach's Coefficient alphas have clustered in the 0.92 range for the knowledge scale and in the 0.78 range for the awareness scale, indicating that the two factors are internally consistent.

Data Collection Process

The researcher gained permission from the American Counseling Association to recruit mental health professionals that are part of their website for inclusion in the survey research. The researcher introduced the current study to the leaders of the American Counseling Association to provide them details about the study's purpose and describe the survey methodology that the mental health professionals would undergo. After receiving permission to recruit the mental health professionals from the association leaders, data collection proceeded. The researcher conducted the data collection procedure for the quantitative survey electronically or online. Michaelidou and Dibb (2006) identified several advantages of online data collection procedures, including easy access, lesser cost, and the promise of anonymity. In addition, when conducting a survey through the Internet, the researcher can eliminate any effect that the presence of the surveyor may have on the subjects.

The survey was posted in the online survey tool of Survey Monkey for the study participants to easily gain access the survey questionnaire. Survey Monkey is a web-based survey instrument that specializes in providing a platform and participants for surveys. The use of Survey Monkey allows random sample selection of a sample, where each participant has an equal opportunity to be selected to answer the survey (Garson, 2013). The link to the survey questionnaire was e-mailed to the American Counseling Association members. The researcher obtained their contact information from the American Counseling Association website.

In the online page of Survey Monkey, an introductory page provided an explanation of the purpose of the study, instruction on how to answer the surveys, informed consent form of promise of anonymity and confidentiality, and then the survey questionnaires. After reading the introductory paragraphs, the informed consent form appeared. The informed consent disclaimer appeared at the start of the survey and required an affirmative response prior to advancing to the actual survey; the disclaimer ensured the informed consent of the individual participants. The respondent was required to click “agree” to participate in the study and to access the survey questionnaire. The researcher did not allow the respondents to answer the survey questionnaire if they did not provide electronic consent for participation. The disclaimer in the informed consent form made it clear that participation was voluntary and could be withdrawn at any time, and that responses would remain anonymous.

Each of the respondents were allotted a maximum of 30 minutes or less to complete the survey process. At the end of the survey, the participants were thanked for

their participation. Data collection stopped when the researcher received responses from a) 28 mental health professionals who received multicultural counseling training either in their degree program or while a practitioner and b) 28 mental health professionals who did not receive multicultural counseling training.

After collected the required number of responses from the sample, all of the responses from the different respondents were coded to ensure that their responses could not be identified during data analysis and reporting of results. The researcher assigned codes to each respondent instead of putting their name in order to maintain their anonymity. The researcher summarized the collected data in an Excel sheet to prepare the data for the analysis. The different study variables were enumerated in the columns of the Excel sheet, while the rows listed the response data of the different samples.

Data Analysis

The researcher entered all survey question responses and collected demographic data into SPSS (Version 18.0) for analysis. Prior to the statistical analysis to address the research questions of the study, The researcher conducted descriptive analysis to summarize the data of the measured study variables and demographic information. The study variables include the independent variables of exposure to multicultural training in one's graduate program, multicultural training received as a practitioner and the demographics of age, gender, and education, as well as the dependent variable of multi-cultural counseling skill. The researcher used central tendency measures of means and standard deviation to summarize the data for the continuous measured study variable of multi-cultural counseling skill. The researcher used frequency and percentage summaries

to summarize the data of the categorically measured study variables of exposure to multicultural training in one's graduate program and the demographics of age, gender, and education. In addition, the researcher obtained skewness and kurtosis statistics and histograms of the study variables in order to verify that the data were normally distributed. This is a required assumption when using parametric statistical analysis. The researcher generated scatter plots in order to investigate presence of anomalies or outliers in the data before conducting the statistical analysis. The researcher removed any identified outliers from the data set.

For RQ1, to determine whether there was a significant difference in the awareness of mental health professionals who received or did not receive multicultural counseling training, I ran an independent sample t-test. For RQ2, to determine whether there was a significant difference in the knowledge of mental health professionals who received or did not receive multicultural counseling training, I ran an independent sample t-test. The independent variables were exposure to multicultural training in one's graduate program and multicultural training received post-graduation as a practitioner, while the dependent variable was multicultural counseling skill. The dependent variable of multicultural counseling skill had two measures based on the two-factor of the MCKAS instrument: knowledge and awareness.

A *t*-test is a statistical analysis that compares the means of two categorical groups (Green & Salkind, 2011). In this study's case, the two categorical groups for the independent variable of exposure to multicultural training were mental health professionals who received and did not receive multicultural counseling training.

Through the *t*-test, the researcher determined whether the mean scores on the two-factors of multicultural counseling skill of knowledge and awareness between the two categorical groups were significantly different based on a level of significance of 0.05. A significant difference in the multicultural counseling skill measures of knowledge and awareness existed if the *p*-value of significance of the *t*-test is less than or equal to the level of significance value of 0.05. This determined whether the researcher supported or rejected the hypotheses. After the *t*-test shows the significance of the difference of the multicultural counseling skill, the researcher compared the mean differences of the multicultural counseling skill between the two population groupings. Through this analysis, the researcher determined whether participants who had multicultural training had higher multicultural counseling skill scores than the ones who did not participate in the training.

For Research Questions 3 through 8, the researcher performed multiple linear regression analysis to determine the relationship between exposure to multicultural training in a graduate program or post-graduation and the multicultural counseling skills of mental health professionals after controlling for the demographics of age, gender, and education. The independent variables were exposure to multicultural training in one's graduate program and multicultural training received post-graduation as a practitioner, while the dependent variable was the two-factors of multicultural counseling skills of knowledge and awareness. Age, gender, and education were considered as control variables in the regression model. The researcher generated separate regression models,

one for each dependent variable, wherein each of the models included the same independent variable and control the same demographic information.

The researcher used a level of significance value of 0.05 to determine the statistical significance of relationships in the regression analysis. The researcher determined the presence of a statistically significant relationship between the independent variables and the dependent variables if the probability value of significance (*p*-value) of the regression was less than or equal to the level of significance value after controlling the effects of the control variables. If the parameter estimate is significant at the 0.05 significance level, the null hypothesis was rejected, which implies that there is a statistically significant relationship between independent variable and the dependent variable. Then, the beta coefficient of the regression was investigated to determine how strongly the independent variable is associated with the dependent variable. A positive regression coefficient means that the dependent variable increases as the independent variable increases, while a negative regression coefficient means that the dependent variable decreases as the independent variable increases.

In SPSS, the researcher added the control variables of age, gender, and education of mental health professionals in the first block to determine their effects to the dependent variables. This analysis controlled for the effects of these control variables. The independent variables of interest of exposure to multicultural training in one's graduate program and multicultural training received post-graduation as a practitioner were then added to the second block of the multiple regression model. The researcher then determined any statistically significance of additional variances accounted for by this

independent variable to the dependent variable. This process allowed the individual effects of each control variable to be isolated. The result of the analysis determined the individual effects of each independent variable of interest to the dependent variable in the presence of the control variables by examining the statistical significance of the change in the correlation coefficient R^2. Age and education variable were coded as ordinal measures in SPSS and used in the analyses. The only options for gender that were selected were male and female so it was dummy coded. The regression equations can be written as follows:

$$Y_{\text{knowledge}} = \text{constant} + B_1 X_{\text{exposure to multicultural training}} + B_2 X_{\text{age}} + B_3 X_{\text{sex}} + B_4 X_{\text{education}} + e, \quad (1)$$

$$Y_{\text{awareness}} = \text{constant} + B_1 X_{\text{exposure to multicultural training}} + B_2 X_{\text{age}} + B_3 X_{\text{sex}} + B_4 X_{\text{education}} + e, \quad (2)$$

where *Y* is the value of a dependent variable, *X* is the value of an independent variable, *B* is a beta coefficient, and *e* is an error term, since the regression equation has not been estimated yet.

Ethical Considerations

The researcher took several steps to ensure participants' confidentiality and anonymity in this research. The University Institutional Review Board (IRB) reviewed the measures for the protection of participants, both ethically and legally. Prior to conducting the survey process, the purpose of the study and the survey process that the participants would undergo was first explained clearly to the participants. The participants indicated their consent by agreeing to the informed consent form in order to

ensure that they understand the purpose of the study. The researcher did not use written consent forms due to this being an electronic survey, as well as to protect the confidentiality of participants, as consent forms would be the only identifying information linking the surveys to the participants' identifying information.

The researcher notified the participants that they had the right to discontinue participation whenever they want to, and their survey responses would be discarded if they requested this. To ensure the anonymity and confidentiality of the survey responses, the researcher marked all gathered data using an alphanumeric code instead of putting the names of the respondents. The researcher kept in confidence names and any information that may lead to the identification of the participants and were not given to any third party.

For data storage, the researcher uploaded the data into a personal computer. The researcher maintained a cloud-based server and database as a collection point, which is encrypted and password protected. Data received remained secure and confidential during the study and will be held for 3 years after its conclusion. The researcher stored soft copies of the results obtained digitally in a personal portable hard disk drive inside of a safe. The drive will be electronically wiped clean and physically destroyed after 3 years.

Summary

In this chapter, the researcher discussed the methodology for this study. The purpose of this quantitative correlational study was to investigate the effectiveness of multicultural counseling between mental health professionals who did and did not receive

formal training in multicultural competencies in their degree programs as well as post-graduation as a practitioner. The researcher also compared the participants' multicultural counseling skills based on the demographics to include age, gender, and education. The researcher used quantitative methods to answer the research questions. Specifically, a correlational research design using survey instruments was employed to collect the needed data of the study variables. The researcher collected survey data using an online survey tool of Survey Monkey. The researcher analyzed the data using descriptive statistics, *t*-tests, and multiple linear regression to address the eight research questions of the study.

In summary, this chapter discussed a plan for the methodology of this study. The chapter also discussed the methods through which the data were collected and analyzed. Then, the chapter described the sample population, sample size, and sampling plan in detail, as well as the data collection and analysis process that took place, including how the data relates to the research questions. The next chapter will discuss the results of the analysis and answer the research questions of the study.

Chapter 4: Results

Introduction

The purpose of this quantitative study was to investigate if counselors' multicultural counseling awareness and knowledge differed based on the training they received as formal training in multicultural competencies in their degree programs as well as post-graduation. A further objective was to compare the participants' multicultural counseling awareness and knowledge based on the demographics of age, gender, and education. For this study, the independent variables included exposure to multicultural training in a graduate program, or multicultural training received post-graduation as a practitioner. The control variables were the demographics of age, gender, and education. The dependent variables were multicultural counseling awareness and knowledge. The researcher conducted descriptive statistics analyses, independent sample *t*-tests, and multiple linear regression analyses in order to answer the research questions. The researcher used SPSS version 21 to run the different statistical analyses. Specifically, the researcher answered the research questions by testing the following hypotheses:

Research Question 1

What is the relationship between multicultural training received and multicultural counseling skills awareness of mental health professionals (measured through Multicultural Counseling Knowledge and Awareness Scale) who received and did not receive multicultural counseling training in the completion of graduate program?

H_{01}: There is no significant difference in the awareness of mental health professionals who received or did not receive multicultural counseling training

H_{a1}: There is a significant difference in the awareness of mental health professionals who received or did not receive multicultural counseling training

Research Question 2

What is the relationship between multicultural training received and multicultural counseling skills knowledge of mental health professionals (measured through Multicultural Counseling Knowledge and Awareness Scale) who received and did not receive multicultural counseling training in the completion of graduate program?

H_{02}: There is no significant difference in the knowledge of mental health professionals who received or did not receive multicultural counseling training

H_{a2}: There is a significant difference in the knowledge of mental health professionals who received or did not receive multicultural counseling training

Research Question 3

Does the multicultural training received and the age of the counselor individually or in linear combination predict the counselor's mental health awareness?

H_{03}: Multicultural counseling training and age of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' awareness

H_{a3}: Multicultural counseling training and age of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' awareness

Research Question 4

Does the multicultural training received and the age of the counselor individually or in linear combination predict the counselor's mental health knowledge?

H_{04}: Multicultural counseling training and age of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' knowledge

H_{0a4}: Multicultural counseling training and age of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' knowledge

Research Question 5

Do the multicultural training received and the education of the counselor individually or in linear combination predict the counselor's mental health awareness?

H_{05}: Multicultural counseling training and education of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' awareness

H_{a5}: Multicultural counseling training and education of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' awareness

Research Question 6

Do the multicultural training received and the education of the counselor individually or in linear combination predict the counselor's mental health knowledge?

H_{06}: Multicultural counseling training and education of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' knowledge

H_{a6}: Multicultural counseling training and education of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' knowledge

Research Question 7

Do the multicultural training received and the gender of the counselor individually or in linear combination predict the counselor's mental health awareness?

H_{07}: Multicultural counseling training and gender of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' awareness

H_{a7}: Multicultural counseling training and gender of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' awareness

Research Question 8

Do the multicultural training received and the gender of the counselor individually or in linear combination predict the counselor's mental health knowledge?

H_{08}: Multicultural counseling training and gender of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' knowledge

H_{08}: Multicultural counseling training and gender of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' knowledge

Summary of Demographic Information

The initial sample included 55 mental health professionals practicing in the United States; however, eight (14.5%) of these mental health professionals were removed due to missing responses in the majority of the items in the MCKAS instrument. The final sample of the study consisted of 47 mental health professionals, an underpowered study representing an 85.5% discrepancy in the number of respondents from which data was collected compared to the planned number of respondents from which data would be collected. Table 1 summarizes the demographic information of the sample.

Table 1

Frequency and Percentage Summaries of Demographic Information

	Frequency	Percent
Age		
21-45	35	74.5
46+	12	25.5
Sex		
Male	22	46.8
Female	23	48.9
Missing	2	4.3
Race/Ethnicity		
White/Caucasian	26	55.3
Black/African American	6	12.8
American Indian/Eskimo/Aleut	1	2.1
Asian/Native Hawaiian/Pacific Islander	3	6.4
Hispanic or Latino Origin	11	23.4
Number of years in professional practice		
1-5 years	4	8.5
6-10 years	6	12.8
11-15 years	16	34.0
16-20 years	14	29.8
20+ years	6	12.8
Missing	1	2.1
Highest Degree Obtained		
Bachelor’s	10	21.3
Master's	24	51.1
Advanced Graduate Status/ Doctoral	13	27.7
Professional Credentials		
Professional License	33	70.2
State Certification	6	12.8
Missing	8	17.0
Nature of Formal Multicultural Training		
Multicultural counseling graduate course	22	46.8
Multicultural graduate counseling or related degree program	7	14.9
In-service professional development	2	4.3
None	16	34.0

The researcher first categorized the participants by age: 35 (74.5%) participants were aged 21 to 45 years old and 12 (25.5%) were 46 and older. By gender, there was almost equal number of male (22; 46.8%) and female (23; 48.9%) samples of mental health professionals. For race/ethnicity, more than half of the 47 of mental health professionals were White/Caucasian (26; 55.4%). There were 11 (23.4%) Hispanic or Latino Origin, six (12.8%) were Black/African American, three (6.4%) were Asian/Native Hawaiian/Pacific Islander, and one (2.1%) was American Indian/Eskimo/Aleut. By number of years in professional practice, 16 (34%) of mental health professionals had 11 to 15 years of professional practice, while 14 (29.8%) had 16 to 20 years of professional practice. By education, more than half of the sample had a master's degree (24; 51.1%) as the highest degree obtained, 13 (27.7%) had doctoral degree or advanced graduate status, and 10 (21.3%) had a bachelor's degree. By professional credentials, the majority of the mental health professionals possessed a professional license (33; 70.2%).

By the nature of formal multicultural training, almost half of the sample (22; 46.8%) completed a multicultural counseling graduate course. There were seven (14.8%) mental health professionals that received multicultural graduate counseling training or related degree program and two (4.3%) who received in-service professional development. In summary, 31 (66.0%) of the participants had received multicultural counseling training, while 16 (34.0%) did not receive multicultural counseling training.

In terms of how representative the sample is of the population of interest or how proportional it is to the larger population, the final sample of the study of 47 mental health professionals was not representative of the sample using a purposive sample found from the American Counseling Association (1995). A representative sample consist of a subset within a population that looks to accurately define the characteristic of the larger group. The use of a non-probabilistic sampling procedure of purposive sampling would not allow for a representative sample. The final sample number of 47 mental health professionals was also less than the minimum of 55 mental health professionals that the researcher calculated using power analysis. This represented a limitation in terms of the external validity of the sample, wherein the final sample used in the analysis was not representative of the larger population.

Results

Test of Required Assumptions of Parametric Statistical Analysis

This study involved the use of the parametric statistical analyses of independent sample *t*-tests and multiple linear regression analyses to address the different objectives of the study. The different required assumptions of these statistical analyses included normality and no presence of outlier in the data. The researcher tested each of these assumptions, and the results are presented below. Where assumptions were violated, the researcher followed up the test with non-parametric tests.

Normality

The first assumption tested was the normality of the data of the study variable. The independent sample *t*-test and multiple linear regression analysis has a required assumption that the data of the dependent variable should exhibit normal distribution. The dependent variables included the two multi-cultural counseling skill scores for knowledge and awareness scales to determine whether the data follow normal distribution, skewness statistics, and kurtosis statistics: between -2 and 2 are acceptable (George & Mallery, 2010). As seen in Table 1, the skewness (-1.21 and -0.11) and kurtosis (-1.24 to 0.30) statistic values of knowledge and awareness scale scores were within the acceptable range, which showed that all the data of the two measures of dependent variable of multi-cultural counseling skill scores exhibited normal distribution. With these results, the data of multicultural knowledge and awareness did not violate normality. The histograms illustrated in Figures 1 and 2 did not show a perfect representation of the bell-shaped curve for normality distribution, but investigation of the skewness and kurtosis statistics showed that the values were within the normality range. With these results, the researcher concluded that the dependent variables did not violate the normality distribution assumption.

Table 2

Skewness and Kurtosis Statistics of Awareness and Knowledge Scale Scores

	N	Skewness		Kurtosis	
	Statistic	Statistic	Std. Error	Statistic	Std. Error
Knowledge scale	47	-1.21	0.35	0.30	0.68
Awareness scale	47	-0.11	0.35	-1.24	0.68

Figure 1

Histogram of Knowledge Scale Score

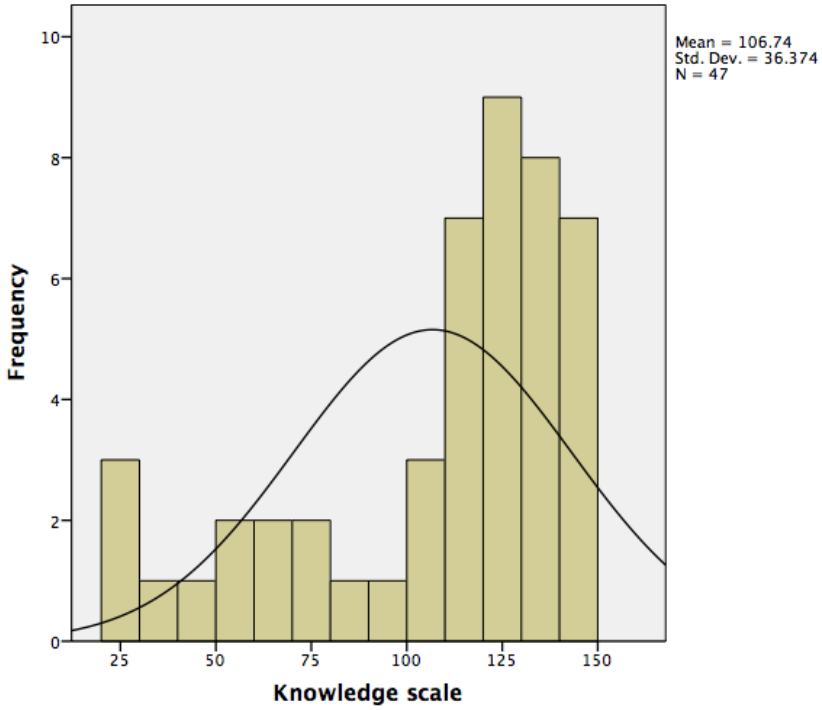
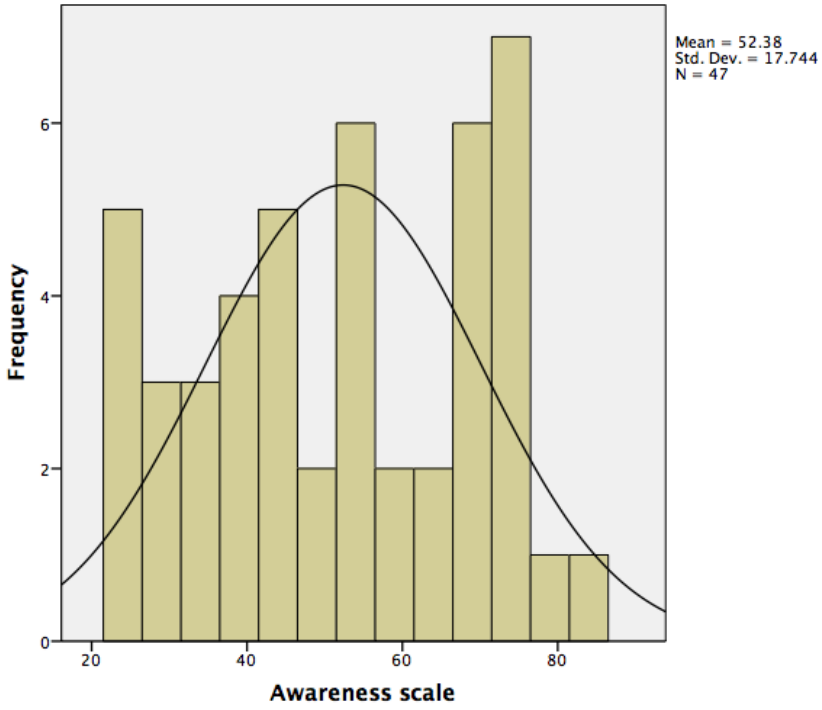


Figure 2

Histogram of Awareness Scale Score



Outlier

For the second assumption, the researcher tested for outliers in the dataset of multicultural awareness and knowledge because both independent sample *t*-tests and multiple linear regression analyses are sensitive to outlier effects. The researcher created scatter plots to investigate the presence for outliers of each of the two measures of the dependent variable of multi-cultural counseling skill scores for knowledge (Figure 3) and awareness (Figure 4) scales. The scatter plot for knowledge scores showed that there was no presence of outlier because the data seemed to be randomly distributed. The scatter plot for awareness scores showed that there was no presence of outlier because the range

of awareness scores among the 47 mental health professionals was within the range of the possible scores, from 12 to 84. The visual inspection go the scatterplot did not show any extreme values.

Figure 3

Scatter Plot of Knowledge Scale Scores

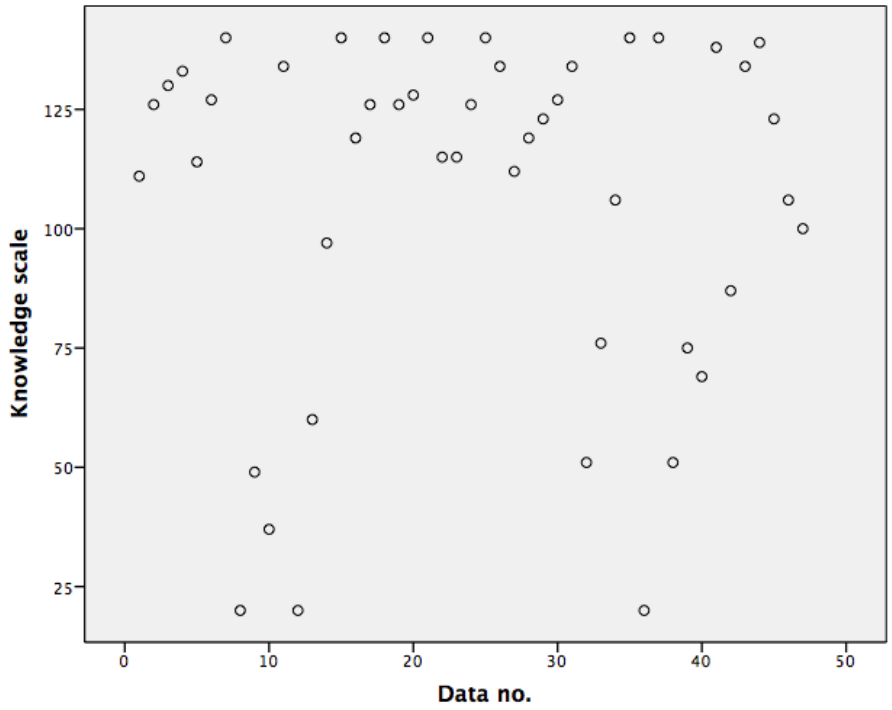
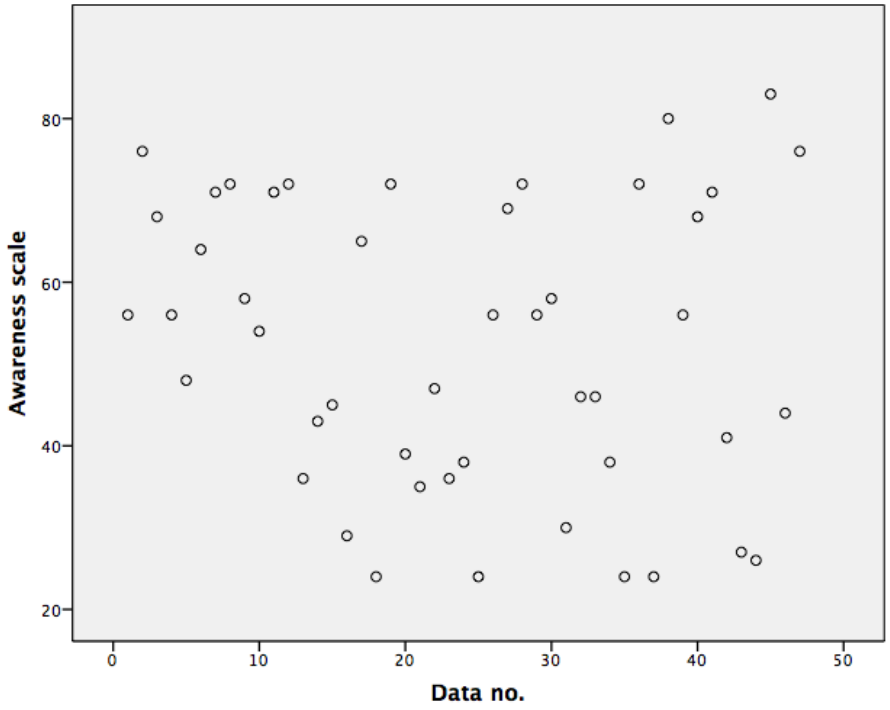


Figure 4

Scatter Plot of Awareness Scale Scores



Results for Research Question 1

To answer RQ1, the researcher used an independent samples *t*-test to investigate these differences and when assumptions were violated, followed that test with the Mann-Whitney U to confirm results. The dependent variable was awareness as it pertains to multicultural counseling skills and the independent variable was counselor multicultural training. The descriptive statistics are presented in Table 3. The researcher used a level of significance of 0.05 in the test of difference. The results of the independent samples *t*-test is presented in Table 4.

Normality was assessed with Shapiro-Wilk's test. No violation of normality was detected in awareness for those who had received multicultural training ($W = .93$, $p = .052$) and those who had not ($W = .91$, $p = .113$). Homogeneity of variance was assessed by Levene's Test for Equality of Variances and was not violated for awareness ($F = 2.76$, $p = .104$).

An independent samples *t*-test was run to assess differences in awareness and it was found that there was no significant differences in awareness between those who had received training and those who had not, $t(45) = -1.24$, $p = .223$. Thus, the null hypothesis was not rejected as the researcher found no evidence for statistically significant differences between the groups.

Results for Research Question 2

To answer RQ2, the researcher used an independent samples *t*-test to investigate these differences and when assumptions were violated, followed that test with the Mann-Whitney U to confirm results. The dependent variable was knowledge as it pertains to multicultural counseling skills and the independent variable was counselor multicultural training. The descriptive statistics are presented in Table 3. The researcher used a level of significance of 0.05 in the test of difference. The results of the independent sample *t*-tests are presented in Table 4.

Normality was assessed with Shapiro-Wilk's test. There was a violation of normality in knowledge for those who had received multicultural training ($W = .81$, $p < .001$) and those who had not ($W = .84$, $p = .009$). Homogeneity of variance was assessed

by Levene's Test for Equality of Variances and was violated for knowledge ($F = 5.52$, $p = .023$).

The researcher could not use an independent samples *t*-test to assess differences in knowledge because normality and homogeneity of variance were violated. Thus, an independent sample Mann-Whitney U test was conducted. As the null hypothesis could not be rejected, results of the test indicated no statistically significant differences in knowledge between those who had received training and those who had not, $U = 221.50$, $p = .551$.

Table 3

Descriptive Statistics Summaries of Awareness and Knowledge Scale Scores by Groupings of Receiving Multicultural Training

	Multicultural training received	*N*	Mean	Std. Deviation	Std. Error Mean
Awareness Scale	Did not receive multicultural counseling training	16	42.19	16.31	4.08
	Received multicultural counseling training	31	49.45	20.35	3.66
Knowledge scale	Did not receive multicultural counseling training	16	98.06	44.08	11.02
	Received multicultural counseling training	31	111.23	31.56	5.67

Table 4

Independent Sample t-test Results of Difference of Awareness and Knowledge Scale Scores by Groupings of Receiving Multicultural Training

		Levene's Test for Equality of Variances		*t*-test for Equality of Means						
		F	Sig.	*t*	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference Lower	Upper
Awareness scale	Equal variances assumed	2.76	.10	-1.24	45	.223	-7.26	5.88	-19.11	4.58
Knowledge scale	Equal variances not assumed	5.52	.02	-1.06	23.18	.30	-13.16	12.39	-38.79	12.46

Note. Significant difference at level of significance of 0.05.

Results for Research Questions 3

To answer Research Question 3, the researcher conducted multiple linear regression analyses to determine the relationship between exposure to multicultural training in one's graduate program and multicultural counseling awareness of mental health professionals after controlling for age of mental health professionals. For the model, the independent variable was exposure to multicultural training in one's graduate program, while the dependent variable was multicultural counseling skills of awareness. Counselor age was considered as the control variable in the regression

model. The researcher used a level of significance of 0.05 in the multiple linear regression analyses, meaning that there would be a significant relationship if the *p*-value of the *F* statistic was less than the level of significance value.

A multiple linear regression was run to determine the effect between having taken multicultural training and the counselors' awareness, while controlling for age. While controlling for age, multicultural training does not predict awareness ($F(2,44) = 0.82$, $p = .448$), with an R^2 of 0.04, or capturing 4% variance in predicting multicultural awareness after controlling for age. Investigating the individual effect of multicultural training showed no significant effect on multicultural awareness $\beta = 0.18$, $p = .226$. Age also did not predict multicultural awareness $\beta = -0.06$, $p = .713$ (Table 5; Model 1).

Results for Research Questions 4

In order to answer Research Question 4, the researcher conducted multiple linear regression analyses to determine the relationship between exposure to multicultural training in one's graduate program and multicultural counseling knowledge of mental health professionals after controlling for age of mental health professionals. For the model, the independent variable was exposure to multicultural training in one's graduate program, while the dependent variable was multicultural counseling skills of knowledge. Counselor age was considered as the control variable~~s~~ in the regression model. The researcher used a level of significance of 0.05 in the multiple linear regression analyses, meaning that there would be a significant relationship if the *p*-value of the *F* statistic was less than the level of significance value.

A multiple linear regression was run to determine the effect between having taken multicultural training and the counselors' knowledge, while controlling for age. While controlling for age, multicultural training does not predict knowledge ($F(2,44) = 2.01$, $p = .146$), with an R^2 of 0.08, or capturing 8% variance in predicting multicultural knowledge after controlling for age. Investigating the individual effect of multicultural training showed no significant effect on multicultural knowledge $\beta = 0.17$, $p = .242$. Age also did not predict multicultural knowledge $\beta = 0.23$, $p = .115$. (Table 5; Model 2).

Table 5

Results of Multiple Linear Regression for Impact of Receiving Multicultural Training on Awareness and Knowledge Scale Score After Controlling the Impact of Age

		B	*β*	*SE*	*t*	*p*
1	(Constant)	45.18		9.40	4.81	.000
	Age	-2.39	-.06	6.45	-0.37	.713
	Multicultural training received	7.28	.18	5.94	1.23	.226
2	(Constant)	74.15		17.34	4.28	.000
	Age	19.13	.23	11.91	1.61	.115
	Multicultural training received	13.01	.17	10.96	1.19	.242

Note. Model 1 dependent variable-Awareness.

Model 2 dependent variable-Knowledge.

Predictors: (constant), multicultural training, age.

Results for Research Questions 5

To answer Research Questions 5, the researcher conducted multiple linear regression analyses to determine the relationship between exposure to multicultural training in one's graduate program and multicultural counseling awareness of mental

health professionals after controlling for education of mental health professionals. For the model, the independent variable was exposure to multicultural training in one's graduate program, while the dependent variable was multicultural counseling skills of awareness. Counselor education was considered as the control variables in the regression model. The researcher used a level of significance of 0.05 in the multiple linear regression analyses, meaning that there would be a significant relationship if the *p*-value of the *F* statistic was less than the level of significance value.

A multiple linear regression was run to determine the effect between having taken multicultural training and the counselors' awareness, while controlling for counselor education. While controlling for education, multicultural training does not predict awareness ($F(2,44) = 1.23$, $p = .303$), with an R^2 of 0.05, or capturing 5% variance in predicting multicultural awareness after controlling for education. Investigating the individual effect of multicultural training showed no significant effect on multicultural awareness $\beta = 0.16$, $p = .278$. Education also did not predict multicultural awareness $\beta = 0.14$, $p = .340$. (Table 6; Model 1)

Results for Research Questions 6

In order to answer Research Questions 6, the researcher conducted multiple linear regression analyses to determine the relationship between exposure to multicultural training in one's graduate program and multicultural counseling knowledge of mental health professionals after controlling for education of mental health professionals. For the model, the independent variable was exposure to multicultural training in one's graduate program, while the dependent variable was

multicultural counseling skills of knowledge. Counselor education was considered as the control variables in the regression model. The researcher used a level of significance of 0.05 in the multiple linear regression analyses, meaning that there would be a significant relationship if the *p*-value of the *F* statistic was less than the level of significance value.

A multiple linear regression was run to determine the effect between having taken multicultural training and the counselors' knowledge, while controlling for education. While controlling for education, the model with multicultural training does predict knowledge ($F(2,44) = 4.37$, p = .019), with an R^2 of 0.17, or capturing 17% variance in predicting multicultural knowledge after controlling for education. Investigating the individual effect of multicultural training showed no significant effect on multicultural knowledge $\beta = 0.13$, $p = .373$. Education predicted multicultural knowledge $\beta = 0.371$, $p = .010$, where more educated counselors had more multicultural knowledge when taking multicultural training into account. (Table 6; Model 2).

Table 6

Results of Multiple Linear Regression for Impact of Receiving Multicultural Training on Awareness and Knowledge Scale Score After Controlling the Impact of Education

		B	*β*	*SE*	*t*	*p*
1	(Constant)	34.64		9.17	3.78	.000
	Education	3.90	.14	4.04	0.97	.340
	Multicultural training received	6.52	.16	5.94	1.10	.278
2	(Constant)	60.89		16.29	3.74	.001
	Education	19.19	.37	7.17	2.67	.010
	Multicultural training received	9.49	.13	10.55	0.90	.373

Note. Model 1 dependent variable-Awareness.

Model 2 dependent variable-Knowledge.

Predictors: (Constant), multicultural training, education.

Results for Research Questions 7

To answer Research Question 7, the researcher conducted multiple linear regression analyses to determine the relationship between exposure to multicultural training in one's graduate program and multicultural counseling awareness of mental health professionals after controlling for gender of mental health professionals. For the model, the independent variable was exposure to multicultural training in one's graduate program, while the dependent variable was multicultural counseling skills of awareness. Counselor's gender was considered as the control variables in the regression model. The researcher used a level of significance of 0.05 in the multiple linear regression analyses, meaning that there would be a significant relationship if the *p*-value of the *F* statistic was less than the level of significance value.

A multiple linear regression was run to determine the effect between having taken multicultural training and the counselors' awareness, while controlling for counselor's gender. While controlling for gender, multicultural training does not predict awareness ($F(2,42) = 70$, $p = .502$), with an R^2 of 0.03, or capturing 3% variance in predicting multicultural awareness after controlling for gender. Investigating the individual effect of multicultural training showed no significant effect on multicultural awareness $\beta = 0.18$, $p = .282$. Gender also did not predict multicultural awareness $\beta = 0.00$, $p = .999$. (Table 7; Model 1).

Results for Research Questions 8

In order to answer Research Question 8, the researcher conducted multiple linear regression analyses to determine the relationship between exposure to multicultural training in one's graduate program and multicultural counseling knowledge of mental health professionals after controlling for gender of mental health professionals. For the model, the independent variable was exposure to multicultural training in one's graduate program, while the dependent variable was multicultural counseling skills of knowledge. Counselor's gender was considered as the control variables in the regression model. The researcher used a level of significance of 0.05 in the multiple linear regression analyses, meaning that there would be a significant relationship if the *p*-value of the *F* statistic was less than the level of significance value.

A multiple linear regression was run to determine the effect between having taken multicultural training and the counselors' knowledge, while controlling for counselor's gender. While controlling for gender, multicultural training does not predict

knowledge ($F(2,42) = 1.16$, $p = .325$), with an R^2 of 0.05, or capturing 5% variance in predicting multicultural knowledge after controlling for sex. Investigating the individual effect of multicultural training showed no significant effect on multicultural knowledge $\beta = 0.08$, $p = .590$. Gender also did not predict multicultural knowledge $\beta = 0.-18$, $p = .279$. (Table 7; Model 2).

Table 7

Results of Multiple Linear Regression for Impact of Receiving Multicultural Training on Awareness and Knowledge Scale Score After Controlling the Impact of Gender

		B	*β*	*SE*	*t*	*p*
1	(Constant)	42.20		12.08	3.49	.001
	Gender	-.01	.00	6.32	-.00	.999
	Multicultural training received	7.19	.18	6.59	1.09	.282
2	(Constant)	120.93		22.77	5.31	.000
	Gender	-13.06	-.18	11.90	-1.10	.279
	Multicultural training received	6.75	.09	12.43	0.54	.590

Note. Model 1 dependent variable-Awareness.

Model 2 dependent variable-Knowledge.

Predictors: (Constant), Multicultural training, gender.

With the results of the independent samples t-tests that were conducted, the researcher did not find any significant differences in multicultural awareness based upon multicultural counseling training (RQ1, See Table 4). There were also no significant differences in multicultural knowledge based upon multicultural counseling training (RQ2, See Table 4). There was also no significant effect on awareness based upon multicultural counseling after controlling for the age of mental health professionals (RQ3, See Table 5). There was also no significant effect on knowledge based upon multicultural counseling after controlling for the age of mental health professionals (RQ4, See Table 5). There was also no significant effect on awareness based upon multicultural counseling after controlling for education (RQ5, See Table 6). There was also no significant effect on knowledge based upon multicultural counseling after controlling for education (RQ5, See Table 6). Finally, there was also no significant effect on awareness

based upon multicultural counseling after controlling for gender (RQ7, See Table 7). There was also no significant effect on knowledge based upon multicultural counseling after controlling for gender (RQ8, See Table 7). However, continuing education of mental health professionals did significantly predict knowledge (RQ6). (See Table 6).

With the results of the multiple linear regressions that were conducted, the researcher did not find any significant differences in the multicultural awareness based upon multicultural counseling training. The researcher conducted two separate multiple linear regression analyses on two models with the findings reported in Table 8 to determine the relationship between exposure to multicultural training in one's graduate program and multicultural counseling awareness and knowledge of mental health professionals after controlling for age, gender, and education of mental health professionals.

For the first model, the independent variable was exposure to multicultural training in one's graduate program, while the dependent variable was multicultural counseling skills of awareness. For the second model, the independent variable was exposure to multicultural training in one's graduate program, while the dependent variable was multicultural counseling skills of knowledge. Counselor's age, gender, and education were considered as the control variables in both regression models. The researcher used a level of significance of 0.05 in the multiple linear regression analyses, meaning that there would be a significant relationship if the *p*-value of the *F* statistic was less than the level of significance value.

A multiple linear regression was run to determine the effect between having taken multicultural training and the counselors' awareness. While controlling for age, gender, and education, multicultural training does not predict awareness ($F(4,40) = 0.74$, $p = .568$), with an R^2 of 0.07, or capturing 7% variance in predicting multicultural awareness after controlling for age, gender, and education (Table 8; Model 1). Investigating the individual effect of multicultural training showed no significant effect on multicultural awareness $\beta = 0.15$, $p = .399$. Age ($\beta = -0.11$, $p = .556$), gender ($\beta = -0.04$, $p = .827$), and education ($\beta = 0.19$, $p = .241$) also did not predict multicultural awareness.

A multiple linear regression was run to determine the effect between having taken multicultural training and the counselors' knowledge, while controlling for counselor age, gender, education. While controlling for age, gender, and education, multicultural training does not predict knowledge ($F(4,40) = 2.44$, $p = .063$), with an R^2 of 0.20, or capturing 20% variance in predicting multicultural knowledge after controlling for age, sex, and education (Table 8; Model 2). Investigating the individual effect of multicultural training showed no significant effect on multicultural knowledge $\beta = 0.09$, $p = .555$. Age ($\beta = 0.16$, $p = .337$) and gender ($\beta = -0.06$, $p = .763$) did not predict multicultural knowledge. Education did predict multicultural knowledge $\beta = 0.34$, $p = .026$, where more educated counselors had more multicultural knowledge when taking multicultural training into account.

Table 8

Results of Multiple Linear Regression for Impact of Receiving Multicultural Training on Awareness and Knowledge Scale Score After Controlling the Impact of Age, Gender, and Education

		B	*β*	*SE*	*t*	*p*
1	(Constant)	41.00		21.52	1.91	.064
	Age	-4.65	-.11	7.83	-0.59	.556
	Gender	-1.64	-.04	7.43	-0.22	.827
	Education	5.10	.19	4.28	1.19	.241
	Multicultural training received	5.80	.15	6.80	0.85	.399
2	(Constant)	54.19		38.09	1.42	.163
	Age	13.46	.16	13.86	0.97	.337
	Gender	-4.00	-.06	13.14	-0.30	.763
	Education	17.57	.34	7.58	2.32	.026
	Multicultural training received	7.16	.09	12.04	0.60	.555

Note. Model 1 dependent variable-Awareness.

Model 2 dependent variable-Knowledge.

Predictors: (Constant), multicultural training, age, gender, education.

Summary

The purpose of this quantitative study was to investigate the perceptions of multicultural counseling between counseling professionals who did and did not receive formal training in multicultural competencies in their degree programs as well as post-graduation. Another objective was to compare the multicultural counseling skills based on the demographics of age, gender, and education of mental health professionals. The researcher conducted descriptive statistics analysis, independent sample *t*-tests, and multiple linear regression analysis to test the research hypotheses posed in this study. For Research Questions 1 and 2, the results showed that participants who had received

multicultural training did not differ in multicultural awareness or knowledge from those who had not received multicultural training. For Research Question 3 through 8, the results of the multiple linear regression analyses showed that participants who had received multicultural training did not differ in multicultural awareness or knowledge from those who had not received multicultural training, while controlling for age, gender, or education. Similarly, they didn't differ in multicultural knowledge if they had received multicultural training, when controlling for age or gender. However, Education predicted multicultural knowledge where more educated counselors had more multicultural knowledge when taking multicultural training into account.

Chapter 5: Discussion, Conclusions, and Recommendations

Many researchers have examined the effectiveness of graduate courses and practice in enhancing multicultural counseling competency among psychology graduate students (Chao & Nath, 2011; Chao et al., 2011; Newell et al., 2010; Sehgal et al., 2011). In the current literature review, the researcher identified only two studies that considered the multicultural counseling skills of counseling professionals (Bellini, 2002; Dodson, 2013). The gap in the literature pertains to the effects of training in multicultural counseling skills in school and post-graduation and perceptions of the counselors about multiculturalism. Researchers have reviewed racially and culturally responsive training and found that there was empathy, knowledge, and awareness for counselor trainees (Thrower, Helms, and Price, 2020).

The purpose of this quantitative study was to investigate the effectiveness of multicultural counseling between counseling professionals who did and did not receive formal training in multicultural competencies in their degree programs as well as post-graduation. The researcher aimed to compare the counselors' multicultural counseling skills based on the demographics such as age, gender, and education. The researcher conducted descriptive statistics analysis, independent sample *t*-tests, and multiple linear regression analysis to answer the research questions. The researcher used SPSS to run the different statistical analyses. Specifically, the researcher tested the following research hypotheses in the quantitative analysis:

Research Question 1

What is the relationship between multicultural training received and multicultural counseling skills awareness of mental health professionals (measured through Multicultural Counseling Knowledge and Awareness Scale) who received and did not receive multicultural counseling training in the completion of graduate program?

H_{01}: There is no significant difference in the awareness of mental health professionals who received or did not receive multicultural counseling training

H_{a1}: There is a significant difference in the awareness of mental health professionals who received or did not receive multicultural counseling training

Research Question 2

What is the relationship between multicultural training received and multicultural counseling skills knowledge of mental health professionals (measured through Multicultural Counseling Knowledge and Awareness Scale) who received and did not receive multicultural counseling training in the completion of graduate program?

H_{02}: There is no significant difference in the knowledge of mental health professionals who received or did not receive multicultural counseling training

H_{a2}: There is a significant difference in the knowledge of mental health professionals who received or did not receive multicultural counseling training

Research Question 3

Do the multicultural training received and the age of the counselor individually or in linear combination predict the counselor's mental health awareness?

H_{03}: Multicultural counseling training and age of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' awareness

H_{a3}: Multicultural counseling training and age of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' awareness

Research Question 4

Does the multicultural training received and the age of the counselor individually or in linear combination predict the counselor's mental health knowledge?

H_{04}: Multicultural counseling training and age of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' knowledge

H_{04}: Multicultural counseling training and age of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' knowledge

Research Question 5

Does the multicultural training received and the education of the counselor individually or in linear combination predict the counselor's mental health awareness?

H_{05}: Multicultural counseling training and education of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' awareness

H_{a5}: Multicultural counseling training and education of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' awareness

Research Question 6

Does the multicultural training received and the education of the counselor individually or in linear combination predict the counselor's mental health knowledge?

H_{06}: Multicultural counseling training and education of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' knowledge

H_{06}: Multicultural counseling training and education of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' knowledge

Research Question 7

Do the multicultural training received and the gender of the counselor individually or in linear combination predict the counselor's mental health awareness?

H_{07}: Multicultural counseling training and gender of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' awareness

H_{a7}: Multicultural counseling training and gender of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' awareness

Research Question 8

Do the multicultural training received and the gender of the counselor individually or in linear combination predict the counselor's mental health knowledge?

H_{08}: Multicultural counseling training and gender of mental health professionals, independently or in linear combination, are not significant predictors of the mental health professionals' knowledge

H_{08}: Multicultural counseling training and gender of mental health professionals, independently or in linear combination, are significant predictors of the mental health professionals' knowledge

For the first two research questions, the findings indicated that participants with multicultural training did not have higher multicultural counseling skill scores than the ones who did not participate in the training. The findings for Research Question 3 and 4 indicated that participants with multicultural training did not differ in awareness and knowledge than the ones who did not participate in the training, after controlling for the variable of age. For Research Question 5 and 6, the researcher found that participants with multicultural training had higher multicultural counseling skill scores in awareness than the ones who did not participate in the training, after controlling for the variable of education. The findings for Research Question 7 and 8 indicated that participants with multicultural training did not differ in awareness and knowledge than the ones who did not participate in the training, after controlling for the variable of sex.

The subsequent sections of this chapter include the interpretation of the findings, limitations, recommendations, implications, and conclusion. In the next section, the

interpretation of the findings, the researcher described how the findings confirm, disconfirm, or extend existing knowledge in the discipline by comparing them with what has been found in the peer-reviewed literature described in Chapter 2. The researcher then analyzed and interprets the findings in the context of the theoretical framework.

Interpretation of the Findings

For the first two research questions, the researcher could not reject the null hypothesis and concluded that participants with multicultural training did not differ in multicultural counseling skill scores than the ones who did not participate in the training. The results confirm existing knowledge in the discipline, as previous researchers have highlighted the importance of multicultural training to mental health professionals. Researchers have acknowledged that cultural competence is important to the development of psychology students and mental health professionals (Horevitz et al., 2013; Kratzke & Bertolo, 2013; Paasche-Orlow, 2004). Fickling et al (2019) revealed that learning about another cultural is the key to understanding their environment and being lifetime cultural social practitioners. Newell et al. (2010) highlighted the importance of incorporating multicultural component to the training of school psychologists to be able to address the needs of a diverse student population. In a similar study, Sheu et al. (2012) recognized the benefits of multicultural training environments in treating cross-racial client contacts. This was consistent with the findings of Diallo and McGrath (2013), who emphasized the importance of cultural competence programs and provision of culturally sensitive quality care to address the shift in the ethnic groups of patients. These three sets of scholars emphasized the need for multicultural training of

mental health professionals in order to address needs of a diverse population. Hart (2018) acknowledged that many of an individual's environment affects how the worldview and self-perception is.

Despite the evidence that cultural competency is important in psychology, researchers have suggested that mental health professionals are generally unprepared to address issues that are multicultural in nature or those related to cultural diversity (Chao & Nath, 2011; Crook-Lyon et al., 2012). The current study's finding that multicultural training increases multicultural counseling skills could address this gap in the practice participants who had received multicultural training did not differ in multicultural awareness or knowledge from those who had not received multicultural training. Similarly, age or sex did not impact awareness or knowledge. However, education predicted multicultural knowledge where more educated counselors had more multicultural knowledge when taking multicultural training into account. Multicultural training can improve how mental health professionals consider the ethnicities of their patients, as Sperry (2012) noted that lack of cultural competence among healthcare professionals can cause fatal repercussions. Multicultural training could also improve the reflection of mental health professionals about their own cultural group, especially for supervisors. Rust et al. (2013) claimed that mental health professionals and their respective supervisors must understand their own cultural group memberships and how this might influence their evaluation methods toward their trainees.

In a similar study, Pernell-Arnold et al. (2012) implemented 2-day monthly multicultural competence sessions for 10 months. The results showed that there was a

change in the view of the participants of the session due to cultural competence training in those sessions. Additionally, there was a shift from ethnocentric views to ethno-relative thinking, by which participants accepted the differences in of views and adapted to this difference. These results were more specific in terms of the ethno-relative thinking of the participants, while the results of the current study showed a general concept of multicultural counseling skills. Another similar study, Lenes et al. (2020) found that having sessions over 4 weeks showed very significant results. These results were more significant increases in mindfulness and multicultural competence, while the results for color blind racial attitudes decreased significantly.

The theoretical framework for this study was the theory of multicultural counseling and therapy (Sue et al., 1996). The premises of TMCT were consistent with this study's findings that participants with multicultural training had higher multicultural counseling skill scores than the ones who did not participate in the training after controlling for age of mental health professionals. One of the premises of TMTC is the need to develop multicultural skills among professionals who interact with people from diverse cultural backgrounds (Sue et al., 1996). This links to TMCT's promotion of multiculturalism, as the results of the current study indicated that multicultural training was associated with higher multicultural counseling skill scores.

For the third and fourth research questions, the researcher did not reject the null hypothesis. Participants with multicultural training did not differ in multicultural counseling skill scores in awareness than the ones who did not participate in the training after controlling for age of mental health professionals. This finding extends knowledge

in the discipline because no previous scholars had investigated the difference in the effectiveness in multicultural counseling between mental health professionals who did and did not receive training in multicultural competencies in their degree programs and post-graduation using demographic such as age.

Previous researchers had highlighted that demographic characteristics are important in the field of cultural competence programs; however, no researchers had previously explored the role of age in acquiring multicultural skills. Diallo and McGrath (2013) noted that training programs should address how to provide culturally sensitive quality care, but also noted that changes in demographic should be considered in these training programs (Gallardo & Kaivan, 2000). The current study's finding that multicultural training can lead to high multicultural counseling skill scores, even after controlling for the demographic variable of age, implies that mental health professionals of all ages can undergo multicultural training and gain multicultural counseling skills. Lenes et al. (2020) reported that by utilizing multicultural trainings will help with the development of multicultural competence.

For the fifth research question, the researcher could not reject the null hypothesis but the researcher was able to reject the null for the sixth research question. Participants with multicultural training had higher multicultural counseling skill scores in knowledge but not awareness than the ones who did not participate in the training after controlling for education of mental health professionals. This finding extends knowledge in the discipline because there is limited knowledge regarding the contribution of continuing education in the multicultural competency based on the literature. According to the study,

continuing education such as training programs can improve the multicultural counseling skill of mental health professionals.

For the seventh and eighth research questions, the researcher did not reject the null hypothesis based on the results. The researcher discovered that participants with multicultural training had higher multicultural counseling skill scores in awareness than the ones who did not participate in the training after controlling for sex of mental health professionals. This finding extends knowledge in the discipline, as no previous researchers had investigated the difference in the effectiveness in multicultural counseling between mental health professionals who did and did not receive training in multicultural competencies in their degree programs and post-graduation using demographic such as gender. Several researchers focused on ethnicity of the therapists compared to other demographic characteristics. For instance, L. K. Berger et al. (2014) and Pope-Davis and Ottavi (1994) both found that ethnicity is a demographic variable that has significant relationship with the multicultural skills of individuals. The result that multicultural training can lead to high multicultural counseling skill scores, even after controlling for the demographic variable of gender, would imply that mental health professionals of all sexes can undergo multicultural training and gain multicultural counseling skills.

The results of this study indicated that participants in a multicultural training did not have higher multicultural counseling skill scores than the ones who did not participate in the training after controlling for age and gender of mental health professionals. However, education predicted multicultural knowledge where more educated counselors

had more multicultural knowledge when taking multicultural training into account, but it did not impact multicultural awareness which aligns with the premises of TMTC. TMTC proposes that mental health professionals have higher tendencies of encountering clients or client groups who differ from them racially, culturally, and ethnically. According to TMTC, mental health professionals need to achieve an understanding of acculturation, alternative worldviews, and the dangers of stereotyping, and a consciousness of the need to exhibit respect for the client's culture (Sue et al., 1996). The results of this study suggested that mental health professionals who underwent multicultural training gained multicultural counseling skills because of the training program. It can be said that the mental health professionals who have participated in the study regardless of their age, gender, and continuing education are able to better address the needs of a diverse population. Lenes et al. (2020) reported that in s similar study that the Color-Conscious Multicultural Mindfulness (CCMM) training addressed the ruptures and intercultural relationships, individual inequities, and systematic disparities. The study revealed CCMM training can be offered as a continuing education or as a core counseling curriculum.

Limitations

One limitation of the study was that the information collected was self-reported. The responses of the participants might accurately reflect the details of their programs; however, the participants might have overestimated or underestimated their own multicultural competence. It is possible that some participants did not want to reveal the

status of their lack of sufficient training to improve multicultural competence and counseling skills.

The instrument used in this study also served as a limitation. The answers to the survey were based on a set of questions already prepared for the interview. The participants did not have the opportunity to elaborate or explain on the inclusions or presence of the training and how training has improved their multicultural counseling skills. Another limitation was the use of Survey Monkey as a platform to collect data. As a result of this method, the researcher had less personal interaction with the participants. As a result of this lower level of interaction the researcher may have an effect on the participants' familiarity with and trust.

The correlational design of the study also served as a limitation. Through this research methodology, the researcher was able to determine the differences in the effectiveness in multicultural counseling between mental health professionals who did and did not receive training in multicultural competencies in their degree programs as well as post-graduation, controlling for demographics such as age, gender, and education. However, the results do not necessarily mean that the multicultural training caused the difference of the multicultural counseling skill scores of the participants. There might be other factors that influenced the differences of the scores.

The sample was also a limitation. The final sample of the study consisted of 47 mental health professionals. There was an 85.5% discrepancy in the actual number of samples collected compared to the planned number of samples. This could have limited the results of the study by increasing the margin of error of the results of the study.

Recommendations

There is a need for additional knowledge about the impact of multicultural training to multicultural counseling skills of mental health professionals using demographics such as age, gender, and education. Previous researchers focused on the demographic ethnicity of mental health professionals in exploring MCC professionals (L. K. Berger et al., 2014; Pope-Davis & Ottavi, 1994). More information is necessary in order to understand the importance of multicultural training and to determine whether the demographic characteristics of mental health professionals have an effect on the outcomes of multicultural training. Bakioğlu & Türküm (2020) found in a similar study among counseling students and included multicultural competence, gender role, self-efficacy, and mindfulness. The result of the study showed that the psychological counselor student's mindfulness and perceived gender had a significant impact their counseling self-efficacy based upon multicultural competence.

Another quantitative study could also be conducted to support generalizations about the relationships among the variables. Future researchers might strive for an oversampling in their quantitative study to improve statistical power. In addition, a larger sample could also lessen the margin of error. By performing a quantitative study, the researcher may develop conclusions that would be applicable to the whole population of mental health professionals.

Future researchers could also use qualitative methods utilizing interviews with mental health professionals. The participants could have the opportunity to elaborate or explain on the inclusions or presence of the training and how training has improved their

multicultural counseling skills. This method could provide in-depth information about the effect of training to mental health professionals. This could also reveal challenges that mental health professionals face during training programs or even during counseling sessions with patients from diverse background.

Another recommendation is to include observation and other documents and reports in the data collection and data analysis. The current study included self-reported data that could have been biased based from the memory of the individual. If researchers conducted future observations including the evaluation of peers and supervisors about multicultural counseling skills of the participants of multicultural training, the validity and reliability of the results may improve.

Implications

In this section, the researcher presents the implications for positive social change, as well as methodological and empirical implications. This section also includes recommendations for practice. The results of this study may promote positive social change in the field of mental health and psychology by encouraging mental health institutions to ensure that the service providers are culturally competent to deal with culturally diverse clients and patients (Ivey et al., 2013). This may promote positive social change because the ethnicity of clients and patients would be considered in the approach of the mental health professional. Hospital and university officers might find this study's findings useful in terms of developing with the cultural competency of mental health professionals.

Mental health professionals can help make social change and can impact society, sharing the basic principles of life, honesty, trust, fairness, respect, and responsibility due to their awareness of the different cultures that they may encounter in their practice. The results of this study highlighted the impact of multicultural training that would make mental health professionals more adaptive to the needs of the society. As a result, patients and clients may be more satisfied with the mental health services that they receive.

The results of the study can also be used for recommendations for practice. Psychology school administrators can use the results as a guide on how to incorporate multicultural concepts in their respective curricula. Psychology school administrators should incorporate multicultural training in the curricula of their undergraduate and graduate education to improve the performance of mental health professionals in the field. They could also develop their own multicultural training framework to be able to equip mental health professionals with the necessary knowledge and skill to interact with client from diverse cultural backgrounds (Kratzke & Bertolo, 2013; Panayiotopoulos et al., 2013; Smith et al., 2013). Don-Medeiros et al. (2020) reported that counselor educators must make sure that future counselors are culturally competent to help take care of their clientele that are from diverse backgrounds.

Conclusion

The purpose of this quantitative study was to investigate the effectiveness in multicultural counseling between counseling professionals who did and did not receive formal training in multicultural competencies in their degree programs as well as post-graduation and compare the multicultural counseling skills based on the demographics

such as age, sex, and education of mental health professionals. In the literature review, the researcher identified a continued need for innovations within the field of mental health, especially with the advancement in technology and the role that multicultural settings play in society (Jones-Smith, 2011; McLaren, 2010; Sue et al., 1996).

The final sample of the study consisted of 47 mental health professionals. The researcher conducted descriptive statistics, independent sample *t*-tests, and multiple linear regression analyses to test the research hypotheses posed in this study using SPSS. The findings indicated that participants with multicultural training had higher multicultural counseling skill scores than the ones who did not participate in the training. Specifically, participants who participated had higher multicultural counseling skill scores in awareness the ones who did not participate in the training, after controlling for the variables of age, gender, and education. The results implied that mental health professionals who would participate in multicultural training could have higher multicultural counseling skills compared to mental health professionals who would not participate in such training programs. Moreover, the researcher concluded that all mental health professionals—Regardless of age or gender —can undergo multicultural training and gain multicultural counseling skills.

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Appendix A: Utilization Request Form

In using the Multicultural Counseling Knowledge and Awareness Scale (MCKAS), I agree to the following terms/conditions:

1. I understand that the MCKAS is copyrighted by Joseph G. Ponterotto (Ph.D.) at the Division of Psychological and Educational Services, Fordham University at Lincoln Center, 113 West 60th Street, New York, New York 10023-7478 (212-636-6480); Jponterott@aol.com.

2. I am a trained professional in counseling, psychology, or a related field, having completed coursework (or training) in multicultural issues, psychometrics, and research ethics, or I am working under the supervision of such an individual.

3. In using the MCKAS, all ethical standards of the American Psychological Association, the American Counseling Association, and/or related professional organizations will be adhered to. Furthermore, I will follow the "Research with Human Subjects" guidelines put forth by my university, institution, or professional setting. Ethical considerations include but are not limited to subject informed consent, confidentiality of records, adequate pre- and post-briefing of subjects, and subject opportunity to review a concise written summary of the study's purpose, method, results, and implications.

4. Consistent with accepted professional practice, I will save and protect my raw data for a minimum of five years; and if requested I will make the raw data available to scholars researching the multicultural counseling competency construct.

5. I will send a copy of my research results (for any study incorporating the MCKAS) in manuscript form to Dr. Ponterotto, regardless of whether the study is published, presented, or fully completed.

Signature:_____ Date:_____

Name: _____Phone:_____

Address:_____

If a student, supervisor/mentor's name and phone number, affiliation, and signature:

Name:_____Phone:_____

Affiliation:_____

Signature:_____Date:_____

Appendix B: Informed Consent Form

You are invited to take part in a research study about the effectiveness in multicultural counseling between professionals who received and did not receive formal training in multicultural competencies. The researcher is inviting mental health professionals who are part of the American Counseling website to be in the study. I obtained your name/contact info via the American Counseling Association website. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named_____ who is a doctoral student at Walden University

Background Information:
The purpose of this study is to investigate the effectiveness in multicultural counseling between counseling professionals who did and did not receive formal training in multicultural competencies in their degree programs as well as post-graduation and compare the multicultural counseling skills based on the demographics such as age, sex, and education of mental health professionals.

Procedures:
If you agree to be in this study, you will be asked to:

- Provide demographic details through answering a demographic questionnaire
- Answer the Multicultural Counseling Knowledge and Awareness Scale (MCKAS) questionnaire

Here are some sample questions:
Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at All True					Somewhat True	Totally True

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

1 2 3 4 5 6 7

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

1 2 3 4 5 6 7

Voluntary Nature of the Study:

This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at Walden University or American Counseling Association will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:
Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as becoming upset. Being in this study would not pose risk to your safety or wellbeing.

With this study, mental health professionals who maintain a licensure can help the society and make social change by sharing the basic principles of life, honesty, trust, fairness, respect, and responsibility because of the awareness of the different cultures that they may encounter every day. Socially, the research will bring about change because the results will make the mental health professionals more adaptive to the needs of the society.

Payment:
There will not be any thank you gifts provided to participants.

Privacy:
Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by storing this information in an encrypted, password protected cloud-based server and database. Data gathered will be marked by alphanumeric code instead of putting names of the respondents. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via email_____ which is and my telephone number is_____ . If you want to talk privately about your rights as a participant, you can call _____. She is the Walden University representative who can discuss this with you. Her phone number is _____. Walden University's approval number for this study is **IRB will enter approval number here** and it expires on **IRB will enter expiration date.**

Please print or save this consent form for your records.

Obtaining Your Consent
If you feel you understand the study well enough to make a decision about it, please indicate your consent by replying to this email with the words, "I consent"

Appendix C: American Counseling Association Agreement

DATA USE AGREEMENT

This Data Use Agreement ("Agreement"), effective as of Enter Date ("Effective Date"), is entered into by and between ("Data Recipient") and _____ ("Data Provider"). The purpose of this Agreement is to provide Data Recipient with access to a Limited Data Set ("LDS") for use in research **in accord with laws and regulations of the governing bodies associated with the Data Provider, Data Recipient, and Data Recipient's educational program.** In the case of a discrepancy among laws, the agreement shall follow whichever law is more strict.

1. Definitions. Due to the study's affiliation with Laureate, a USA-based company, unless otherwise specified in this Agreement, all capitalized terms used in this Agreement not otherwise defined have the meaning established for purposes of the USA "HIPAA Regulations" and/or "FERPA Regulations" codified in the United States Code of Federal Regulations, as amended from time to time.

2. Preparation of the LDS. Data Provider shall prepare and furnish to Data Recipient a LDS in accord with any applicable laws and regulations of the governing bodies associated with the Data Provider, Data Recipient, and Data Recipient's educational program.

Data Fields in the LDS. **No direct identifiers such as names may be included in the Limited Data Set (LDS).** In preparing the LDS, Data Provider shall include the **data fields specified as follows**, which are the minimum necessary to accomplish the research: A survey will be used to gather the data needed for numerical analysis. Survey research provides a holistic view of the problem derived from a systematic process of evaluation and produces numerical descriptions about targeted aspects of the population being studied. The survey is chosen as the data collection method for its cost and time efficiency advantages in gathering large amounts of data to analyze. the demographic questionnaire that will measure the independent variables of exposure to multicultural training in one's graduate program and the demographics such as age, sex, and education. These demographic information will be measured using nominal or ordinal responses by creating groups of categories for each of the study variables.

3. Responsibilities of Data Recipient. Data Recipient agrees to:

    a. Use or disclose the LDS only as permitted by this Agreement or as required by law;

    b. Use appropriate safeguards to prevent use or disclosure of the LDS other than as permitted by this Agreement or required by law;

c. Report to Data Provider any use or disclosure of the LDS of which it becomes aware that is not permitted by this Agreement or required by law;

d. Require any of its subcontractors or agents that receive or have access to the LDS to agree to the same restrictions and conditions on the use and/or disclosure of the LDS that apply to Data Recipient under this Agreement; and

e. Not use the information in the LDS to identify or contact the individuals who are data subjects.

4. Permitted Uses and Disclosures of the LDS. Data Recipient may use and/or disclose the LDS **for its Research activities only.**

5. Term and Termination.

a. Term. The term of this Agreement shall commence as of the Effective Date and shall continue for so long as Data Recipient retains the LDS, unless sooner terminated as set forth in this Agreement.

b. Termination by Data Recipient. Data Recipient may terminate this agreement at any time by notifying the Data Provider and returning or destroying the LDS.

c. Termination by Data Provider. Data Provider may terminate this agreement at any time by providing thirty (30) days prior written notice to Data Recipient.

d. For Breach. Data Provider shall provide written notice to Data Recipient within ten (10) days of any determination that Data Recipient has breached a material term of this Agreement. Data Provider shall afford Data Recipient an opportunity to cure said alleged material breach upon mutually agreeable terms. Failure to agree on mutually agreeable terms for cure within thirty (30) days shall be grounds for the immediate termination of this Agreement by Data Provider.

e. Effect of Termination. Sections 1, 4, 5, 6(e) and 7 of this Agreement shall survive any termination of this Agreement under subsections c or d.

6. Miscellaneous.

a. Change in Law. The parties agree to negotiate in good faith to amend this Agreement to comport with changes in federal law that materially alter either or both parties' obligations under this Agreement. Provided however, that if the parties are unable to agree to mutually acceptable

amendment(s) by the compliance date of the change in applicable law or regulations, either Party may terminate this Agreement as provided in section 6.

b. Construction of Terms. The terms of this Agreement shall be construed to give effect to applicable federal interpretative guidance regarding the HIPAA Regulations.

c. No Third Party Beneficiaries. Nothing in this Agreement shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

d. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

e. Headings. The headings and other captions in this Agreement are for convenience and reference only and shall not be used in interpreting, construing or enforcing any of the provisions of this Agreement.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf.

DATA PROVIDER	**DATA RECIPIENT**
Signed: _____	Signed: _____
Print Name: _____	Print Name: _____
Print Title: _____	Print Name: _____