COUNSELING STUDENTS’ ATTITUDES TOWARDS POVERTY AND ITS RELATIONSHIP TO PROGRESSION IN CACREP PROGRAMS

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COUNSELING STUDENTS’ ATTITUDES TOWARDS POVERTY AND ITS RELATIONSHIP TO PROGRESSION IN CACREP PROGRAMS

by

Hannah Jean Maust

A Dissertation
Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

Major: Counselor Education and Supervision

The University of Memphis
December 2023
Acknowledgements

I would like to both thank and acknowledge a multitude of people who have contributed to my journey and have helped form me into who I am today. I would like to thank my parents, Johnny and Donna Maust, for instilling a desire to learn and love of knowledge in me in a young age, by fostering my curiosity and creativity. I would also like to thank my friends and family who have believed in, encouraged, and supported me with consistency and genuineness these past years. I would like to thank my chair, Dr. Steve West, for all of his support through this process. I would also like to thank all of the staff at University of Memphis, who all had a comforting way of coming along side me and helping me believe in myself. I would especially like to thank my husband, Zach Boatwright, for his unwavering belief in me and his ability to support me in so many ways throughout this journey. Lastly, I would like to thank the pets that sat next to me and provided comfort through difficult times, Pancake, Lucy, Cocoa, and Muffin.
Abstract

Poverty is an intersectional issue that affects at least 11.5% of the population in the United States. Research has shown that there is a relationship between a clinician’s attitudes towards poverty and how they treat their impoverished clients. People in poverty present with unique counseling needs and mental health concerns. Prior research has shown a connection between multicultural competency along with time in a helping field and decreased stigma towards poverty. With CACREP programs emphasizing multicultural competency and fieldwork through practicum and internships, this study sought to explore the relationship between student time in a CACREP program and attitudes towards poverty. Participants were 182 counseling students in the United States currently in a CACREP accredited program. The researcher sent out a survey containing the Attitudes Towards Poverty- Short Form scale, as well as gathered information on how many classes the participants had completed, and whether they had completed a multicultural course, practicum, and internship. Results indicated no statistically significant differences between the groups that were further along in the program or who had taken certain courses and those that had not. Implications for future research include continued research into counseling students’ attitudes towards poverty, as well as examinations of CACREP programs effectiveness in covering topics of poverty.
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Chapter One

Introduction

Statement of Problem

With both the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and the American Counseling Association (ACA) code of ethics requiring counselors to have multicultural competency and be able to counsel people from all walks of life, it is imperative that counseling students both learn about poverty and develop the skills necessary for counseling people in poverty (ACA, 2014; CACREP, 2015). People in poverty are a distinct population that have unique counseling needs (Clark et al., 2020; Foss-Kelly et al., 2016; Goodman et al., 2013; Vick et al., 2012). Research shows that counselor attitudes and beliefs can impact the counseling relationship particularly in cases with historically stigmatized groups (Foss-Kelly et al., 2017; Smith et al., 2013; Sturm, 2008; Toporek & Pope-Davis, 2005).

Poverty is pervasive in the United States, with 11.4% of the population falling below the Census Bureau’s poverty line threshold (Census Bureau, 2021). The Census Bureau threshold is considered low by many standards, with some scholars considering poverty to be held at 200% of the threshold, resulting in a significant increase in the percentage of the population living in poverty (Goodpaster, 2021). Poverty disproportionately affects minority groups, such as people of color, women, children, the LGBTQ+ population, and immigrants (Badgett et al., 2019; Proctor et al., 2016; Semega et al. 2019). The inherent intersectional nature of poverty leads to many in poverty experiencing racism, sexism, and homophobia, leading to multiple stressors and compounded physical and mental health problems (Meyer, 2003; Wong et al., 2014).
People in poverty have unique counseling needs. Unlike people who are not experiencing poverty, those struggling with poverty may be in need of resource support, budgeting skills, and other aids that many counselors may be hesitant or less fluent in helping with (Tucker et al., 2021). People in poverty are more likely to experience psychological distress and have higher rates of almost every psychological disorder, along with decreased access to services (Douthit, 2015; Farrigan, 2020; Walker, 2015). Maslow’s (1943) hierarchy of needs further highlights these unique necessities by emphasizing how people in poverty may be experiencing unique stressors related to survival needs that may need to be prioritized over self-actualization. For example, people in poverty may be experiencing distinct sets of circumstances that hinder both their mental health and physical health such as hunger, decreased sleep, and instability in their living situations.

There is also a stigma associated with people who live in poverty. Unlike other minority groups, people in poverty are assumed to have brought their circumstances upon themselves (Smith, 2010; Yun & Weaver, 2010). People in poverty are sometimes assumed to be lazy, unintelligent, and less deserving than those not in poverty, who are viewed as having succeeded and “earned” their way to the top (Greenleaf et al., 2016). Stigma is known to have a negative effect on multiple domains (Flaherty et al., 2013; Hansen, 2014). Despite no evidence-based reasoning to support poverty is a result of laziness, those in poverty are often seen as “lazy”, “neglecting responsibility” or as “expecting handouts” (Gitterman, 2009; Kraus & Keltner, 2010). Stigma can greatly affect those in poverty from a mental health standpoint, given that a professional’s attitude toward poverty can affect how they treat and behave towards clients (Smith et al., 2013; Sturm, 2008; Toporek & Pope-Davis, 2005).
Thus, poverty is part of multiculturalism, and therefore a prominent component of counselor competencies. CACREP programs have a strong emphasis on multiculturalism. The CACREP guidelines require programs to thread multicultural topics throughout their classes. Research shows that both education and time spent in a field both contribute to decreased stigma towards poverty (Toporek & Pope Davis, 2005; Wittenauer, et al., 2015). Additionally, multicultural competency is a predictor of structural views towards poverty (Toporek & Pope Davis, 2005) and decreased views of poverty being an individual issue (Clark et al., 2017). With CACREP programs designed to prepare future counselors in multiculturalism, students in counseling programs should receive education that leads to decreased stigma towards people in poverty.

**Purpose of the Study**

The purpose of this study is to examine the effect of CACREP programs on students’ attitudes towards poverty. CACREP programs emphasize and require multiculturalism as a part of counseling curriculums (CACREP, 2015). Due to research showing multicultural competency and education being related to decreased stigma towards people in poverty (Clark et al., 2017; Toporek & Pope Davis, 2005; Wittenauer, et al., 2015), it can be expected that students exiting a counseling program will have less stigmatized attitudes towards poverty when compared to students at or towards the beginning of a CACREP program.

**Theoretical Framework**

This study approaches its topic with a poverty-aware social work framework (Krumer-Nevo, 2009). This framework was developed to help develop practice with an awareness of poverty. Although designed for social work, it is applicable to the field of counseling as well. The poverty-aware social work framework highlights knowledge acquisition, structuring of
professional values, skills development, and experiencing (Krumer-Nevo et al., 2009). This framework provides advantageous guidance for this study.

First, this framework emphasizes education and knowledge acquisition on poverty. With poverty considered a part of multiculturalism, CACREP guidelines inherently align with this focus by emphasizing multicultural perspectives being included throughout programs. Additionally, the ACA also emphasizes multicultural competency, stating the professional values that are to be promoted in counselors and counseling students.

Further, the ACA (2016) highlights the structuring of professional values. According to this framework, “students will identify and be aware, through a process of self-reflection of their personal and cultural values regarding poverty” (p. 230). Krumer-Nevo et. al, (2009) emphasize in their framework the development of self-reflection specifically to avoid “othering.” Likewise, both the ACA code of ethics and CACREP standards emphasize self-reflection and awareness. CACREP standards state that students meet the standard of “the impact of heritage, attitudes, beliefs, understandings, and acculturative experiences on an individual’s views of others”, whereas ACA standards state that counselors should be aware of and explore their own values and cultural identities and be aware of how they can impact the counseling process (ACA, 2016; CACREP, 2015 section 2.d). Thus it is clear that the focal point of structuring professional values in order to increase poverty awareness aligns with the counseling field.

In addition to knowledge acquisition and the structuring of professional values, there is also an alignment with the final highlights, skills development, and experiences aspects of CACREP-accredited courses. In addition to classes emphasizing skills and techniques development, counseling students are required to complete multiple hours in the field through a practicum and internships (CACREP, 2016). Both the classwork and field work allow students
to develop the skills needed and to gain experience in the field that can influence their attitudes and views of poverty.

Due to CACREP emphasizing all aspects of this framework through classes and field experiences, it is clear to see the match between this social work designed framework and the field of counseling. Since CACREP programs emphasize the impact of multiculturalism, experience in the field, and education on counselor ethics and values, it follows that attitudes towards poverty should be reflected in students’ progress in such programs. This framework purports that all of these factors should impact views and beliefs on poverty.

**Research Questions**

This was a quantitative study that used a survey containing the Attitudes Towards Poverty-Short Form (ATP-SF) scale as well as demographic information and student progress in a program to examine the above questions. Participants were Masters’ level counseling students in CACREP accredited programs across the United States. The survey provided the information to answer the following three research questions:

1) How is counseling student progress related to attitudes towards poverty?

2) Does a multicultural course mediate the relationship between time in program and ATP?

3) Do practicum and internship experience mediate the relationship between time in program and ATP?

In summary, this research is seeking to examine the question of: Does progress in a CACREP program and completion of certain program courses affect attitudes towards poverty?
Significance of the Study

This study explored how counseling programs are influencing students’ attitudes towards poverty. Although there is existing literature on counseling students’ multicultural competencies and poverty, attitudes towards poverty, and similar topics, there remains a gap with regard to the relationship between student progress in a program and attitudes towards poverty. The researcher hoped to shed light onto the effectiveness of CACREP programs in educating students on poverty and impacting student attitudes. At the completion of this study, the researcher provides suggestions for strategies going forward that will hopefully guide future counselor educators in addressing this critical area.

Methods

This study was a quantitative study. I sent out a survey to students in CACREP programs using Qualtrics. The survey contained the ATP-SF as well as demographic questions including student time in a CACREP-accredit program (tenure), participant region as defined by zip code, age, and childhood SES status.

Results

A total of 222 total responses were obtained. Of these, 182 participants completed all questions, and 197 completed all of the ATP-SF questionnaire. The ATP-SF scores were generally positive. The average structural perspective score was 23.25 out of a possible score of 30, the average personal deficiency score was 28.41 out of a possible score of 35, and the average stigma score was 31.5 out of a total number of 40. On each scale, a higher number indicates lower stigma. In addition to each subscale, a total score can also be attained. The ATP-SF total score averaged 83.31 for all respondents out of a total possible score of 105.
Prior to conducting the multivariate analysis, I calculated the correlation between the various variables of interest. To that end, participant’s attitudes—both in terms of their overall ATP-SF scores and by the three subscales—were correlated with the demographic variables to determine if sufficient association existed to justify the multivariate analysis.

Years in the program, or tenure, and courses completed were positively correlated with all subscales such that students that have been in the program for more time was positively correlated with more open attitudes. Students’ childhood SES status correlated negatively with all subscales. Respondent census bureau region correlated negatively with the ATP-SF total score, the personal deficiency subscale, and the stigma subscale. Respondent’s region also correlated positively with the structural subscale. In all instances, respondent region was significantly correlated with the various beliefs about poverty. All the specific classes taken (multicultural, practicum, and internship) correlated positively to all subscales and to the ATP-SF total score.

MANOVAs were conducted to explore potential differences in terms to attitudes to poverty by the various independent variables. Overall, four MANOVAs were conducted using all three sub-scales from the ATP-SF, as well as the total score, as dependent variables with the various demographic items serving as independent variables. These included the completion of a multicultural class, the completion of a practicum, and experience in internship, respondent region, age, tenure in program, and childhood SES. There were no statistically significant findings for any of the ATP-SF subscales. In other words, there were no statistical differences found between participant region, childhood SES, tenure in their academic program, nor completion of a multicultural class, practicum, or internship.
Discussion

This study contained some limitations. The number of participants and being unable to control the environment the survey was taken in are both limitations to this study. Another limitation was that this study compares students to other students, rather than to their own past views and stigma, limiting the ability to truly assess change. Additionally, response bias could have influenced the students’ answers, resulting in them answering what they believe they should answer instead of their true beliefs.

There are many areas for future study. This study leaves a lot questions that allow for further research opportunities. First of all, research looking at other fields and their attitudes towards poverty could provide insight into the scores found in this study by providing something to compare the results to. Research examining the attitudes from students of other fields could provide helpful insight. Secondly, examining this same topic through a different method, such as a longitudinal, qualitative, or experimental design, could help provide further insight into whether attitudes towards poverty shift within the individual students as they progress through their programs. Additionally, repeating this study design with other attitude scales could provide useful information into whether CACREP programs lead to changed attitudes. Completing this study by examining attitudes towards other marginalized groups, such as the LGBTQIA+ community, race, gender, and addiction could all provide valuable information.

Conclusion

Although previous research has demonstrated a relationship between knowledge a question and experience with decreased stigma towards poverty, no correlation was found between completion of multiculturalism, practicum, or internship and positive attitudes towards poverty. There were some limitations to this study including sample size, environment factors,
and possible response bias. Further research is needed to examine CACREP programs and the attitudes towards poverty in students.
Chapter Two

Literature Review

The purpose of this study is to explore the relationship between students’ progress in a Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredited program and their attitudes towards poverty. This chapter will introduce and explore the concepts and definitions of poverty, multiculturalism, CACREP-accredited programs, poverty stigma, unique counseling needs of people in poverty, as well as provide an overview of the current literature pertaining to CACREP students and their attitudes towards poverty.

Poverty is a state of being marked by lack of funds and/or necessities needed for quality of life. Affecting approximately 11.4% of the U.S. population, poverty is an intersectional issue, impacting people from all walks of life, gender and sexual identities, race and ethnic identities, education levels, locations, and all other categories. (Badgett et al., 2019; Lin & Harris, 2008; Proctor et al., 2016; Semega et al., 2019). Marginalized individuals such as women, people of color, transgender people, children, and others are more likely to experience poverty (Badgett et al., 2019; Cawthorne, 2008; Proctor et al., 2016; Semega et al., 2019). Clients in poverty have unique mental health needs (World Health Organization [WHO], 2010), needing distinct and intentional interventions from their counselors (Clark et al., 2020; Foss-Kelly, et al., 2017; Goodman et al., 2013; Vick et al., 2012). With both the American Counseling Association (ACA) and CACREP emphasizing the need for multicultural competency, students in CACREP-accredited programs should be exposed to education on the unique needs for clients in poverty, which should lead to decreased stigma towards poverty.
Poverty

The definition of poverty varies widely among sources, with some experts viewing poverty from a monetary amount or by resources, and others looking at it in a more contextual way (Bradshaw, 2006; Nolan & Whelan, 2010; Semega, et al., 2019; Sylvestre et al., 2017). Specifically, the primary definers of poverty consider three distinct criteria: monetary status, basic needs, and capabilities or social deprivation (Sylvestre, et al., 2017). The monetary resource view is the most common definition (Census Bureau, 2020; Nolan & Whelan, 2010). This view considers certain thresholds of income to evaluate whether someone meets a criterion or set number for poverty (Census Bureau, 2020; Nolan & Whelan, 2010). In contrast, defining poverty from a basic needs perspective considers non-monetary indicators such as lack of education, poor health, and inadequate housing, among other factors, all of which contribute to social exclusion for the poor (Nolan & Whelan, 2010). The United Nations elaborates, defining “absolute” poverty as “a condition characterized by severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information, that poverty is defined not only on income but also on access to social services” (United Nations, 1995, para. 19). Lastly, the contextual definitions places basic needs into consideration within the context of geographical location in which people live and whether they have what they need and are able to live beyond just the basic needs (Bradshaw, 2016). These definitions focus on different aspects of poverty and the impact on the individuals. With the varying definitions, it is possible for individuals to meet poverty thresholds in some definitions but not in others.

In the U.S., the monetary view is generally applied at the household-level, considering the number of individuals in the household and total household income (Census Bureau, 2020).
Using this perspective, the Census Bureau’s 2021 report indicates about 11.6% of the US population is living in poverty (Census Bureau, 2021). The Census bureau’s threshold for defining poverty is $13.8k per year for individual, $21.5k a year for a family of three, and $32.8k a for a family of five. This threshold is low, considering the amount does not meet the cost of rent and living for many areas in the United States (Aurand, et al., 2021). For an individual, this equates to approximately $1,200 a month, an amount that fails to reach the threshold of most rental properties in both urban and suburban areas, which often requires one to make three times the rent to qualify for a lease agreement. For example, the National Low Income Housing Coalition (2021) has found no location in the United States where a family with one full-time worker earning minimum wage can afford to rent a two-bedroom apartment.

Furthermore, if one’s income is less than half of the poverty threshold, one qualifies for living in “deep poverty” (Shaefer & Edin, 2012). Deep poverty can have a lasting impact on individuals’ social, emotional, and educational development and is often generational. For instance, in the United States, 51.7 million people are living below 125% of the poverty line, a greater number than those under the poverty threshold (Semega et al., 2019). Due to the federal poverty measure not being adjusted to the cost of living since 1963 or taking into account debt-to-income ratio (U.S. Census Bureau, 2017), some researchers consider being at 200% of the poverty level as qualifying for low-socioeconomic status (Goodpaster, 2021). Thus, defining poverty by the Census Bureau’s threshold eliminates many who would still meet more contextual or needs based definitions of poverty.

Another view is to define poverty by looking at lack of necessities and a sense of social deprivation, viewing poverty in a contextual manner rather than a uniform definition (Bradshaw, 2005). The United Nations includes lack of social services in its definition of poverty (United
Looking at poverty from a more individualized standpoint in terms of how it impacts one’s quality of life and ability to thrive allows for more flexibility and understanding of poverty than can be obtained via the simple use of a financial threshold. Using lack of necessities, one can argue that a variety of incomes could qualify as being in poverty and that the threshold changes depending on factors such as individual needs, the area one lives in, and other such factors. Where one income might suffice for a certain standard of living in one city, the same income might result in homelessness in another city.

Additionally, social deprivation definitions extend the view of poverty beyond necessities to include the resulting treatment and stigma that those in poverty experience. People in poverty experience unique oppression and stigma due to their status. Yun & Weaver (2010) assert that many people view living in poverty as a moral failing. People in poverty are often perceived as lazy, expecting handouts, and lacking responsibility (Gitterman, 2009). There is also stigma against welfare recipients, with prejudiced ideas such as the notion that women in poverty have more children to receive more government aid, or that that able-bodied people are using government resources in order to avoid working, being extremely prominent.

Other definitions include both the capabilities perspective and the resources view of poverty. The capabilities perspective looks at the ability and freedom people have to live the life they want to; it conceptualizes poverty as the deprivation of capabilities rather than limited resources (Sen, 1999). This perspective emphasizes individual’s unique needs and how poverty impacts functioning. The resources view of poverty looks at poverty from whether or not someone can get access to needed resources, such as housing costs food and other basic needs (Edwards, 2014).
Looking at the varying definitions, it is easy to see the benefits and shortfalls of each one. Whereas the monetary threshold for poverty does allow for a clearly defined criteria that is useful for having specific numbers for statistics and research, it intone the less neglects many key components of poverty. Contextual views of poverty allow for people to consider poverty beyond a simple number and understand more of the struggles and lived experiences of those in poverty. The downside to the contextual view is that it requires more attention to be paid to different regions and areas as to what level of income constitutes poverty and requires one to take into account factors such as rent costs and debt payments, which can vary widely depending on the individual and the location.

There is a matter of debate over what constitutes being in poverty at a capacities level, in terms of the point at which an individual should be considered as living in poverty. With varying definitions and thresholds for poverty, it is plain to see that different factors can affect different individuals in varying ways. Whereas one may meet above the poverty line according to the Census Bureau, they might be living with a lack of necessities and deprivation with limited resources. Due to the wide variety of definitions, there are many interpretations and multiple perspectives on what the threshold or meaning of poverty is. For the purpose of this study, no definition will provided for the participants to allow for their own interpretation. Participants will be given a survey with questions regarding “people in poverty”, “poor people” and “people on welfare” without any other definers of the terms. One benefit to not having a definition included in the study is that it will allow for individuals to form their own definition and potential bias. A downside, however, is that there will be no way to know what the respondents’ definitions may be. A benefit to not defining poverty is the fact that the terms “poverty” and “poor people” invoke in themselves a certain image to mind, which will allow us to assess the bias that comes
with the words itself rather providing a defining which may then alter any automatic assumptions participants may have.

Poverty is becoming increasingly prevalent (De France & Evans, 2020; Shrider, et al., 2021; Schoch, et al. 2022). According to the World Bank, poverty rates were on a decline before the onset of the COVID-19 pandemic, which caused a world-wide increase in poverty (Schoch et al., 2022). In the U.S. alone, the poverty rate increased by one percentage point from 2019 to 2020, the first increase seen after five years of consecutive declines (Shrider et al., 2021). Additionally, the U.S. also experienced a decline in the median household income of 2.9% during the same period, the first decline since 2011 (Shrider, et al., 2021). With recent reports estimating that one in four children are born into poverty in the United States, the impact of this on the population as a whole is very concerning and of increasing importance (De France & Evans, 2020).

Poverty does not discriminate; it affects people from all backgrounds (Semega et al., 2019). Although it can affect all people, in the U.S. it disproportionately impacts individuals from minority groups or status. For instance, women experience poverty at a rate of 12.6%, whereas men experience poverty at a rate of 10.5%; 25.3% of female householder families live at or below the poverty line compared to 12.7% of male householder families (Creamer et al., 2022). Furthermore, whereas African Americans experience poverty at a rate of 20.8%, white individuals experience it at 10.8%. Additionally, people with disabilities experience poverty at a rate of 25.7% vs 9.5% of individuals with no disability (Semega et al., 2019). Other ethnic and racial minority groups are also disproportionately affected by poverty, with 24.3% of American Indian and Alaska Natives, and 17.1% of Hispanic Americans living below the poverty line in 2021 (Creamer et al., 2022). From the above statistics, it is clear to see that poverty is a
prominent issue that affects people of every identity, while simultaneously disproportionately affecting people of minority status.

**Poverty and Mental Health**

Poverty uniquely impacts mental health symptoms as well as access to mental health services (Douthit; 2015; Farrigan, 2020; Walker; 2015). In 2018, all the counties with extreme poverty in the United States were rural (Farrigan, 2020). People in rural areas are more likely to be reluctant to seek healthcare, and to be in poorer health (Douthit, 2015; Nadeem et al., 2008). People in poverty often have limited access to healthcare due to a variety of internal and external factors, such as cost and access to both mental and physical healthcare. In addition to cost as a barrier, attitudinal beliefs about mental health also serve as a major barrier for people in poverty accessing mental health services (Walker, 2015).

There is also a distinct difference between situational poverty (e.g., temporary job loss) versus generational poverty (a cycle of poverty passed down through generations) and how each impacts people in poverty and their mental health. Situational poverty is a result of misfortune and events that lead to unexpected poverty. Generational poverty, on the other hand, is a result of being born into poverty and causes greater and longer-lasting socioemotional challenges, mental health concerns, stress, and increases difficulty for individuals or families to gain access to resources to get out of poverty (Edwards, 2014). Cycles of poverty, limited access to transportation, and stigmas can lead to decreased mental health seeking behaviors for people in poverty.

People in poverty report significantly higher levels of stress than those not in poverty, which is associated with lower life satisfaction levels, and high levels of sadness, worry, pain, and anger (Graham, 2015). Having a mental illness may increase one’s chances of living in
poverty, and poverty in turn may increase the likelihood of developing a mental illness, creating an amplifying effect (Anakwenze, & Zuberi, 2013; Hudson, 2005). The experiences of being a member of a marginalized or minority group or identity can intersect with poverty and lead to multiple factors of minority stress (Meyer, 2003). Minority stress is a term coined by Meyer to describe the unique stressors experienced by minority groups and how those stressors are related to health outcomes. With poverty disproportionately affecting minority populations, it is evident that minority stress can be compounded onto the other stressors experienced by people in poverty.

There is a strong link between poverty and mental health disorders. Approximately one-fourth (2.5 million out of the 9.8 million) of adults who have a diagnosis of serious mental illness live below the poverty line in the United States (SAMHSA, 2016). People in poverty report higher rates of psychological distress than those not in poverty (Becerra et al., 2015; Meyers, 2020; Weissmen et al., 2015). People living below the poverty line are over seven times more likely to experience serious psychological distress compared with those living with incomes at 400% or greater above the poverty line (Weissman et al., 2015). With the prevalence of mental health disorders in impoverished communities, it is evident that there is a need for understanding and proper interventions for those in poverty.

Poverty can affect mental health in a variety of ways, including increased worries, uncertainty, environmental factors, physical health, early life conditions, trauma, violence and crime, as well as social status, shame, and isolation (Ridley et al., 2020). People living in poverty are often in a constant state of hypervigilance and stress from anticipation of unexpected expenses, such as medical bills. In addition, living in poverty exposes people to higher rates of crime, trauma, and violence (Sharkey et al., 2016). Youth in impoverished communities are more
likely to be exposed to gun homicides and conflict-based violence (Kravitz-Wirtz, 2022; Tollefsen, 2020). Exposure to violence both within a household and elsewhere is a predictor of depression and other mental illness (Cornaglia et al., 2014; Goodman et al, 2009).
Marginalization of people in poverty from social stigma or other reasons can result in isolation and loneliness (Walker and Bantebya-Kyomuhendo, 2014), which are themselves correlated with depression (Cacioppo et al., 2006). Long exposure to stress can threaten mental health (Staufenbiel et al., 2013). This increased stress and unique experiences lived by people in poverty highlight the unique nature of their needs.

In addition to the factors listed above, people in poverty are exposed to environmental factors that increase their risks for mental health illnesses. Impoverished areas are more often exposed to environmental irritants that can be linked to both physical and mental illness, such as pollutants, temperature extremes, and challenging sleep environments (Dean et al., 2018). These irritants, combined with financial stress, hypervigilance, trauma, and violence, highlight the abundance of factors contributing to the distinct experiences of those living in poverty.

Rates of depression, anxiety, and suicide correlate negatively with income (Banks et al., 2018; Costello et al., 2003; Iemmi et al., 2016; Lund et al., 2010; Sareen et al., 2011). Those with the lowest incomes in a community suffer up to 3 times more frequently than those with the highest incomes from depression, anxiety, and other common mental illnesses (Lund et al., 2010). Children who have experienced being poor have more psychiatric symptoms than children who have not experienced poverty (Costello et al., 2003).

Poverty also greatly affects children. Children who live in poverty experience higher rates of adverse childhood events (ACEs) than children that do not live in poverty (Child Trends, 2016). More than 15 million children in the United States live below the federal poverty level
(National Center for Children in Poverty, 2016). Exposure to ACEs can lead to long-term effects in brain development and behavior which can impact a person’s ability to learn and can subsequently result in long-term health and mental health problems (Shonkoff et al., 2012; Shonkoff, et al., 2009). Children with greater amounts of ACEs experience disproportionately high effects of mental health diagnosis and school achievement difficulties (Porche, et al., 2016). Childhood and adolescent poverty is related to increased risk of drug use later in life (Manhica, et al. 2020). Moreover, Mersky et al. (2018) found that mothers who were at or below 200% of the Census Bureau’s poverty threshold experienced an average of 3.3 childhood adversities as well as 3.7 adult adversities.

In addition to increased risks in mental health, people in poverty are at risk of higher levels of physical ailments (Conroy et al., 2010; Cutler et al., 2008; Patel et al., 2020). The higher risk for individuals in poverty is well demonstrated through the events surrounding the COVID-10 pandemic. In the midst of the COVID-19 pandemic, many people were considering everyone “in the same boat,” suggesting that the pandemic affected everyone at a similar level. Research has shown this notion to be false, indicating that people in poverty were more greatly affected by the ramifications of COVID-19 infections and lockdowns (Patel et al., 2020; Whitehead, et al., 2021). People in poverty are more likely to live in smaller, more crowded spaces which resulted in an increased risk of infection of COVID-19 (Patel, et al. 2020). There are multiple factors that result in people in poverty having increased health risks.

Lower income often co-occurs with poor physical health (Conroy et al., 2010; Cutler et al., 2008;). Poor physical health is also likely to co-occur with anxiety and depression (Scott et al., 2016) and unemployment (Frasquilho et al., 2016; Lund et al., 2010). Impoverished adults have a greater risk for adverse health effects from smoking, substance misuse, chronic stress, and
obesity (Khullar & Chokshi, 2018). In addition, they are also likely to have difficulty paying for medical care and obtaining health insurance (Khullar & Chokshi, 2018). Furthermore, lower income is associated with higher rates of disability and mortality in older adults (Minkler, et al. 2006). With the impact and prevalence of poverty, the need for counseling competencies and knowledge is undeniable.

**CACREP programs**

Counseling licensure is the required credential that helps protect the public from malpractice in mental health settings by providing a minimum standard of competence for all counseling providers. Licensure requirements vary by state but generally include standards for graduate program hours and class requirements, supervision requirements, clinical contact hours post-graduate school, and satisfactory scores on a professional examination. The Counsel for Accreditation of Counseling and Related Educational Programs (CACREP) is currently the most wide-spread accrediting body and associated program standard for counseling programs in the United States. Most state licensure groups require an individual to have graduated from a CACREP or equivalent program to be able to practice in their state.

CACREP requirements emphasize knowledge of multicultural competency, effects of power and privilege, and awareness of one’s own biases and barriers as a practitioner (CACREP, 2015). Multicultural competency places emphasis on awareness of other cultures and groups as well as on having cultural humility, which is to approach multiculturalism with an attitude of curiosity and with the ability to self-reflect and explore one’s own cultural identity (Tervalon & Murray-Garcia, 1998). The ability to approach new cultures and populations with an openness to learning, humility, and curiosity is at the core of multicultural competency. Previous research has found a significant relationship between multicultural competency and poverty beliefs, although
each study has been limited to either one counseling specialty (Bray & Schommer-Aikins, 2015) or level of counseling experience (Toporek & Pope-Davis, 2005). CACREP-accredited programs are tasked with providing students with the needed knowledge and exposure to be aware of their own biases and develop in attitudes or beliefs that may impact a counseling relationship.

Although there have been studies examining CACREP-accredited programs and various multicultural competencies (Gonzalez-Voller, et al., 2020; Holcomb-McCoy & Myers, 1999), including students’ attitudes towards poverty (Tucker et al., 2021), there is a lack of research specifically exploring CACREP programs and the students’ attitudes towards people in poverty and the relationship to the students’ advancement in the program. An intensive review of the Psychinfo database on September 13, 2023 revealed no publications on the topic. Key words included were poverty, attitudes, counseling student, CACREP, and stigma. Due to the counseling standards emphasizing working with people from all backgrounds, cultural competency and the ability to work with a variety of populations, including people in poverty is essential for the counseling field. Students need to be trained to be able to effectively work with the populations to which they will be exposed, including populations of people living in poverty. It is also crucial to examine programs and evaluate their respective effectiveness in promoting cultural competency with regard to people in poverty.

**Multicultural Competency and Counseling People in Poverty**

Multicultural competence is an important aspect of the counseling profession, defined as a set of beliefs, knowledge, and skills needed to effectively treat members of various cultures (Gilbert et al., 2007; Sue, 2006). Multicultural competence is the ability to administer interventions and help people from all walks and backgrounds of life, including those affected by
poverty (Kaplan et al., 2014; Ratts, et al., 2016). Researchers have found that professionals who score higher on multicultural competency scales hold less stigmatizing views on poverty.

According to the American Counseling Association’s (ACA) code of ethics (2014), counselors should be able and willing to serve persons of all social classes (Standard A.2.c.). Multicultural competency and the ability to provide services for individuals from all backgrounds and socioeconomic status is a necessary skillset. CACREP standards also require multicultural competence and the ability to treat people from all backgrounds. It is a required learning outcome of CACREP-accredited programs (CACREP, 2016). With many students treating people in poverty from their first experiences in the field with their practicum and internship placements, it is easy to see the need for education and knowledge on poverty.

The ACA provides frameworks for advocacy competencies to guide counselors in engaging in social justice with all clients, including clients in poverty (Lewis et al., 2003; Toporek & Daniels, 2018). The competencies discuss engaging in advocacy on the micro-, meso-, and macro levels. The micro levels focus on individual clients and may be seen while in session with the client, the meso levels are those seen within a community, and the macro sessions are at a national level. Counselors need to be proficient in helping clients in poverty at all levels. Existing counseling literature also emphasizes advocacy at all levels and highlights the importance of advocacy for those clients experiencing poverty (Clark et al., 2020; Doyle, 2017; Foss-Kelly, et al., 2017; Heijnders & Van Der Meij, 2006; Kayman et al., 2015).

The ACA code of ethics calls for counselors to advocate at individual, group, institutional, and societal levels (ACA, 2014). Therapists are to help tear down barriers that inhibit client growth or access to mental health care. Advocacy for people in poverty is critical to help tear down the systemic issues and barriers that inhibit people in poverty. Advocacy for
people in poverty needs to extend past the individual level and seek social justice in monetary resources, basic needs, and capabilities of those in poverty (Sylvestre, et al., 2017).

The Multicultural and Social Justice Counseling Competencies framework developed to help counselors implement social justice and multicultural competencies into their practice and research, identifies counselor self-awareness as its first domain (Ratts et al., 2015). It states that counselors need to be aware of their biases against oppressed groups and actively dismantle them. Foss-Kelly and colleagues (2017) endorse a practice wherein counselors internally reflect on their biases and personal beliefs. Such reflection is essential to competently counsel people in poverty. Multicultural competency is also highlighted by both the ACA code of ethics and in the CACREP education requirements.

Cultural humility is a newer approach to multiculturalism which takes into account the never-ending learning experience and humility that comes with learning about other cultures (Tervalon & Murray-Garcia, 1998). Davis and colleagues (2011) define humility through both interpersonal and intrapersonal lenses. From the intrapersonal perspective, it means having an accurate view of oneself; whereas from the interpersonal perspective humility is other-focused and characterized with respect for others. Hook and colleagues (2013) define cultural humility as the “desire and ability to maintain an other-oriented interpersonal stance in relation to features of cultural identity that are important to others” (p. 2). This perspective can help guide counselors in continuing development towards treating clients in poverty and other intersecting populations.

Lorian (1974) identified unique needs for clients in poverty and asserted that they have different expectations and needs for therapy. He directed therapists to adapt treatment to the unique needs experienced by those in poverty. To best serve clients in poverty, therapists need to address clients’ physiological and safety needs, and conceptualize the meeting of basic needs as
critical and meaningful therapeutic interventions. With poverty being included in multicultural competencies, and attitudes affecting counseling relationships, we can see why using an attitude towards poverty assessment can be a helpful measurement to assess clinical multicultural competency skills.

Culturally competent practice is an essential component to the counseling profession. Multicultural competency guidelines require that counselors cultivate the necessary attitudes, beliefs, knowledge, and skills to work effectively with all populations (ACA, 2014; Kaplan et al., 2014; Ratts et al., 2016). Poverty is intersectional, affecting people of all genders, sexual identities, racial and ethnic identities, relationship and statuses, education levels, and areas. Furthermore, it affects marginalized individuals such as women and people of color at higher rates than non-marginalized individuals (Semega et al., 2019).

People in poverty present with unique needs in counseling settings. People in poverty have distinct experiences and there is a high correlation between poverty and mental health needs, making it crucial for counselors to be aware of the needs of those in poverty (Clark et al., 2020; Foss-Kelly et al., 2016; Goodman et al., 2012; Vick et al., 2012). Maslow’s hierarchy of needs highlights this need when it describes how people need to have their physical and safety needs met (Maslow, 1943). For example, people in poverty may be at risk of hunger, not affording rent or utilities, homelessness, increased work hours, and decreased time to sleep. Counselors need to be prepared not just to implement interventions that focus on needs such as depression and anxiety, but to be conscious and intentional to help with the physical and safety needs as well. A client who is feeling anxious about the very real possibility of losing their home needs more than just anxiety coping skills. Counselors should have the capacity and resources to
help meet the physical and safety needs for clients as well. Additionally, counselors should be aware of their counseling costs and availability for people in poverty (Ridley et al., 2020).

There are existing modalities and models for effectively helping people in poverty. Clark and colleagues (2020) explored counselor competency in working with people in poverty and identified five major best practices: (1) training, (2) awareness, (3) knowledge, (4) skills, and (5) advocacy. The first practice, training, can be formal (e.g., schooling, training, books) or informal (e.g., personal and job experiences). The second practice refers to awareness of clients and of self. The practice of knowledge includes knowledge of barriers, privilege, oppression, intersectionality, systems theory, and any other relevant information. The skills needed include poverty sensitive assessments and person-centered relational skills. The final practice, advocacy, includes helping with client access to mental health services, assisting clients with finding resources, and challenging poverty stereotypes. The authors suggest using this model to competently treat clients in poverty.

Another strategy for counseling people in poverty is the I-CARE model, standing for “internally reflect, cultivate relationships, acknowledge realities, remove barriers, and expand on strengths.” (Foss-Kelly, et al., 2016). The I-CARE model was developed to help counselors effectively counsel people in poverty. Specifically, it is designed to help counselors develop personal insight, acknowledge realities, remove barriers, and help clients expand their strengths. Formerly known as the “care” model, the creators recently added the “I” for internally reflecting when working with people in poverty, emphasizing the need to be aware of one’s own biases and stereotypes. This model reflects the need for advocacy and understanding as therapists are prompted to both help clients on a personal as well as from a systemic level. There is research that shows that people in poverty may not always receive adequate care, especially since most
evidence-based interventions were designed in a way that aligns more with values of those in middle class than those in poverty (Foss et al. 2011) and that they are more likely to experience care that is not evidence-based (Castro-Ramirez, et al. 2021).

Furthermore, research shows that public education, advocacy, intercultural exchanges, and integration of stigmatized groups are strategies that can help reduce public stigma (Doyle, 2017; Heijnders & Van Der Meij, 2006; Kayman et al., 2015). This aligns with both the I-CARE model as well as the five major practices as identified by Clark (2020). People in poverty need their counselors to extend beyond therapeutic skills and work on advocacy and being involved in education in the surrounding communities.

Student Growth

CACREP standards highlight several requirements that endorse the need for students to be trained in the needs of clients in poverty. As far as counseling and helping relationships, the guidelines highlight the need for ethical and culturally relevant strategies for maintaining relationships, using evidence-based counseling strategies, and using strategies to promote awareness and access to community-based resources (CACREP, 2016). Additionally, CACREP guidelines highlight the needs for multicultural counseling competencies. These competencies include understanding views of others, and the need to address barriers that impede client’s access, equity, and success in counseling (CACREP, 2016). With CACREP-accredited programs needing to adhere to these standards, it is critical for counseling programs to highlight these unique needs and to foster empathy for clients in poverty.

Tucker and colleagues (2021) found that graduate students do not feel as competent or trained to address clients in poverty as they do clients seeking issues surrounding self-growth. They also found that graduate students reported a preference to work with issues surrounding
self-growth over issues surrounding people in poverty, such as financial assistance and career attainment. The researchers suggest that any subtle indications from the student therapist that communicate to a client that concerns surrounding financial assistance are not their preferred focus may confirm clients’ fears of stigma.

Length of time spent in a counseling program can lead to student growth and development as future counselors gain knowledge and skills on various populations and topics. There is evidence that student growth leads to increased empathy. Lyons and Hazier (2002) found in their research on counseling graduate students that those in the second year of their programs had increased cognitive empathy. Another study found that practicum experience for counseling students led to increased empathetic concern in students (DePue & Lambie, 2014). Additionally, counselors-in-training have been shown to have more structural views of poverty than the general population, supporting the notion that counseling education leads to student growth in attitudes and perceptions of the world (Crumley, 2013).

It is imperative that counselor educators help students evaluate internal biases and explore whether their favored presenting concerns align with the ability to help people from all backgrounds. Counselor educators should endorse this by aligning preferences with Kaplan et al. (2014)’s definition of counseling, meeting diverse clients’ “mental health, wellness, education, and career goals” (p. 358). Smith and colleagues (2013) suggest that advocacy efforts may need to be emphasized and enhanced for clients in poverty in counseling-training programs, given that mental health professionals reported feeling unprepared to meet and address the practical needs for their clients in poverty (Smith, et al., 2013).
Attitudes

To best serve those in poverty, one must assess their attitudes towards those living in poverty. Researchers have determined three underlying beliefs and attitudes towards individuals in poverty (Yun & Weaver, 2010). These are individualistic, structural, and fatalistic. Someone with the individualistic attitude views poverty as a result of individual factors such as laziness or apathy. This view sees poverty as a moral failing. Structural views look at poverty as a result of systemic issues. A person from this perspective will believe that poverty is largely a result of societal barriers which prevent individuals from coming out of poverty and will consider the impacts of generational wealth and poverty as an influence. A fatalistic view sees poverty as a result of uncontrollable factors and misfortune; in other words poverty is simply a result of “bad luck” (Yun & Weaver, 2010). A therapist who has individualistic views of poverty may see clients in poverty as lazy, having moral failing, and may blame the client for their situation. A therapist with a fatalistic view may express empathy or sympathy for the client. A counselor with a structural view will be able to see the environmental factors affecting their clients’ situation and may also be more aware of ways to advocate for their client as they fight against systemic barriers.

Systemic barriers towards people in poverty is very well explained in the following quote from author Terry Pratchett (1993, p. 32):

Take boots, for example. He earned thirty-eight dollars a month plus allowances. A really good pair of leather boots cost fifty dollars. But an affordable pair of boots, which were sort of OK for a season or two and then leaked like hell when the cardboard gave out, cost about ten dollars. Those were the kind of boots Vimes always bought, and wore until
the soles were so thin that he could tell where he was in Ankh-Morpork on a foggy night by the feel of the cobbles.

But the thing was that good boots lasted for years and years. A man who could afford fifty dollars had a pair of boots that’d still be keeping his feet dry in ten years’ time, while the poor man who could only afford cheap boots would have spent a hundred dollars on boots in the same time and would still have wet feet.

A therapist’s attitude toward poverty is important as their views can substantially influence the care they give their clients, as well as inform their interventions. Research shows that attitude is a predictor of how a mental health professional behaves toward and treats clients (Sturm, 2008). Clinicians that understand poverty from a systemic perspective can more effectively treat clients in poverty and are more prepared to advocate for changes that will help their clients. A therapist that views poverty as solely stemming from individual factors may have false perceptions of their clients and endorse feelings of self-blame or feelings of being misunderstood in their clients (Toporek & Pope-Davis, 2005). Professionals who serve in low-income communities often associate poverty with mental illness, laziness, and violence which can undermine therapist’s desires to work with clients in poverty (Smith et al., 2013). Therapists need to be trained and equipped to help those in poverty and ensure they are educated in causes of poverty and can reflect on their own biases.

Foss-Kelly et al. (2017) purport that due to stigma and negative interactions they experience, impoverished clients may presume judgement from their therapists before even meeting them. This expectation can hinder and/or alter the therapeutic relationship before it even begins. Counselors need to be aware of this possibility and work towards creating welcoming, non-stigmatizing interactions with their clients of every background.
The class hierarchy found in the United States negatively impacts the quality of life for people who are dependent on unlivable incomes though both lower life expectancy and poor standards of living (Zimmer et al., 2016), as well as contributes to preserving the cycle of poverty for later generations (Gitterman, 2009; Goodpaster 2021). This continuous cycle is propelled forward through both societal and self-stigma which contributes to barriers experienced by people in poverty. Poverty stigma influences how people view and respond to policies that are designed to help people living in poverty (Ruetter et al., 2008). People in poverty are at risk for stigma from their communities as well as from welfare use (Besbris et al., 2015; Blank, 2005). It is essential for the counseling profession to be at the forefront of fighting stigmas and advocating for people in poverty.

**Stigma**

Stigma is defined by Goffman (1963) as “an attribute that is deeply discrediting,” it was originally used in reference to a physical marker of someone’s moral status. It can also be defined as the “endorsement of negative stereotypes” (Baker et al., 2020). Yet, poverty stigma differs from other forms of stigma (Smith, 2010). Smith (2010) noted that when compared to other marginalized statuses, “people who are poor [] may be tacitly assumed to have brought their predicament on themselves” (p. 9). Since poverty can afflict people from any background, people tend to associate it with moral failings rather than from systemic issues and barriers. Many scholars hypothesize that under the system of capitalism and the inherent competitiveness within, the poor and working class are often assumed and judged to be lazy, unintelligent, and less deserving than those who have succeeded and “earned” their way to the top (Greenleaf et al., 2016).
Stigma is also known to have a negative effect on physical, social, emotional, and cognitive domains (Flaherty et al., 2013; Hansen, 2014). Although there is no evidence-based reasoning to support that poverty is a result of laziness or other biological factors (Kraus & Keltner, 2010), people trapped in poverty are often seen as “lazy”, “neglecting responsibility” or as “expecting handouts” (Gitterman, 2009). Stigma itself can also contribute to increased ACEs (Anda et al., 1999). Research shows that social mobility is connected to social and financial connections with other successful people and not just hard work on its own (Waxman, 1977; Banerjee et al., 2006). Intersectionality compounds poverty’s impact where poverty and marginalized groups intersect. The term “intersectionality” was coined by Crenshaw (1989) and is used to describe the ways in which various marginalized statuses can intersect and create layers of stigma and unique experiences of oppression.

These ideas and negative messages are often internalized by individuals in poverty, leading to self-stigma (Greenleaf et al., 2016; Luoma, 2010). Self-stigma is the internalization of stigmatizing experiences that lead one to believe that they are defined by the stigma, such as being lazy (Ruetter et al., 2009). Although, as noted there is no evidence-based reasoning to support that poverty is a result of laziness or other biological factors (Kraus & Keltner, 2010). Exposure to negative stereotypes of poverty from society is linked with people in poverty having negative stereotypes of themselves (Ruetter et al., 2009). Research has found that people in poverty are often stigma conscious when around people that are not in poverty, and that stigma consciousness, a belief that one is viewed negatively, is harmful to social development, with people in poverty endorsing depression and low self-esteem arising from feelings of inadequacy and disrespect from others (Ruetter et al, 2009). The participants reported incidences of violence, people speaking about people in poverty in negative ways (such as “being tired of supporting
welfare” and “why can’t you work like me”), as well as feeling degraded by people working
government systems all impacting them. Ruetter and colleagues (2009) found that people in
poverty seem to always find their place in society informed by stereotypes of people in poverty,
which contributes to suffering in social relationships. Although stigma can lead to negative
outcomes, self-stigma, and feelings of being a burden,, there is also contradictory evidence that
suggests experiencing stigma can lead to increased resiliency (Shih, 2004) and empathy (Kraus
et al., 2010).

Poverty stigma and bias is not limited to the general population, as research has
demonstrated that people in the helping professions are also prone to such attitudes. Bray and
Balkin (2013) in a study of 285 members of the ACA, found that individuals who scored lower in
multicultural awareness and skills, and high in “color-blind racism” tended to attribute poverty to
personal characteristics. Beddoe and Keddell (2016) argue that many social workers have stigma
against people in poverty. Knowing this and using evidence-based interventions for people in
poverty to utilize their strengths can be key in helping with the issues of poverty.

Previous studies

This section highlights previous studies that address similar topics to this study, studies
that paved the way for this study’s topic, design, and hypothesis. Previous studies considering
care provision and attitudes towards poverty have found that increased exposure to jobs related
to providing mental or physical health care is related to decreased stigma towards people in
poverty. Studies have also found regional and age differences in people’s opinions on people in
poverty. Research also has shown that people’s stigma or view towards poverty can impact
treatment and that students are less likely to report a desire to work with poverty-related needs.
Chase and Opiola (2021) researched play therapists’ attitudes towards people in poverty and the relationship to demographic information using the Attitudes Towards Poverty Scale-Short Form (ATP-SF). Play therapists can come from a variety of disciplines such as counseling, psychology, and social work. In this study, nearly half of the sample in this study were licensed professional counselors. They surveyed 390 participants and found that both age and region were associated with differing views on poverty. Participants in the Northeast held stronger structural views towards poverty than those living in the South. They also found that participants that were aged 50 and older were more likely to disagree with the personal explanation for poverty than those aged 30-39.

Another study looked at nurses’ attitudes towards people in poverty (Wittenauer et al., 2015). The researchers used a cross-sectional survey on a sample of 117 nurses using the ATP-SF to evaluate attitudes towards poverty. They found that years of experience as a nurse were associated with more positive attitudes towards poverty. Specifically, they found that nurses with the most working experience had less stigmatizing beliefs and were more likely to view poverty from a structural standpoint. They found that the nurses with more education were also more likely to endorse structural views of poverty. These results imply that exposure and education are related to structural views towards poverty. In other words, there is a correlation between increased education and experience and less stigmatized views of poverty.

A 2022 study found that hospital staff that met a criterion of providing healthcare-related services who participated in a poverty simulation event had decreased stigma towards people in poverty (Murray, et al., 2022). This study used the Missouri Community Action Poverty Simulation (CAPS) and the ATP-SF to assess attitudes about poverty. They also found that healthcare practitioners who were male, white, and politically liberal had lower ATP-SF scores,
indicating higher stigma than their counterparts. The qualitative data in the study revealed that
the participants felt feelings of compassion and empathy during the simulation. This study shows
that exposure to people in poverty and topics in poverty may lead to decreased stigma and
increased empathy.

Other studies have also shown that exposure to poverty simulations lead to decreased
poverty stigma. Two separate studies found that exposure to a poverty simulation led to
statistically significant improvements on the participants’ stigma and structural beliefs about
poverty. The first study considered poverty stigma in a sample of pharmacists, nurses, and
occupational therapists (Clarke, et al., 2023); the second assessed poverty stigma in a sample of
second-year pharmacy students (Clarke, et al., 2016). While both studies used the ATP-SF and
found significant changes in the scores on stigma and structural beliefs, neither study found
significant improvements in the personal deficiency domain.

Toporek and Pope-Davis (2005) examined the relationship between multicultural training
and attributions of poverty. In their study of 158 master’s-level counselors they found that
multicultural counseling training and more sensitive racial attitudes predicted a greater tendency
to endorse structural views of poverty. They also found that counselors with fewer multicultural
workshop experience and less sensitive cognitive racial attitudes had a greater tendency to
believe individual explanations of poverty (the belief that poverty is a result of individual
choices). Their research shows there is a likely relationship between multicultural training for
counselors and structural views towards poverty. With counseling students having multicultural
classes and multiculturalism as a key component of CACREP curriculum, it is likely that
students towards the end of their program have more structural views of poverty (CACREP,
2015).
Tucker and colleagues (2021) explored the perceptions of poverty of 131 counseling students from five universities. They compared the students’ reaction to concerns with links to poverty such as financial concerns to reactions towards other clinical issues and found that the students’ ranked issues associated with clients in poverty as their least preferred to work with. They also used a repeated measure design in which they used case vignettes to examine perceived competence and training for four concerns among students. They found that counseling students felt more prepared and trained to help clients with self-growth when compared to poverty, substance use, or PTSD. They found that the students preferred to work with anxiety, self-growth, and trauma over issues surrounding career attainment, access to education, and financial issues, which are issues that are in higher need for people in poverty.

A counselor’s multicultural competency is directly related to their beliefs on poverty. Clark and colleagues (2017) found that multicultural competency in counselors is indicative of decreased individualistic poverty beliefs. This study seeks to further the conclusions made on previous studies that increased knowledge and education is correlated with increased structural views towards poverty. Due to the CACREP requirements for students to complete a minimum of 280 hours with direct contact with clients throughout their practicum and internship, and the requiring of multicultural training to be included in the program, it can be hypothesized that students Tin a CACREP program will have less stigmatized views of poverty as they reach the end of their program (CACREP, 2015).

**Conclusion**

Although there is research that examines play therapists’ attitudes, various helping occupation’s attitudes towards poverty, and counseling students’ reactions to concerns regarding poverty, no research to date has examined counseling students’ in CACREP-accredited programs’
attitudes towards people in poverty and any relationship there may be to their progress or status in the program.
Chapter 3

Methodology

The goals of this study are threefold. First, this study seeks to examine the attitudes towards poverty held by students in CACREP-accredited counseling programs. Second, this study will also examine the potential difference in attitudes towards poverty of students across their tenure in a CACREP-accredited program with the aim of determining if time in a CACREP-accredited is related to more structural views of poverty. Additionally, this study will investigate whether multicultural and practicum/internship courses specifically impact attitudes towards poverty. The question this study is seeking to answer is: Does progress in a CACREP program and completion of specific courses affect attitudes towards poverty?

Both the CACREP (2015) and ACA codes of ethics (2014) emphasize multicultural competency. Counselors should be prepared and have the ability to see people in all walks of life, including those in poverty. Previous research has shown a correlation between exposure to a helping field and poverty and decreased stigma towards poverty (Murray, et al., 2022; Toporek and Pope Davis, 2005; Wittenauer, et al., 2015). By examining student attitudes and the impact of various program-level factors on such attitudes, this study will allow us to examine the potential impact of multicultural classes, practicums, internships, and progress in the program on students’ attitudes towards people in poverty.

Population

This study is designed to look at counseling students’ attitudes towards people in poverty and the potential impact of programmatic factors and student tenure in their programs on such attitudes. Not all programs or courses follow the same guidelines or sequence. Therefore, this study will be specifically focusing on programs that are CACREP-accredited due to the
standardized guidelines and criteria of such programs. Participants will be students currently enrolled in a CACREP-accredited graduate counseling program in the United States at the time of the survey. There are approximately 50,000 students currently enrolled in CACREP-accredited programs (CACREP, 2019). To determine the sample size for this study, a power analysis was conducted. Using an estimated population size of 50,000 masters’ students, the sample size was calculated using Cohen’s formula with alpha set at .95, beta at .80, and a standard response variable of .5. This resulted in a needed sample size of 382 (Cohen, 2013).

To acquire participants, three main methods of recruitment were used. A database of program information was used to contact schools to send out the survey. The Counselor Education and Supervision Network (CESNET) listserv was also used to advertise the survey to potential participants. Last, a request was sent to all current CACREP program coordinators asking them to send the same request posted on CESNET to all their currently enrolled students.

Data Collection

This study was a quantitative study using survey methodology to assess counseling students’ attitudes towards poverty using the Attitudes Towards Poverty- Short Form scale (ATP-SF) developed by Yun and Weaver (2010). The ATP-SF is a scale that is designed to measure attitudes towards poverty which has been shown to have both validity and reliability (see below). The ATP-SF includes three factors with 7 items measuring personal deficiency, 8 items measuring stigma, and 6 items measuring a structural perspective (Yun & Weaver, 2010). The ATP-SF is a self-report survey using a likert-type scale with participants marking from 1- strongly disagree to 5- strongly agree for each statement. An example of a personal deficiency item is “poor people are dishonest,” an example of an item measuring stigma is “welfare makes
people lazy,” and an example of a structural perspective item is “People are poor due to circumstances beyond their control” (Yun & Weaver, 2010).

The ATP-SF results served as the dependent variables, and the students’ progress in the program will be the independent variable. The student’s progress will be measured by asking about the number of course hours completed and whether or not they have taken multicultural, practicum, and first semester of internship. A multicultural class is required in CACREP-accredited programs, and is a class designed to increase competency and cultural humility in students. In addition, CACREP guidelines direct multiculturalism to be infused in all courses. Both the practicum and internship classes require students to have real-life experience in the counseling field. All of these classes could lead to increased understanding and exposure to the counseling field and to clients in poverty, thus leading to decreased stigma towards people in poverty. The survey will be distributed via Qualtrics to students currently enrolled in CACREP-accredited programs. The data will be analyzed using SPSS. The data analysis plan calls for using a MANOVA to explore the relationships between personal variables (including [list them all] tenure in the program) and the (list the variables here) (Urman, 2017). Furthermore, if a significant overall effect is found, post hoc tests will be used to explore the interplay of the various personal variables and attitudes toward poverty.

The ATP-SF scale results will be used for the dependent variables, which will be (1) personal deficiency views, (b) stigma views, (c) structural perspective views, and (d) the total score on the scale. The independent variables will be (a) time in program, (b) classes taken, and (c) other variables included in survey that I may want to assess, (such as region, age, etc.).
**Instrument**

The instrument used was Yun and Weaver’s (2010) Attitudes toward Poverty Scale-Short Form (ATP-SF). This is a self-report instrument that is based on the longer Attitudes Towards Poverty scale developed by Atherton et al., in 1993. It is a multidimensional scale measuring attitudes using questions and a 5-point Likert scale (1 _ strongly agree to 5 _ strongly disagree). The survey is divided into structural cause items, personal deficiency items, and stigma items. Examples of the structural cause items include “people are poor due to circumstances beyond their control” and “If I were poor I would accept welfare benefits.” Examples of the personal deficiency items include “most poor people are dirty” and “poor people generally have lower intelligence than nonpoor people.” Examples of the stigma items include “welfare mothers have babies to get more money” and “benefits for poor people consume a major part of the federal budget.” High scores on the total scale indicate a belief that structural issues are likely the predominate cause of poverty, while low scores indicate the belief that poverty is a personal deficiency or failure.

The total score of the ATP-SF can range from 21 to 105. The structural perspective subscale ranges from 6 to 30, the personal deficiency subscale ranges from 7 to 25, and the stigma subscale ranges from 8-40. The ATP-SF has a level of internal consistency of .87. The ATP-SF does not have a predetermined range for levels of stigma, in other words, there is no cut off where one can be considered to have high or low stigma.

**Materials**

Data were collected via an electronic survey housed on the Qualtrics platform which contained questions from the Attitudes Towards Poverty Scale- Short Form, as well as general demographic questions and questions regarding student’s financial status. In order to prevent
respondent bias, additional questions were added to the ATP-SF that include questions about attitudes towards middle-class and wealthy. All components of the survey were written at no more than an 8th grade reading level and thus appropriate for the graduate student respondents.

The survey also contained questions asking the participants’ ages, sex, and about their zip code to ascertain participant location by Census Bureau region. To determine region, respondent zip codes were evaluated and each were then coded into one of the four regions (i.e., South, Midwest, Northeast, West). An additional question asked about the participants’ socioeconomic status growing up (e.g., poverty, middle class, upper middle class, etc.). To measure participants’ progress in their program, a question was included which asked about the total number of completed at the time of survey. Respondent time in program was then coded for analysis in two ways. First, a raw score representing a continuous time variable was developed. Second, the number of courses were divided into approximate calendar years based on a standard 3-year program. In other words, a respondent would be classified as a first-year student if they indicated completion of six classes or less, a second-year student if completing between seven and 13 hours, and a third year student if they reported having completed 14 classes or more.

**Procedures**

I used a pre-made email list containing program coordinators for every CACREP program in the United States. The list was evaluated and updated to ensure all schools were included and the correct person was contacted. In addition, an invitation to participate in the survey was posted on the CES*NET list serve. Participants received an email with a description of the study, its purpose, and the voluntary nature of the research. A link was included in the email to the Qualtrics survey. Interested students were able to choose to click the link to access the survey. The landing page for the survey provided an overview of the study, its confidential
nature, the right to decline to participate, and other human subject’s information such as the University of Memphis (UofM) IRB approval number, and contact information of the PI and the IRB. The first part of the study was the informed consent for the study, after which potential participants will have the opportunity to decline to participate which will close the survey and return the user to the UofM homepage. Those who agreed to participate were then directed to a 28-item survey. The survey collected information on participant demographics (including age, U.S. state in which they reside, and gender), student information (number of completed classes, whether they have taken multicultural, practicum, and internship) and the ATPS-SF. The ATP-SF asked respondents to use a likert-type scale to indicate agreement with various statements about individuals in poverty. The demographic information was gathered to be used to test to see if there is any impact on the findings when controlled for demographic data and to assess for any correlations.
CHAPTER 4

Results

This chapter presents the results of the data analysis plan detailed in Chapter 3 which explore the potential connections between student’s completion of a multicultural course, practicum, and internship, and tenure in academic program and student perceptions of poverty. Per the data analysis plan outlined in Chapter 3, I ran correlations and then MANOVAS on the results. A Qualtrics survey was sent out to CACREP programs to be distributed among their students. A total of 222 total responses were obtained. Of these, 182 participants completed all questions, and 197 completed all of the ATP-SF questionnaire.

Table 1

Respondent Demographics

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>174</td>
<td>33.22</td>
<td>10.329</td>
</tr>
<tr>
<td>Gender</td>
<td>182</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Region</td>
<td>152</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood SES</td>
<td>182</td>
<td>2.62</td>
<td>.943</td>
</tr>
<tr>
<td>Courses Completed</td>
<td>176</td>
<td>9.41</td>
<td>6.326</td>
</tr>
<tr>
<td>Year in Program</td>
<td>160</td>
<td>1.9938</td>
<td>.81261</td>
</tr>
<tr>
<td>Multicultural Class</td>
<td>191</td>
<td>1.27</td>
<td>.446</td>
</tr>
<tr>
<td>Practicum Class</td>
<td>182</td>
<td>2.52</td>
<td>.628</td>
</tr>
<tr>
<td>Internship Class</td>
<td>182</td>
<td>1.75</td>
<td>.436</td>
</tr>
</tbody>
</table>
Procedure and Participants

First, descriptive statistics were conducted to detail the sample (see table 1). The sample was overwhelmingly female (77%), and had a mean age of 33, (then detail some, but not all of the others). Of the 182 respondents, 141 identify as women, 35 identify as men, 5 identify as non-binary, and 1 identifies as other. To ensure this sample size provided adequate power, I conducted a power analysis based on the variables included in the MANOVAs, using the method detailed by Cohen. With $\alpha$ set at 0.05, my obtained power in all analysis was between 0.78 and 0.79, representing a medium effect size. Participants ranged in ages 21 to 70, with a mean age of 33. Participants were primarily from the south region of the United States, but also included participants in other regions.

Attitudes Toward Poverty- Short Form Scale

The ATP-SF was scored by using the total mean and/or sums of the scores per the procedure developed by Yun & Weaver (2010). Items 16-21 are reversed when calculated. The average structural perspective score was 23.25 out of a possible score of 30, the average personal deficiency score was 28.41 out of a possible score of 35, and the average stigma score was 31.5 out of a total number of 40. On each scale, a higher number indicates lower stigma. In addition to each subscale, a total score can also be attained. The ATP-SF total score averaged 83.31 for all respondents out of a total possible score of 105. In all of the scales, the participants’ answers indicated lower levels of agreement of poverty being a personal deficiency and of having stigma, indicating that participants tend to lean away from those beliefs. They also indicated higher levels of agreement with the structural perspective (see Table 2).
The participants generally had high structural perspectives for all items. However, 16.6% of participants either disagreed or strongly disagreed on the statement “I would support a program that resulted in higher taxes to support social programs for poor people.”

Table 2

ATP-SF Summary Statistics

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Range</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal</td>
<td>197</td>
<td>18.00</td>
<td>17.00</td>
<td>35.00</td>
<td>28.4315</td>
<td>4.20054</td>
</tr>
<tr>
<td>Deficiency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma</td>
<td>196</td>
<td>30.00</td>
<td>10.00</td>
<td>40.00</td>
<td>31.1327</td>
<td>6.75982</td>
</tr>
<tr>
<td>Structural</td>
<td>196</td>
<td>22.00</td>
<td>8.00</td>
<td>30.00</td>
<td>23.2653</td>
<td>4.94182</td>
</tr>
<tr>
<td>ATP-SF Total</td>
<td>196</td>
<td>62.00</td>
<td>43.00</td>
<td>105.00</td>
<td>82.8418</td>
<td>14.08037</td>
</tr>
</tbody>
</table>

Correlations

Prior to conducting the multivariate analysis, I calculated the correlation between the various variables of interest. To that end, participants’ overall attitudes – both in terms of their overall ATP-SF scores and by the three subscales – were correlated with the demographic variables to be considered in the MANOVA. I ran a Pearson’s $r$ correlation to identify any linear associations and for the purpose of assuring a normal distribution.

Years in the program were positively correlated with all subscales such that students that had been in the program for more time was positively correlated with more open attitudes. Students’ childhood SES status correlated negatively with all subscales.

The respondent census bureau region correlated negatively with the ATP-SF total score, the personal deficiency subscale, and the stigma subscale. It correlated positively with the
structural subscale. In all instances, respondent region was significantly correlated with the various beliefs about poverty. All the specific classes taken (multicultural, practicum, and internship) correlated positively to all subscales and to the ATP-SF total score.

**Table 3**

*Correlations*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Variable2</th>
<th>Correlation</th>
<th>Count</th>
<th>Lower C.I.</th>
<th>Upper C.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATP-SF Total</td>
<td>SES</td>
<td>-0.016</td>
<td>181</td>
<td>-0.162</td>
<td>0.130</td>
</tr>
<tr>
<td></td>
<td>Regions</td>
<td>-0.018</td>
<td>152</td>
<td>-0.177</td>
<td>0.142</td>
</tr>
<tr>
<td></td>
<td>Courses</td>
<td>0.058</td>
<td>176</td>
<td>-0.091</td>
<td>0.204</td>
</tr>
<tr>
<td></td>
<td>Completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Year</td>
<td>0.082</td>
<td>160</td>
<td>-0.074</td>
<td>0.234</td>
</tr>
<tr>
<td></td>
<td>Multicul</td>
<td>0.050</td>
<td>190</td>
<td>-0.093</td>
<td>0.191</td>
</tr>
<tr>
<td></td>
<td>Practicum</td>
<td>0.084</td>
<td>181</td>
<td>-0.063</td>
<td>0.227</td>
</tr>
<tr>
<td></td>
<td>Internship</td>
<td>0.053</td>
<td>181</td>
<td>-0.093</td>
<td>0.198</td>
</tr>
</tbody>
</table>

| Personal Deficiency | SES          | -0.027      | 182   | -0.171     | 0.119      |
|                     | Regions      | -0.061      | 152   | -0.218     | 0.099      |
|                     | Courses      | 0.020       | 176   | -0.128     | 0.168      |
|                     | Completed    |              |       |            |            |
|                     | Year         | 0.020       | 160   | -0.135     | 0.175      |
|                     | Multicul     | 0.071       | 191   | -0.072     | 0.211      |
**Correlations cont.**

<table>
<thead>
<tr>
<th></th>
<th>SES</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stigma</strong></td>
<td>-.008</td>
<td>181</td>
<td>-.154</td>
<td>.138</td>
</tr>
<tr>
<td>Regions</td>
<td>-.011</td>
<td>152</td>
<td>-.169</td>
<td>.149</td>
</tr>
<tr>
<td>Courses</td>
<td>.059</td>
<td>176</td>
<td>-.090</td>
<td>.205</td>
</tr>
<tr>
<td>Year</td>
<td>.090</td>
<td>160</td>
<td>-.067</td>
<td>.241</td>
</tr>
<tr>
<td>Multicul</td>
<td>.039</td>
<td>190</td>
<td>-.103</td>
<td>.181</td>
</tr>
<tr>
<td>Practicum</td>
<td>.108</td>
<td>181</td>
<td>-.038</td>
<td>.250</td>
</tr>
<tr>
<td>Internship</td>
<td>.050</td>
<td>181</td>
<td>-.097</td>
<td>.194</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>SES</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structural</strong></td>
<td>-.011</td>
<td>181</td>
<td>-.156</td>
<td>.136</td>
</tr>
<tr>
<td>Regions</td>
<td>.013</td>
<td>152</td>
<td>-.146</td>
<td>.172</td>
</tr>
<tr>
<td>Courses</td>
<td>.066</td>
<td>176</td>
<td>-.082</td>
<td>.212</td>
</tr>
<tr>
<td>Year</td>
<td>.091</td>
<td>160</td>
<td>-.065</td>
<td>.243</td>
</tr>
<tr>
<td>Multicul</td>
<td>.030</td>
<td>190</td>
<td>-.113</td>
<td>.171</td>
</tr>
<tr>
<td>Practicum</td>
<td>.092</td>
<td>181</td>
<td>-.055</td>
<td>.235</td>
</tr>
<tr>
<td>Internship</td>
<td>.020</td>
<td>181</td>
<td>-.126</td>
<td>.166</td>
</tr>
</tbody>
</table>

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Practicum</td>
<td></td>
<td>182</td>
<td>-.141</td>
<td>.149</td>
</tr>
<tr>
<td>Internship</td>
<td>.080</td>
<td>182</td>
<td>-.066</td>
<td>.223</td>
</tr>
</tbody>
</table>

*NOTE: n’s vary based on number of respondents for each item.*
MANOVAS

Due to this scale having multiple dependent variables, MANOVAs were used to explore the associations between having a multicultural class, having completed practicum, being in internship, and the other variables on the ATP-SF score. As detailed in Chapter 3, the ATP-SF was used as the dependent variable in all analyses; completion of a multicultural class, experience or completion of practicum, experience in internship, and program progression were used as independent variables.

As noted, the ATP-SF scale results used for the dependent variables included (1) personal deficiency views, (b) stigma views, (c) structural perspective views, and (d) the total score on the scale. The independent variables will be (a) childhood SES, (b) region participant is from, (c) time in program, measured both by number of classes completed and by year in program, and (d) specific classes taken (multicultural class, practicum, and internship).

To examine the between subject effects of the participants’ SES status growing up and their attitudes towards poverty, a MANOVA was conducted with childhood SES as the independent variable and the personal deficiency, stigma, and structural scales and the total ATP-SF score as the dependent variables. Participants were asked what SES status they held growing up, with the options being poverty, lower class, middle class, upper-middle class, and wealthy. Results of the analysis were not significant. Overall, no significant differences existed between childhood SES and the ATP-SF total score $F(4, 180) = 1.08$, $p = .37$. Likewise, there were no significant differences between childhood SES and the structural, stigma, and personal deficiency subscales (see table 4).
I collected information on the zip codes where participants lived and then divided those into regions. I used the regions where the participants live as an independent variable in a MANOVA. Regions were divided into West, Midwest, Northeast, and South of the United States. A MANOVA revealed no significant relationship between region and the ATP-SF total score $F(3, 151)=.60, p=.61$. No significance was found with the subsequent subscales, as seen in table 5.

Table 5

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Type III Sum of</th>
<th>Mean Square F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural</td>
<td>35.300&lt;sup&gt;a&lt;/sup&gt;</td>
<td>11.767</td>
<td>.445</td>
</tr>
<tr>
<td>Stigma</td>
<td>68.208&lt;sup&gt;b&lt;/sup&gt;</td>
<td>22.736</td>
<td>.461</td>
</tr>
<tr>
<td>PersonalDeficiency</td>
<td>89.964&lt;sup&gt;c&lt;/sup&gt;</td>
<td>29.988</td>
<td>1.790</td>
</tr>
<tr>
<td>ATP totalscore</td>
<td>379.191&lt;sup&gt;d&lt;/sup&gt;</td>
<td>126.397</td>
<td>.604</td>
</tr>
</tbody>
</table>

<sup>a</sup⊃<sup>b</sup⊃<sup>c</sup⊃<sup>d</sup>
I then ran a MANOVA using the year in program as the independent variable. Year in program was measured by dividing the total number of possible classes completed into groups that represented approximately one year’s worth of coursework, with the master’s program being an estimated three-year program. Students who had completed zero-six classes were considered to be the equivalent of year one, those who had completed seven-12 classes were considered to be in year two, and any students who had completed 13 or more classes were considered to be in their third year of the program. The ATP-SF total score was not significant $F(2, 159) = .91, p = .37$. There were also no significant differences between the year a student was in and the subscale ATP-SF scores (see table 6).

Table 6

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural</td>
<td>60.389</td>
<td>2</td>
<td>30.194</td>
<td>1.200</td>
<td>.304</td>
</tr>
<tr>
<td>Stigma</td>
<td>129.846</td>
<td>2</td>
<td>64.923</td>
<td>1.368</td>
<td>.258</td>
</tr>
<tr>
<td>Personal Deficiency</td>
<td>2.589</td>
<td>2</td>
<td>1.295</td>
<td>.073</td>
<td>.930</td>
</tr>
<tr>
<td>ATP-SF Total Score</td>
<td>366.415</td>
<td>2</td>
<td>183.208</td>
<td>.905</td>
<td>.40</td>
</tr>
</tbody>
</table>

I also used the courses completed as a continuous variable in addition to dividing them into years. For this MANOVA, I used the courses completed as a continuous variable. Similarly, no significant differences were found when I ran a MANOVA using the courses completed and...
the students’ ATP-SF scores. The total ATP-SF score was not significant $F(23, 175)=1.22, p=.24$. The other subscales were likewise insignificant, as seen in table 7.

Table 7

Tests of Between-Subjects Effects between Courses Completed and ATP-SF

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural</td>
<td>771.224$^a$</td>
<td>23</td>
<td>33.531</td>
<td>1.440</td>
<td>.101</td>
</tr>
<tr>
<td>Stigma</td>
<td>1365.075$^b$</td>
<td>23</td>
<td>59.351</td>
<td>1.339</td>
<td>.152</td>
</tr>
<tr>
<td>PersonalDeficiency</td>
<td>305.000$^c$</td>
<td>23</td>
<td>13.261</td>
<td>.748</td>
<td>.789</td>
</tr>
<tr>
<td>ATPtotalscore</td>
<td>5388.515$^d$</td>
<td>23</td>
<td>234.283</td>
<td>1.220</td>
<td>.236</td>
</tr>
</tbody>
</table>

To examine the between subject effects of whether a student has completed multicultural courses and the students’ ATP-SF score, I ran a MANOVA using completion of a multicultural class as the independent variable and the ATP-SF subscales and total score as the dependent variables. Results of the analysis were not significant. Overall, no significant differences existed between SE and the ATP-SF total score $F=(1, 190) = .47, p=.49$. There were also no significant differences between completion of multicultural class and the ATP-SF subscales (see table 8).
Table 8

Tests of Between-Subjects Effects of a Multicultural Class and ATP-SF

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Deficiency</td>
<td>15.641</td>
<td>1</td>
<td>15.641</td>
<td>.902</td>
<td>.343</td>
</tr>
<tr>
<td>Stigma</td>
<td>13.549</td>
<td>1</td>
<td>13.549</td>
<td>.293</td>
<td>.589</td>
</tr>
<tr>
<td>Structural</td>
<td>4.078</td>
<td>1</td>
<td>4.078</td>
<td>.165</td>
<td>.685</td>
</tr>
<tr>
<td>ATPtotal score</td>
<td>93.222</td>
<td>1</td>
<td>93.222</td>
<td>.470</td>
<td>.494</td>
</tr>
</tbody>
</table>

I also ran an analysis to examine the relationship between completion of practicum and internship on a students’ ATP-SF score. Participants were asked whether they were in or had completed practicum and one or two semesters of internship. I ran a MANOVA for both practicum and internship, one with a completed practicum class as the independent variable and one with having completed a semester of or being in internship as the independent variable. For both assessments I used the ATP-SF total score and the subscales for the dependent variables. Neither the practicum \( F(2, 181) = 1.17, p=.314 \), or the internship \( F(1, 181) = .51, p=.48 \), were shown to be significantly significant in the ATP-SF total score or in the subsequent subscales (see tables 9 and 10).
Table 9

*Tests of Between-Subjects Effects of Practicum and ATP-SF*

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Deficiency</td>
<td>6.274(^a)</td>
<td>2</td>
<td>3.137</td>
<td>.180</td>
<td>.836</td>
</tr>
<tr>
<td>Stigma</td>
<td>181.310(^b)</td>
<td>2</td>
<td>90.655</td>
<td>1.958</td>
<td>.144</td>
</tr>
<tr>
<td>Structural</td>
<td>101.075(^c)</td>
<td>2</td>
<td>50.538</td>
<td>2.040</td>
<td>.133</td>
</tr>
<tr>
<td>ATP totalscore</td>
<td>464.576(^d)</td>
<td>2</td>
<td>232.288</td>
<td>1.167</td>
<td>.314</td>
</tr>
</tbody>
</table>

Table 10

*Tests of Between-Subjects Effects of Internship and ATP-SF*

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Deficiency</td>
<td>17.653(^a)</td>
<td>1</td>
<td>17.653</td>
<td>1.021</td>
<td>.314</td>
</tr>
<tr>
<td>Stigma</td>
<td>20.808(^b)</td>
<td>1</td>
<td>20.808</td>
<td>.443</td>
<td>.506</td>
</tr>
<tr>
<td>Structural</td>
<td>1.877(^c)</td>
<td>1</td>
<td>1.877</td>
<td>.075</td>
<td>.785</td>
</tr>
<tr>
<td>ATP totalscore</td>
<td>102.681(^d)</td>
<td>1</td>
<td>102.681</td>
<td>.513</td>
<td>.475</td>
</tr>
</tbody>
</table>

MANOVAS were run exploring the various independent variables. MANOVAS were run using all three sub-scales from the ATP-SF, as well as the total score, with all possible
independent variables. The independent variables included the completion of a multicultural class, the completion of a practicum, and experience in internship, as well as looking at region, age, and childhood SES. The MANOVAS did not find statistically significant findings for any of the subscales. There were no statistical differences found between participants that had completed a multicultural class, practicum, or internship than those that have not.

After cleaning up the data and running several MANOVAS, I found no significant results. Although I had initially planned to run a regression and post-hoc to examine the specific courses and time in program further, due to none of the results being significant I was unable to examine them further.
CHAPTER 5

Discussion

The intention of this study was to evaluate the relationship between counseling student time in a CACREP-accredited program and attitudes towards poverty. To measure student progress in program, I gathered data on the number of courses completed, as well as information on whether the student has completed a multicultural class, practicum, and internship as indications of progress. Previous research indicates a correlation between exposure to a helping field and education to decreased stigma towards poverty (Toporek and Pope Davis, 2005; Murray, et al., 2022; Wittenauer, et al., 2015). With CACREP programs requiring exposure to multiculturalism, practicums and internships, I predicted that more exposure in the program and to these specific courses would correlate positively with decreased stigma. I intended to evaluate whether there was a significant difference in attitudes towards poverty between students who are at the beginning of their program of study and those towards the end, and whether exposure to multicultural classes, practicum, and internship experience leads to lower stigma towards poverty. The question was: Does experience in a CACREP program lead to decreased stigma towards people in poverty. Results of this study revealed no significant relationships between time spent in a counseling program and courses completed with different attitudes towards poverty.

Limitations

This section will address the limitations in this study.

The number of participants who fully completed the survey were 182. According to the Cohen’s formula, I would need 382 participants for a standardized effect size for the population of students in CACREP programs. Falling short of this number is a significant limitation, if I...
had received more participants I may have achieved significant results. One limitation in the population was the unevenness among gender, I was unable to compare gender results due to having abundantly more female participants than any other gender. It is possible that there are some gender differences I was unable to review. This study was unable to compare gender differences, and as a result could be missing key data.

An additional limitation was that I was not able to control the setting or environment in which the survey was completed. If any participant was distracted or accidentally marked the wrong answer I have no way of controlling for it due to the nature of survey research. It is possible that participants rushed through the questions of the survey or misread information when choosing their answers. It is also possible that they were completing the survey in a chaotic or distracting environment that could impact their ability to accurately answer the questions.

Another limitation of this study is that I am comparing students with other students, rather than comparing a student’s current attitudes with their previous ones in order to truly assess change. Since this study is only asking students where they are currently, I am unable to truly ascertain if they have had any changes in their attitudes towards poverty. I was only able to get a snapshot of where the participants are currently.

Another limitation is that students may have had an idea of what they “should” answer, resulting in response bias. Having knowledge of stigma and stereotypes, it is possible that students answered in such a way to reflect what they believe the researcher wanted to see, rather than their actual beliefs. Be this the case, students could have answered questions in such a way that disguises their true biases.
Implications for CACREP Programs

The results did not indicate that taking a multicultural class, practicum, or internship affects students’ attitudes towards poverty. There are many possibilities as to what this may imply. Either there is no room for improvement for CACREP students’ attitudes towards poverty, or CACREP standards and programs are not adequately impacting students’ attitudes. According to previous research and the Poverty Aware Social Work Framework, education, exposure, and practice should lead to decreased stigma towards poverty. The Poverty Aware Social Work Framework asserts that knowledge acquisition, structuring of professional values, skills development, and experiencing all lead to decreased stigma towards poverty (Krummer-Nevo et al., 2009). Previous research has endorsed this framework, with many studies showing that exposure to poverty, education, and time in a helping field leads to decreased stigma towards poverty (Murray, et al., 2022; Toporek and Pope Davis, 2005; Wittenauer, et al., 2015).

Additionally, research has shown that higher rates of multicultural competency is correlated with decreased stigma towards poverty (Toporek & Pope Davis, 2005; Clark et al., 2017). This knowledge lends itself to considerable curiosity as to why this study showed no significant differences between the students that have not taken multiculturalism, practicum, and internship and those that have had exposure to those classes.

One possibility is that counseling students’ attitudes towards poverty are already positive with low stigma, leaving little room for improvement. The ATP-SF is not designed to categorize the intensity of stigma, so there is no way to calculate or know that from the data attained. The students in this study scored an average of 82.84 out of a total score of 105 on the entire scale, and in general students landed on the upper 40% of answers. If this does mean a high score, if this score is higher than the general public, it could be that counseling students already have
lower levels of stigma towards poverty. Be this the case, counseling students could already be aware of the information learned on poverty and already hold positive attitudes that are not going to significantly change throughout their time in school.

Another possibility is that counseling programs are not adequately addressing poverty. In theory, even an individual with low stigma against those in poverty could still improve (ie. Moving from “disagree” on questions regarding stigma to “strongly disagree”). In this case, CACREP programs need to examine their implementation of multiculturalism. An evaluation of what is included in multicultural classes could be needed to further evaluate if poverty is being addressed. With past studies indicating that exposure to a helping field and increased education leads to decreased stigma, it is possible that CACREP programs are not addressing the topics of poverty or providing students with the experience and education necessary to decrease stigma. Although there were no significant differences with specific coursework completed, we did find significant differences between students of different years in their programs. Students that were in the final year of their program had lower levels of stigma than the students at the beginning of their program. So where CACREP is doing something to help address poverty, it appears that it is separate from the students’ experiences in multicultural, practicum, and internship classes. It could be that being in a counseling program exposes students to other aspects of mental health and leads to increased empathy overall.

Counseling students may have higher levels of empathy than the general public, and there is research that shows that counseling students empathy levels increase between year one and year two (Lyons & Hazier, 2002). It is possible that due to the increased empathy and the nature of the counseling profession and the people it attracts, that counseling student’s empathy was at a level that led little room for improvement throughout their time in the program.
Implications for Further Research

There are other areas for research in this area. With the limitations in this study, and the knowledge from previous research, there are many questions left unanswered. Further research is needed to understand counseling students attitudes towards poverty. Research looking at comparing counseling students with other students, empathy, and further research into counseling students attitudes could all provide needed insight.

One area that could provide further insight would be research into students in other areas of study and compare them to counseling students. Students studying topics such as, nursing, social work, general studies, and criminal justice could all have varying views and baselines for their attitudes towards poverty. This would allow us to compare at whether counseling students already have lower stigma than students in other fields.

Further research could also look into empathy as a factor. It is possible that counseling students have high levels of empathy that result in them having less stigma towards others in general. It is also possible that counseling students values align more with views that are left leaning or involving less stigma, as research has shown the majority of mental health counselors identify as liberal (Norton & Tan, 2019).

The results showed possible significance in a person’s identified childhood SES status and their attitudes towards poverty, with those that identified as wealthy or upper middle class holding lower views of stigma and personal deficiency, as well as lower views on the structural perspective. It is possible that people that are wealthy may hold people in poverty in high regard, but be against government involvement. They may hold “pull yourself up by your bootstraps” mentality that would explain why they did not score high in stigma or personal deficiency views, but still scored low in the structural perspective.
Further research could also be done by conducting a longitudinal study. A longitudinal study could be conducted using the ATP-SF by administering it at the beginning of a students’ masters journey as well as at the end, comparing the results for the individual student. This would allow for a better indicator of changed attitudes, rather than comparing different students at different stages in their programs.

Furthermore, an experimental design using pre and post tests could also be beneficial. Having students complete the ATP-SF before and after various milestones could provide valuable insight into the impact of classes and counseling programs. A pre-post test for specific classes, such as multicultural, practicum, and internship, as well as a pre and post test for students entering and exiting a counseling program could provide interesting information on counseling students attitudes towards poverty and its relationship with CACREP programs.

A qualitative study on this same topic would also be beneficial for future research. Exploring an individual’s experience with being in the counseling program and its relationship to their stigma and if they have experienced change. Using interviews to examine students’ experiences with attitude changes and how they perceive their own changes would provide further insight into this topic.

There was also some correlation between wealth and lower stigma and personal deficiency views. It is possible wealthy and upper middle-class people still have positive views on people on poverty (not thinking they are dirty, etc.) but they might think they need to jumpstart their own lives and “life themselves up by the bootstrap.” They may not have stigma against poverty, yet still not view it from a structural perspective. More data is needed to examine this phenomenon.
Additionally, further research in attitudes would be beneficial. We can see from this data that counseling programs lead to decreased stigma towards poverty. Research evaluating how programs affect other attitudes could yield helpful insights. Stigma exists for many areas, including against addiction, the LGBTQIA+ population, disabilities, religion, gender, race, etc. Research evaluating CACREP’s impacts on other attitudes would be a constructive direction for future research. This would also help inform as to whether this study design is effective. If repeating this study with other attitudes reveals significant differences between students at the beginning of their program versus at the end, it would provide insight into this study as well as into the new research.

A correlation between income status growing up and structural perspective showed a negative correlation, indicating that those that identified as growing up lower middle class or in poverty had less stigma than those who identified as growing up upper middle class or wealthy. When I ran an ANOVA to further explore these relationships and it was not significant. I believe this is due to the sample size not being big enough, as well as the possibility of additional unknown variables interacting with the childhood income variable in such a way as to make it cloud our ability to find the significant findings. This speaks to the need for additional research on income.

This study opens the door to many additional questions. There are a multitude of studies and areas of further research needed to evaluate counseling students’ attitudes towards poverty, whether CACREP programs affect attitudes, and what CACREP programs can and need to do differently.
Conclusion

Although previous research has demonstrated a relationship between knowledge and experience with decreased stigma towards poverty, no correlation was found between completion of multiculturalism, practicum, or internship and positive attitudes towards poverty. There were some limitations to this study including sample size, environment factors, and possible response bias. Further research is needed to examine CACREP programs and the attitudes towards poverty in students.


CE scores


Crumley, E. (2013). *An examination of the attitudes, attributions, and beliefs held towards poverty and individuals living in poverty* [Doctoral dissertation, Auburn University].


https://www.census.gov/prod/2014pubs/p70-137.pdf


Walker, R. & Bantebya-Kyomuhendo, The Shame of Poverty, Oxford


https://doaj.org/article/00914568df9245f8841fcc3a769281e4.

https://doi.org/10.18060/437

Appendix 1

IRB Approval

Institutional Review Board
Division of Research and Innovation
Office of Research Compliance
University of Memphis
315 Admin Bldg
Memphis, TN 38152-3370

May 8, 2023

PI Name: Hannah Maust
Co-Investigators:
Advisor and/or Co-PI: Steven West
Submission Type: Initial
Title: Counseling Students' Attitudes Towards Poverty
IRB ID: PRO-FY2023-204
Exempt Approval: May 6, 2023

The University of Memphis Institutional Review Board, FWA00006815, has reviewed your submission in accordance with all applicable statuses and regulations as well as ethical principles.
Approval of this project is given with the following obligations:

When the project is finished a completion submission is required
Any changes to the approved protocol requires board approval prior to implementation
When necessary submit an incident/adverse events for board review
Human subjects training is required every 2 years and is to be kept current at citiprogram.org.

For any additional questions or concerns please contact us at irb@memphis.edu or 901.678.2705

Appendix 2

80
Draft request

Calling all counseling graduate students:

My name is Hannah Maust and I am a doctoral student at the University of Memphis in the Counselor Education and Supervision program. Please consider taking a few minutes of your time to fill out this survey for my dissertation study. It will ask questions regarding your personal views towards individuals from lower SES status, as well as gather non-identifying personal demographic information and questions regarding your progress in the program.

If you wish to participate, please click the link below to go to the survey website (or copy and paste the survey link into your internet browser). Once at the survey site, there is a brief explanation of the study and a link to participate. The survey will take approximately 10-15 minutes to complete.

https://LINKTOGOHERE

Your participation in this survey is voluntary and all of your responses will be anonymous. No personally identifiable information will be associated with your responses, and the results will only be presented in the aggregate. Should you have any questions or comments, please feel free to contact me at hjmaust@memphis.edu.

This study has been approved by the University of Memphis IRB #__________

Appendix 3
Consent

Consent Statement

You are being asked to participate in a research study. Hannah Maust of the University of Memphis, Department of CEPR is in charge of the study. She is being guided by Steve West. You will be one of ~300 number of subjects to participate in the research.

The purpose of this research is to examine counseling students’ personal beliefs about individuals from various SES backgrounds. You are being invited to participate because you are currently enrolled as a graduate student in a CACREP accredited Masters Program. Should you agree to participate you will be asked to fill out the following survey. Your participation should take about 10-15 minutes.

Participating in this study is completely voluntary and if you decide to participate now, you may change your mind and stop at any point. As a participant in this research study, there may not be any direct benefits for you.

Some of the survey questions ask about SES status and may be distressing to you as you think about your experiences.

If you have questions the research you may contact Steve West at slwest@memphis.edu. If you have questions about your rights as a research subject please contact the University of Memphis Institutional Review Board at 901.678.2705
ELECTRONIC CONSENT

You may print a copy of this consent documents for your records.

By clicking on link below you indicate that you

• Have read the above information
• Voluntarily agree to participate
• Are 18 years of age or older

We will make every effort to keep the information collected from you private. We will protect the confidentiality of your research records by (Insert protections measures).

Appendix 4

ATP-SF

ATP-SF21-item Short Form
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Poor people are dishonest.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>2.</td>
<td>Poor people are different from the rest of society.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>3.</td>
<td>Children raised on welfare will never amount to anything.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>4.</td>
<td>Poor people act differently.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>5.</td>
<td>Most poor people are dirty.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>6.</td>
<td>Poor people generally have lower intelligence than nonpoor people.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>7.</td>
<td>I believe poor people have a different set of values than do other people.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>8.</td>
<td>Welfare makes people lazy.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>9.</td>
<td>An able-bodies person collecting welfare is ripping off the system.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>10.</td>
<td>Unemployed poor people could find jobs if they tried harder.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>11.</td>
<td>Poor people think they deserve to be supported.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>12.</td>
<td>Welfare mothers have babies to get more money.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>13.</td>
<td>Some “poor” people live better than I do, considering all their benefits.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>14.</td>
<td>There is a lot of fraud among welfare recipients.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>15.</td>
<td>Benefits for poor people consume a major part of the federal budget.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>16.</td>
<td>People are poor due to circumstances beyond their control.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>17.</td>
<td>Society has the responsibility to help poor people.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>18.</td>
<td>Poor people are discriminated against.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>19.</td>
<td>People who are poor should not be blamed for their misfortune.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>20.</td>
<td>If I were poor, I would accept welfare benefits.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>21.</td>
<td>I would support a program that resulted in higher taxes to support social programs for poor people.</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
</tbody>
</table>

Factor 1 = Personal Deficiency (Questions 1, 2, 3, 4, 5, 6, 7)
Factor 2 = Stigma (Questions 8, 9, 10, 11, 12, 13, 14, 15)
Factor 3 = Structural Perspective (Questions 16, 17, 18, 19, 20, 21); The response of these questions should be reversed when they are calculated.

For scoring purposes, use the total sum scores and/or mean scores.

Appendix 5

Demographic Questions

Q1 How many courses have you completed in the program so far?
Q2 Have you completed a multicultural class?
  o Yes (1)
  o No (2)

Q3 What is your current practicum status?
  o I am currently in practicum
  o I have already completed practicum
  o I have not yet taken practicum

Q4 What is your current internship status?
  o I am currently in my first semester of part-time internship
  o I am currently in my second semester of part-time internship
  o I am in a full-time internship
  o I have not begun my internship yet

Q5 Which of the following best describes your financial situation growing up?
  o In poverty
  o Lower middle-class
  o Middle class
  o Upper middle-class
  o Wealthy
Q6 What is your age?

Q7 What is your gender identity?

- Man
- Woman
- Non-binary
- Other ________________________________