DEVELOPMENT AND VALIDATION OF A SCALE MEASURING PSYCHOLOGISTS' PERCEIVED COMPETENCY WITH CLIENTS EXPERIENCING LOW INCOME OR ECONOMIC MARGINALIZATION

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CHAPTER 1: ROLE OF COMMUNITY IN MENTAL HEALTH CARE FOR ECONOMICALLY MARGINALIZED RURAL AREAS

Abstract

The representation of economically marginalized rural communities (EMRC) within psychotherapy literature and training is largely absent, despite these communities' unique experiences with and barriers to mental health care. EMRCs within the United States share specific cultural values and beliefs, including distrust of institutions and outsiders, self-reliance, stoicism, and personal responsibility. This review focuses on these EMRC values to provide context for mental health policies, resources, and therapist multicultural competencies and orientation when working within these communities to ultimately understand the therapy experiences of clients from EMRCs. This review provides recommendations for professional organizations, educators, and practitioners to improve mental health care for clients in EMRCs.

Introduction

Economically marginalized rural communities (EMRCs) are experiencing a shortage of mental health care providers, with the poorest rural regions from Texas to Alabama having only 5 psychologists per 100,000 residents (Andrilla et al., 2018; U.S. Health Resources and Services Administration, 2020). Members of EMRCs have unique experience with and barriers to mental health care, which require an understanding of the political, economic, and cultural context of EMRCs within the United States. This paper will review how EMRC values and beliefs: provide context for explaining differences in access to resources within these communities, inform therapist competencies and orientation when working within these communities, and ultimately influence clients' experiences and outcomes in therapy (see Figure 1). EMRC community level

factors have a ripple effect – impacting intangibles, like the values, beliefs, and treatment experiences of clients from EMRCs, and tangibles, like whether clients from EMRCs even make it into the therapy room. Exploring this ripple effect requires a review of salient EMRC cultural values and beliefs, the policies and differences in resource allocation that reinforce these values, and how these factors interact to shape clients' experiences and outcomes in therapy. This paper will review these community level factors in the context of providing psychotherapy with members of EMRCs, with a focus on providing recommendations for practice.

Community Factors

Rational for Focusing on Community Factors

Rurality and economic marginalization are not solely individual characteristics but rather describe community level differences. For example, economic marginalization does not only differ household-to-household but clusters in certain communities and regions in the United

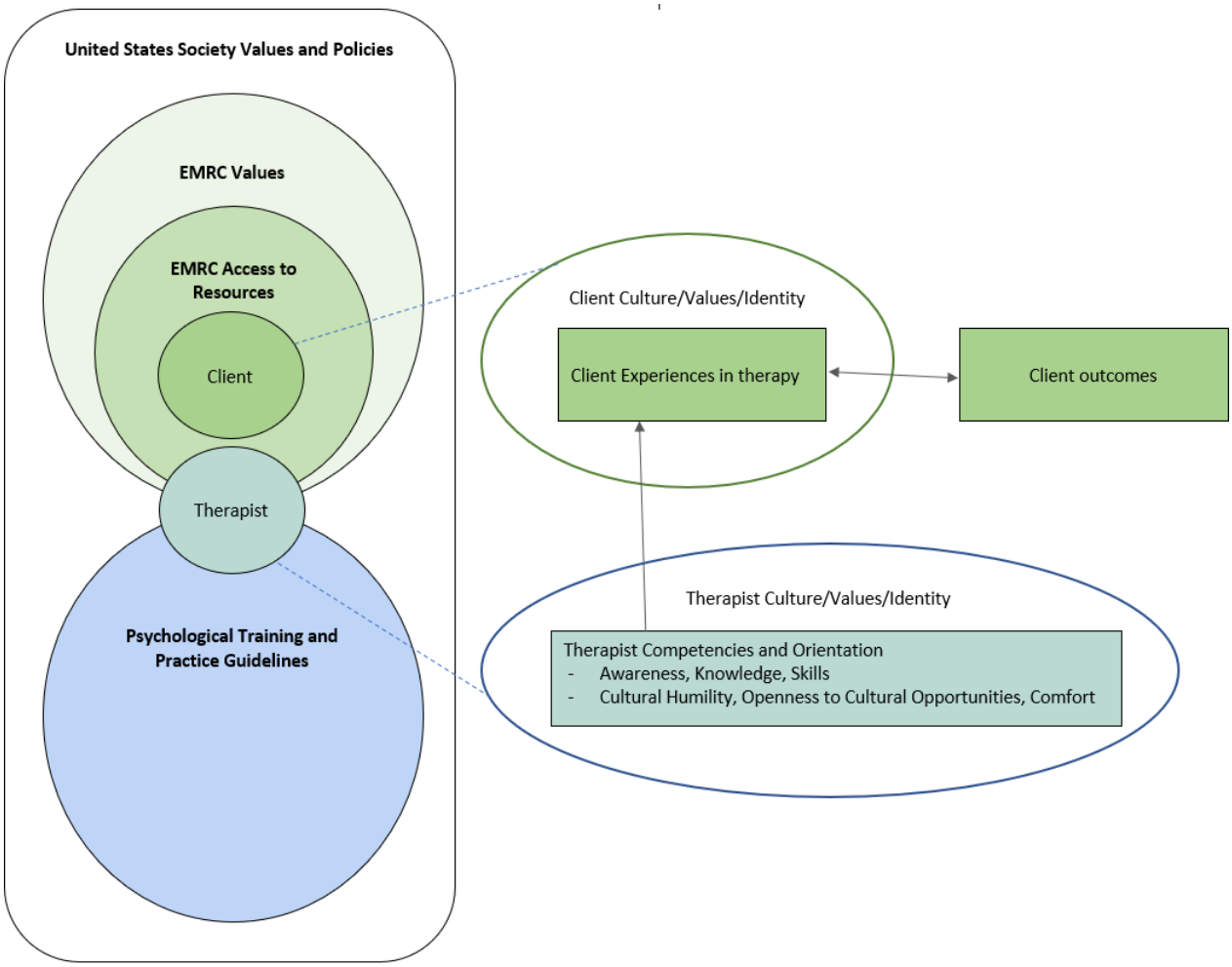

Figure 1. The role of economically marginalized rural community (EMRC) values and access to resources in explaining psychotherapy experiences and outcomes for clients from EMRCs.

States (Lichter & Johnson, 2007; U.S. Department of Census, 2018). Community poverty, in turn, has specific consequences for individual members of those communities, including lower access to health care, safe housing, quality education, decent work, and safe community spaces (U.S. Department of Agriculture, 2020). Similarly, rurality is a community level factor rather than an individual person's trait, with rural communities having different cultural values, strengths, and barriers to mental health care than their urban counterparts (Carpenter-Song & Snell-Rood, 2017). These community factors may influence individuals' help-seeking behaviors and experiences in

psychotherapy (Carpenter-Song & Snell-Rood, 2017; Cheesmond et al., 2019). As a result, recognizing the community level characteristics of rural economic marginalization is critical to understanding the experiences of members of these communities who seek mental health care.

Demographics of EMRCs

The experiences of EMRCs are underrepresented in psychotherapy literature, but not uncommon. Although rural populations are slightly declining, 14-20% of people in the Unuted States live in rural communities (U.S. Department of Agriculture, 2020). Of these, 16.4% lived in poverty in 2017, compared to 18.5% in 2013. The gap in poverty rates between metro and non-metro areas is growing and the proportion of people living in poverty is highest in the most isolated rural areas of the Unites States despite an overall decrease in poverty rates across the country (U.S. Department of Agriculture, 2020). Since the Great Recession in the late 2000s, employment growth has been slower on average in rural areas where participation in the work force also occurs at lower rates. This is likely due to population differences, including that people in rural areas tend to be older, with lower education, and higher rates of disability, as well as to changes in the types of jobs available in these areas (U.S. Department of Agriculture, 2020). Although rural communities share the economic pressures of slow employment growth and poverty, there is significant diversity in the cultural and practical experiences of different rural communities.

Regional differences are a common way to understand the diversity within rural communities in the United States (Hirsch, 2019; Johnson, 2012). Different regions experience different economic realities. For example, although manufacturing, nonspecialized, recreation, and government work has remained stable in rural areas, the decline in farming and mining work over the last decade hit certain regions, like rural Appalachia, the hardest (U.S. Department of Agriculture, 2020). Different regions also experience differences in population density that impact

what rural means for these communities. Although western states like Montana, Wyoming, South Dakota, and North Dakota are almost entirely rural with very low population densities, most rural Americans live in the South and Midwest (Foutz et al., 2020). Across regions, factors like economic resources and population density co-exist with diverse cultures, histories, and practical constraints. Cultural norms and practical restraints (e.g., industry availability) are inextricably linked to resource access, economic marginalization, and psychological wellness.

Different regions also have different patterns of racial and ethnic diversity. Although those in rural areas generally tend to be White, people with marginalized racial and ethnic identities make up 20% of all rural populations and account for 80% of the rural population growth since 2000 (Johnson, 2012; Sharp & Lee, 2017). Broadly, African Americans communities are common in the rural Southeast; Hispanic communities are growing in the Southwest, Southeast, and Midwest; Native American and American Indian communities are more strongly represented in the West, Southwest, and Great Plains regions; and non-Hispanic White communities are more common in the North, Northeast, and Midwest regions (Hirsch, 2019; Johnson, 2012). These communities differ in their historical roots, with some communities – like African Americans in the rural Southeast or Latinx communities in the Southwest – existing for generations, and others – like Latinx communities in the Midwest – representing new population growth (Johnson, 2012). These regional differences in the context of systematic racial oppression in the United States influence how broader patterns of rural culture, values, policies, and access to resources are experienced by members of these communities.

Although economic marginalization is widespread across all rural communities, racial and ethnic minority rural communities are more likely to experience persistent poverty than White rural communities (Johnson, 2012). Rural African Americans are more likely to experience

economic marginalization compared to African Americans in urban areas and more than half of African Americans in rural communities live in high-poverty counties (Procter & Dalaker, 2003). While rural poverty declined in the 1990s, African American communities in the rural South continued to represent some of the largest segments of economic marginalization in the country (Lichter & Johnson, 2007). In terms of income, over half of rural American Indians, African Americans, and Hispanic Americans have household incomes under $25,000 – compared to 32% of non-Hispanic rural Whites (James et al., 2017). Understanding differences in the racial and ethnic patterns of rural communities is important to situate the experiences of these communities in the context of historical and modern systematic racism and economic marginalization. The land and property of American Indians, Native Americans, Mexican Americans, and African Americans was systematically stolen through both government sanctioned and illegal means (Lichter & Johnson, 2007; Paradies, 2016). The repercussions of genocide and slavery include economic marginalization across generations; and this same marginalization is sustained by current economic policies and practices (Kozhimannil, K., & Henning-Smith, 2018; Paradies, 2016). The effects of racial oppression in EMRCs are not only economic but have wider implications, including accounting for racial disparities in access to mental health care within EMRCs (Paradies, 2006).

EMRCs are unique in a few other demographic and cultural ways. Rural adults are more rooted in their communities than urban and suburban adults, having lived in their communities longer and being more likely to live near family and know their neighbors (Parker et al., 2018). Despite the overall decline in the rural population, rural adults are also less likely than urban and suburban adults to want to move away from their communities (Parker et al., 2018). Rural communities have a higher proportion of veterans than non-rural communities, with a quarter of

veterans living in rural areas (U.S. Department of Veterans Affairs, 2019). Rural veterans also tend to be older, which reflects the higher proportion of older adults more generally in rural communities (Hirsch, 2019). Although older adults across the nation are disproportionately affected by poverty, older adults living in rural areas have even higher rates of poverty (Hirsch, 2019). Residents of non-metro areas are also more likely to have multiple chronic health conditions and a disability than their urban counterparts (Hirsch, 2019; U.S. Department of Agriculture, 2020). Although not exhaustive, these different characteristics distinguish EMRCs from more urban and economically secure communities and are helpful for understanding the greater context of mental health and mental health treatment in these areas. For instance, veterans present with higher rates mental health disorders than non-veterans (including, trauma-related disorders, traumatic brain injuries, substance use disorders) and tend to access services through the Veterans Affairs (VA) hospital system (Bumgarner et al., 2017); whereas older adults present with higher comorbid medical concerns than younger adults and tend to access mental health services through Medicare coverage (Davis & Magilvy, 2000). As such, this confluence of demographic factors calls for further understanding of clinical competency and psychological distress among economically marginalized individuals in rural settings.

Values and Beliefs of EMRCs

While there is diversity within EMRCs in the United States, these communities share specific cultural values and beliefs that stem from the intersection of rural culture and economic marginalization. Specifically, this section reviews EMRCs' distrust of public institutions and outsiders as well as values of self-reliance, personal responsibility, and stoicism because of the salience of these values and beliefs to mental health care.

Distrust of Public Institutions and Outsiders

Within rural communities in the United States, neoliberalism and the Christian fundamentalist movement intersect to influence individuals' roles in public life and their distrust of public institutions (Cervone, 2017). A common refrain in EMRCs is the perception that their communities are left behind or forgotten – a refrain visible through the growing trend of urbanization and the general public perception that rural communities receive less than their fair share of federal funding (Parker et al., 2018). Regardless of whether this public perception is accurate, this belief continues to shape rural culture – setting up a false dichotomy that if urban areas receive funding, it is at the expense of rural communities. Community economic marginalization reinforces this distrust. People from high poverty communities report greater distrust in institutions, and health care specifically (Shoff & Yang, 2012). Like rural communities, economically marginalized communities' distrust may stem from beliefs of being forgotten, misused, and underserved by these institutions (Shoff & Yang, 2012). EMRCs' distrust of public institutions is reinforced by fears of losing one's way of life, and especially one's Christian way of life, through increased modernization, urbanization, and immigration (Cervone, 2017). The politically powerful Christian fundamentalist movement has grown in parallel with neoliberal privatization efforts to fuel distrust of public institutions. According to Christian fundamentalist teachings, public institutions, urbanites, and other outsiders are not to be trusted, and the solution is to focus on privatization, isolation, and increased control at a community level (Cervone, 2017). Together, neoliberalism and Christian fundamentalism have shaped rural policy and practice around significant areas of life, such as the movement towards privatization and homeschooling within education (Cervone, 2017).

Distrust of institutions is common across racial groups in EMRCs in United States (Fischer et al., 2016; Murry et al., 2011). Racial threat – White communities' fear of losing power to racial

minority communities – is a factor fueling distrust of government in rural White communities that blame the government for the increased Latinx migration to these communities (Hanson et al., 2019). For rural Latinx people, distrust in government appears related to perceptions of whether government leaders are addressing concerns that affect rural Latinx communities (Munier et al., 2015). People of color in EMRCs have additional reasons to distrust public and health institutions due to the history of exploitation by these systems. Pointedly, one sample of low-income African American mothers in EMRCs reported distrust in White mental health providers, including beliefs that their children will not be treated as well as a White child and that White providers could not understand the problems of African American families (Murry et al., 2011). Although African Americans and other people of color in rural communities have additional reasons to distrust predominately White institutions and providers, these communities share the same concerns of distrust specific to all EMRC communities, including lack of privacy, being negatively judged by their community, and that providers will not understand their concerns (Murry et al., 2011). Lack of trust subsequently is a salient aspect of EMRC's experiences with mental health care.

Self-Reliance and Stoicism

Other values salient to mental health within EMRCs, include personal responsibility, stoicism, and self-reliance. Valuing stoicism – suppressing and attempting to control emotion (Judd et al., 2006) – and self-reliance may lead those in EMRCs to attempt to cope with their problems themselves and to suffer in silence (Cheesmond et al., 2019; Fischer et al., 2016; Judd et al., 2006; Weinert & Long, 1987). Economically marginalized rural adults historically tend to assume greater personal responsibility for their health problems and gauge their health based on their ability to work and be productive (Weinert & Long, 1987). These beliefs, particularly the tendency to define health in terms of their ability to work, echo neoliberal principles of individual

responsibility and the belief that in a just world, we are responsible for our own problems and outcomes (Chandler, 2014; Witt, 1989). Self-reliance, stoicism, and personal responsibility are in line with EMRCs' distrust of institutions and outsiders (if you can't trust outsiders, you need to rely on yourself) and make sense given the geographic isolation and limited economic power of EMRCs (if you cannot access help even if you wanted to, you need to rely on yourself).

Policies and Resources

Recognizing community level values and beliefs relevant to EMRC's mental health treatment helps provide context for community level differences in policy and resources. These differences in policies and the resources available to EMRCs relate to access to mental health services, the communities' relationships with providers, whether people use available services, and what type of services are available. Key differences in the policies and resources in these communities include the defunding of public programs, differences in mental health care, access to health insurance, and access to providers and services.

Deregulation and Defunding of Public Programs

Deregulating and defunding public programs in rural communities contributes to the economic marginalization of these communities and is associated with rural mental health care disparities (Larrison et al., 2011). Neoliberal beliefs of privatization, deregulation, and distrust of public institutions shape federal and state government policies that exacerbate rural poverty (Lawson et al., 2010). At a time when rural communities experienced a loss of economic power due to a market shift away from agricultural and raw resource extraction, local governments are also coping with the loss of federal and state funding and changes to tax policies (Lawson et al., 2010). These changes lead local and state governments to compete against each other through

decreased regulations, decreased environmental protections, and increased incentivization of private investments. For middle- and upper-class rural communities, this competition is associated with investments from entrepreneurs, gentrification, and tourism (Ghose, 2013; Lawson et al., 2010). However, for EMRCs, this competition contributes to a "race to the bottom" (Lawson et al., 2010, p. 664). This economically disadvantaged context becomes attractive for investments from industries that financially benefit from the deregulations in labor and environmental protections such as private prisons, food processing plants, and large-scale industrial animal farming (Bonds, 2009). The consequences for EMRCs, particularly Latinx, African American, and Native American/ American Indian communities, include increased environmental and water pollution, low wages, poor worker protections, limited benefits, seasonal work, and hazardous work environments (Lawson et al., 2010).

In parallel to the increased economic marginalization within rural communities, is the defunding of community mental health agencies by state and local governments which limits the availability of affordable, government-supported services in these economically disadvantaged settings. In this race to the bottom, governments cut mental health and other social services to redirect financial resources to incentivize privatization with tax breaks and subsidies (Larrison et al., 2011). Deregulation and the defunding of social programs are closely related policies that exacerbate rural poverty and strip EMRCs of the community mental health agencies that are often their sole source of mental health care (Larrison et al., 2011).

Access to Health Care Coverage

Despite rural values of self-reliance and distrust in public institutions, rural health care systems could not survive without government programs. About one in four nonelderly rural residents rely on Medicaid (Foutz et al., 2017). For decades, rural hospital systems have

disproportionately relied on government coverage of Medicare and Medicaid, compared to non-rural hospitals (Mohr et al., 1999; U.S. Government Accountability Office, 2018). The importance of Medicaid coverage in rural communities grew following the Affordable Care Act; however, states that expanded Medicaid primarily received these gains. These policy differences across states following the Affordable Care Act led to regional disparities in rural areas. In states that did not expand Medicaid, 15% of nonelderly rural adults did not have health insurance, compared to 9% in states that expanded Medicaid (Foutz et al., 2017). Unfortunately, states that did not expand Medicaid are home to many rural communities. The majority of those without any insurance in rural areas, 59%, live in states that did not expand Medicaid.

Policy decisions limiting access to health insurance are consistent with EMRC beliefs of distrusting public institutions and expectations of self-reliance. That is, if you value self-reliance and do not trust public institutions, there is little reason to fund public programs like health insurance. Policy decisions that limit access to health insurance are consistent with the race to the bottom, where funding is cut for social programs like Medicaid as rural states compete to attract businesses. Kansas exemplifies this connection as years of deregulation and tax incentives intended to attract businesses led to substantial cutting of social programing, including the vetoing of Medicaid expansion by then-Governor Brownback (Bosman et al., 2017; Goodnough & Smith, 2017). As a result, seven rural hospitals have closed in Kansas since 2006, a pattern seen across states that did not expand Medicaid (Cecil G. Sheps Center for Health Services Research, 2020; Kaufman et al., 2016). The defunding of these programs mirrors the low public support in EMRCs for government health care programs, despite their greater reliance on these programs. This discrepancy is explained by the salience of deep-rooted rural community values of self-reliance,

distrust of public institutions, and the neoliberal push towards privatization over government programming.

The Veterans Affairs hospital system represents another large segment of rural health care, with one in four veterans living in rural communities (U.S. Department of Veterans Affairs, 2019). Possibly due to the lack of alternatives in rural settings, veterans in rural areas are over 50% more likely to enroll in the VA healthcare system than veterans in urban areas (U.S. Department of Veterans Affairs, 2019). In addition to providing services, the VA hospital system has also paved the way in developing, researching, and implementing services like telehealth that improve access to care for rural communities (Clancy & Atkins, 2017). Paralleling the policy trends with other government health care programs like Medicaid, there are similar pushes by politicians in rural communities to privatize and block the expansion of veterans' health care (Clancy & Atkins, 2017). The main takeaway is that even though private health insurance coverage remains the most common form of coverage in rural areas, covering 61% of rural residents (Foutz et al., 2017), government programs and institutions have a larger role in providing health care for rural communities than urban communities – especially for those who are economically marginalized.

Access to Mental Health Providers and Treatment

Accessing mental health care does not only require an individual to have health insurance coverage, but also to have the ability to find an accessible provider that accepts that insurance. Since the 1970s, government and non-profit organizations have worked to address the persistent lack of doctoral level psychologists and specialized mental health care providers in rural areas (Smalley et al., 2010). Currently about 60% of shortages in mental health care workers nationwide are in rural communities (U.S. Health Resources and Services Administration, 2020). Some regions are hit even harder, with 70% of rural Appalachia designated as mental health care shortage

areas (Hendryx, 2008). Nationally, over 26 million people live in rural areas that are underserved in terms of mental health care; an additional 55 million people live in underserved partially rural areas (U.S. Health Resources and Services Administration, 2020). These disparities exist across rural areas but are more likely in EMRCs (Hendryx, 2008).

A comparison of national licensure data with U.S. Census data by Andrilla and colleagues (2018) helps illustrate the scarcity of providers across the rural United States. Overall, about 61% of rural counties in the United States do not have any psychologists. Additionally, rural areas are underserved even when considering the number of providers relative to the smaller population size in rural areas. Across the United States, there are about 33 psychologists per 100,000 residents in metropolitan areas of the country, compared to 9 psychologists per 100,000 residents in rural areas. Rural New Englanders have the highest access (35 psychologists per 100,000 residents) and rural South Central states from Alabama to Texas have the lowest access (about 5 psychologists per 100,000 residents). Although mental health providers are scarcer in rural areas generally, Andrilla and colleagues found that regional differences in where rural psychologists practice mirror economic disparities between regions, with New England having the lowest poverty rate and highest health insurance coverage rate. The lack of mental health resources in EMRCs likely has multiple causes, including limited financial resources to fund mental health care services, few incentives for providers to remain or move to these areas, and limited education and training opportunities in rural areas to become licensed providers (Andrilla et al., 2018; Hendryx, 2008; Keeler et al., 2018).

Rural communities have historically advanced the implementation of telehealth care and recently, the COVID-19 pandemic was a catalyst in expanding its use (Krider & Parker, 2021). Telehealth services are feasible, cost-effective, and often just as good as in-person care in terms of

efficacy (Bumgarner et al., 2017). Subsequently, increasing access to telehealth services is a key strategy in addressing the geographic barriers, lack of transportation, and scarcity of providers in EMRCs (Krider & Parker, 2021). However, EMRC-specific barriers like clients' access to reliable internet or camera-enabled devices need to be addressed, with solutions ranging from improve the United States' broadband infrastructure to providing individual clients with tablets (Krider & Parker, 2021; Substance Abuse and Mental Health Services Administration [SAMHSA], 2016). Training programs may also address this need by ensuring training and clinical experience in telehealth, even after the COVID-19 pandemic restrictions fade, so future practitioners have the competencies to routinely offer these services and increase access to EMRCs. On a policy level during the COVID-19 pandemic, many restrictions on the use and reimbursement for telehealth and telephone services through Medicare and Medicaid were waived and funding for telehealth services through the Coronavirus Aid, Relief, and Economic Security (CARES) Act was expanded (Krider & Parker, 2021). The increase in mental healthcare access following these policy changes has resulted in legislators, practicitioners, and the American Psychological Association (APA) advocating for the continuation of policies to expand telehealth access post-COVID-19 (DeAngelis, 2021; Krider & Parker, 2021).

Differences in Accessing Mental Health Care

Rural health providers have ranked mental health disorders as the fourth highest rural health priority, after access to health care generally, coronary problems, and diabetes (Gamm et al., 2003). Despite the need for mental health care, mental health services are underused and often inaccessible in EMRCs. This is consistent with access to healthcare generally, as economically marginalized and rural people across races are less likely to use routine health care services (APA, 2019; Cadwell et al., 2016). The lower access to care in EMRCs is not only due to differences in

policies and resources, but also due to the internalization of the community level values of distrust in institutions and self-reliance.

Within mental health care, distrust towards public institutions translates to a general distrust towards agencies and providers who may be perceived as outsiders (Cheesmond et al., 2019). For example, rural veterans describe a general lack of trust in the VA hospital system, citing beliefs that such large government-run institutions do not care and are inefficient (Fischer et al., 2016). Due to the close-knit quality of rural settings and the difficulty of avoiding multiple relationships with therapists, rural community members' concerns about confidentiality and privacy are legitimate deterrents to seeking care (Larson & Corrigan, 2010). Therapists may also be outsiders who move to rural communities in adulthood and subsequently may not understand rural life or culture (Cheesmond et al., 2019). Instead, of psychotherapy, close family and friends are relied on for support in times of distress (Murry et al., 2011; Weinert & Long, 1987). The consequence of this distress, is that when those from EMRC do access mental health care, it is typically accessed indirectly, following a referral from a primary care provider, school, court system, or other institution (Fischer et al., 2016; Murry et al., 2011).

In terms of mental health, stoicism and self-reliance in rural samples is associated with decreased likelihood of seeking psychological care (Judd et al., 2006). Rural veterans, for example, described stoicism and self-reliance as significant barriers to seeking care as many reported – waiting until symptoms become severe before they finally seek care (Cheesmond et al., 2019; Fischer et al., 2016). This is consistent with evidence that rural residents were half as likely to receive mental health care as their non-rural counterparts after adjusting for presenting concern, insurance coverage, race, and age (Wang et al., 2005), although the availability of services likely accounts for these disparities as well. Self-reliance appears to create pressure to solve mental health

problems privately and independent of professional care for members of EMRCs, exacerbating the economic and geographic barriers to accessing care in EMRCs.

Therapists Working within EMRCs

Therapist EMRC Multicultural Competency and Orientation

Therapist competency working within EMRCs is necessary because multicultural counseling competencies and orientation predict therapy processes and client outcomes (Davis et al., 2018; Sue et al., 2009). When therapists are comfortable attending to opportunities to discussing culture with clients and who approach these conversations from a stance of humility, clients do better in therapy, with greater reductions in symptoms and distress (Davis et al., 2018). And when therapists have the specific cultural competencies needed to shape treatment to the needs, values, and beliefs shared within a community, clients from these communities benefit (Sue et al., 2011). Rural therapists agree, rating competency concerns as a significant ethical issue that they face due to barriers to seeking consultation, supervision, and continuing education (Warren et al., 2014; Witt & McNichols, 2014). Due to the unique cultural values, beliefs, policies, and resources of EMRCs, therapists should possess specific competencies for working effectively with these communities.

Competencies identified by therapists in EMRCs include connecting to the community and diversifying their practice to meet the varied needs of clients (McNichols et al., 2016). Because distrust of institutions and self-reliance deters EMRC members from seeking therapy, it is necessary to build relationships with significant community leaders in schools, houses of worship, court-systems, primary care providers, and local non-profits. These leaders can help therapists learn about and connect with the community to build trust and therapists can provide mental health

training for leaders (Aten et al., 2013; Milstein et al., 2017; Smith et al., 2018; Stansbury et al., 2017). In terms of diversifying their practice, therapists working in EMRCs not only need to have competencies related to practice with rural and economically marginalized clients, but to also have a wide range of competencies to manage the diverse presentations of their clients. EMRC members rely on generalists more than specialists because "you may be the only person in the county that's on their insurance plan. You're it, and you have to know what you're doing" (McNichols et al., 2016, p. 144). Unfortunately, these areas of competency, and multicultural competencies related to social class and rural communities broadly, are often under-addressed in coursework and training (APA, 2019; Smalley et al., 2010; Smith, 2009).

Therapist Bias and Differing Beliefs from EMRCs

Central to therapists' multicultural counseling competency and orientation with clients from EMRCs is therapists' awareness of personal values, beliefs, biases, and cultural discomfort related to EMRCs. Rural therapists describe censoring their personal beliefs about religion, politics, and social values when they differ from their community in order to preserve their relationship with the community and its members (McNichols et al., 2016). The way therapists handle cultural differences is important, given community distrust of outsiders and institutions. Therapists must address biased attitudes related to social class, rural culture, and the intersection of these cultural identities. This intersection is understudied, but clear in the rhetoric and stereotypes within United States culture. Liu described downward classist stereotypes of people as "lazy" or "trashy" (2013, p. 114) and Bassett extends this to rural economic marginalization with "hicks," "hillbillies," and "rednecks" (2006, p. 22). Therapists should work to understand personal class privilege, emotional reactions to poverty, classism, and the invisibility of rural economic marginalization (Bassett, 2006; Smith, 2009). Reflecting these biases and cultural discomfort, both

Smith (2009) and Bassett (2006) discussed how the field of psychology engages in physical and psychological distancing from economically marginalized and rural communities, respectively. In the therapy room, this distancing is apparent in the avoidance of discussing social class and rural cultural identities, values, and beliefs. Systemically, this distancing is apparent in the limited psychotherapy training and research on EMRCs (Briggs, 2015; Bumgarner et al., 2017; Domino et al., 2019; Watanabe-Galloway et al., 2015).

Lack of Training Opportunities

At the post-bachelor level, there is a need for the development of degree programs and practicum or internship training sites in EMRCs. Currently, less than one percent of psychology doctoral programs in the U.S. are in rural areas (Domino et al., 2018). Psychologists in EMRCs recognize rural internship and postdoctoral positions as critical to increasing retention (Briggs, 2015; Watanabe-Galloway et al., 2015), and the Veterans Health Administration is a leader in funding these positions (Bumgarner et al., 2017). Increased training in EMRCs may also increase recruitment of providers from EMRCs, who tend to stay local after graduation (Mackie, 2012). The need for these opportunities is not a novel idea; it is part of the mission statement of the American Psychological Association (APA) committee on rural health.

Another strategy for addressing provider shortages and lack of multicultural training in EMRCs is to incentivize non-locals to train and practice in EMRCs. Psychologists tend to be mobile; for example, 80% of psychologists in North Carolina earned their degrees in a different state (Domino et al., 2018). Psychologists and other providers are also swayed by student loan repayment programs like the National Health Service Corps, with most mental health providers staying in the area for years after their service commitment is completed (Pathman et al., 2012). EMRCs disproportionately benefit from such programs; approximately 35% of NHSC funded

positions in 2018 were in underserved rural areas, including Native American lands (U.S. Department of Health and Human Services, 2018). Subjectively, mental health providers see incentive programs as effective in improving recruitment and retention of providers to EMRCs, along with other interventions like increasing insurance reimbursement, higher pay, and granting psychologists medical staff privileges (Briggs, 2015; Watanabe-Galloway et al., 2015). Because therapists experience the repercussions of the economic hardship in EMRCs, often having fewer resources, little support, larger caseloads, and lower pay (Hastings & Cohn, 2013), it is necessary to provide support for those who do decide to train and practice in these communities.

Psychologists involved in training can play a role in addressing these disparities whether or not they live in EMRCs. For example, through virtual mentorship programs, psychologists have the opportunity to support and recruit potential providers in EMRCs regardless of where they live (Keeler et al., 2018). Those in training roles can ensure course curricula and practicum experiences address competencies in modalities like telehealth as well as cultural, ethical, and other treatment concerns specific to EMRCs. The surge in both telehealth and telesupervision following the COVID-19 pandemic demonstrated how psychologists outside of EMRCs can work to increase access to care, supervision, and mentorship in these communities (Bell et al., 2020). Psychologists in training roles can seize on this shift within the field to teach about these modalities of care and provide supervised training even if they do not practice in rural areas.

Client Therapy Experiences in EMRCs

The values and beliefs of self-reliance, personal responsibility, stoicism, and distrust of institutions salient to EMRCs influence clients' experiences in therapy. Initially, community level differences in policies and resources influence whether clients even can get their foot in the door to access treatment. Once in therapy, EMRC values of self-reliance, personal responsibility,

stoicism, and distrust in institutions are apparent in client expectations of mental health treatment and providers, perceptions of the working alliance, motivation, and hope – processes that constitute common factors in psychotherapy predictive of client outcomes (Wampold, 2015).

Expectations of Mental Health Care and the Working Alliance

Client attitudes towards mental health providers and services are shaped by community values and access to resources and affect how clients engage in therapy. Qualitative explorations of rural economically marginalized clients' experiences in therapy indicated they may approach therapy cautiously, relying on initial impressions rather than the working alliance to judge the effectiveness of therapy (Watson, 2019). These first impressions include evaluations of the therapy office, therapist characteristics like race and social class, and how the client feels when leaving the first session. Clients used these initial evaluations along with perceived accessibility of services and the risk of community stigma to determine if they will return for a second appointment (Murry et al., 2011; Watson, 2019). The caution shown by EMRC clients makes sense given the cultural beliefs about distrusting institutions and outsiders, as well as the value of managing concerns privately consistent with personal responsibility. However, personal factors may attenuate the influence of community values and beliefs. Previous experience with therapy, being in a personal crisis, and positive expectations regarding treatment efficacy appear associated with more positive attitudes towards therapy or, at least, greater motivation to give therapy a try (Watson, 2019). Thus, knowledge of EMRC community values must be integrated with client-specific context and culture to understand attitudes towards mental health treatment.

Research on therapists' working alliance with clients from EMRCs is limited. However, Watson's (2019) findings that the relationship with the therapist was not identified as meaningful in a sample of EMRC clients, suggests there may be unique cultural differences in the development

of the working alliance. EMRC values of personal responsibility may explain clients' description of the working alliance as dependent on the therapists' abilities, rather than viewing this process as collaborative or relational (Watson, 2019). Because research consistently demonstrates the importance of the working alliance to client outcomes, therapists may benefit from being aware of these potential differences working with clients from EMRCs.

Hope and Motivation

EMRC values and beliefs of self-reliance, personal responsibility, and distrust of institutions appear to impact client hope and motivation in treatment. For EMRC clients the pressure to be self-reliant, responsible for personal and family mental health concerns, can be overwhelming and exhausting which can motivate seeking treatment (Hoyt et al., 2018). Stoicism and self-stigma of mental health concerns and treatment appear to also relate to hope and motivation. Rural residents experience greater public and self-stigma related to mental health concerns compared to urban residents (Larson & Corrigan, 2010; Stewart et al., 2015). Lower self-stigma related to mental health concerns is associated with having a greater sense of hope (Larson & Corrigan, 2010; Lysaker et al., 2006; Stewart et al., 2015). Stoicism can be a way to protect against public stigma by hiding psychological distress, expression, or pain (Cheesmond et al., 2019). Understanding this pressure to keep mental health concerns private and to avoid seeking outside help – especially from the therapist – can help provide context to clients' motivation and hope when they enter therapy and if they later hit roadblocks to progress.

Strengths

Clients from EMRCs present to treatment with unique strengths. Community values of self-reliance and distrust of outsiders are a logical consequence of the historical geographic

isolation and lack of resources and are, therefore, part of the rural narrative of survival – providing both meaning and direction when coping with difficulties (Cheesmond et al., 2019; Davis & Magilvy, 2000). For example, one study found Hispanic and White rural residents with chronic illnesses to finding meaning in life through their illness (Davis & Magilvy, 2000). Consistent with those values of personality responsibility and stoicism, they describe a quiet pride and strength in coping with their illnesses; "Country people are more self-reliant and need to depend on each other. We are survivors." (Davis & Magilvy, 2000, p. 388). This self-perception may be meaningful to clients in these communities as a source of identity and self-reliance (Cheesmond et al., 2019).

Distrust of institutions and outsiders corresponds with trust and reliance on the community. The value of community and meaning derived from being a community member represents a strength of EMRC clients coping with health concerns (Davis & Magilvy, 2000). Rural communities are structurally different than their urban counterparts (Rost et al., 2002). Being smaller and denser, the relationships in rural communities have existed for longer and members tend to interact more frequently (Rost et al., 2002). Because outside institutions and people are distrusted, these communities provide a needed support system for survival and finding meaning in life. The perception of close community relationships as a strength appears across Black, Hispanic, and White EMRCs (Davis & Magilvy, 2000; Murry et al., 2011).

Client Presentation and Outcomes in EMRCs

While consistent evidence documents disparities in mental health presentation and treatment outcomes for economically marginalized clients (APA, 2019; Krupnick & Melnikoff, 2012; Levy & O'Hara, 2010), this research has not overlapped with research on rural outcomes. Consequently, this section integrates these two bodies of literature within the context of EMRC

specific values, beliefs, policies, and access to resources, to understand client presentation and outcomes in EMRCs.

Client Presenting Concerns in EMRCs

Presenting concerns differ in prevalence and presentation for clients in EMRCs. Broadly, rates of mental health disorders are similar across rural and urban communities and higher for those with economic marginalization (SAMHSA, 2019). However, rates of mental health disorders appear to differ for women, but not men, based on level of rurality and region, with higher rates of disorders for rural women in all regions except the Midwest (Meit et al., 2014). Compared to more urban and economically secure clients, EMRC clients are also more likely to present with comorbid medical and chronic physical illnesses (particularly, gastrointestinal, oncological, cardiovascular, and musculoskeletal disorders), higher rates of disability, older age, and higher rates of health risks like smoking and obesity (Bumgarner et al., 2017; Rost et al., 2002; Smalley et al., 2010; U.S. Department of Agriculture, 2020). Physical health concerns may cause or worsen mental health symptoms and vice versa (Smalley et al., 2010). Because EMRCs are more likely to include veterans, recent immigrants, migrant workers, older adults, caregivers, and those living on indigenous sovereign lands, EMRC clients often experience discrimination, which can compound mental health concerns. Because of these compounded stressors, those living in EMRCs have unique mental health concerns and presentations that require specialized knowledge, including trauma-related disorders, substance use, and suicidality (Bumgarner et al., 2017). Additionally, valuing self-reliance, distrust of institutions, and lower perceived access to care may lead EMRC clients to wait longer before seeking care compared to their urban and economically secure counterparts (Rost et al., 2002). Thus, these values may account for clients from EMRCs

presenting with higher severity of symptoms, presenting at later in the course of their disorder, and having different motivations for seeking care (Smalley et al., 2010).

Client Treatment Retention and Outcomes in EMRCs

The systematic and cultural barriers to seeking therapy in EMCRs may lead to differences in treatment retention and outcomes, although research on these issues for EMRCs specifically is absent. Researchers consistently find that clients experiencing economic marginalization have high drop-out rates and difficulty maintaining attendance in treatment (Edlund et al., 2002; Krupnick & Melnikoff, 2012; Levy & O'Hara, 2010). However, there is mixed findings for rural clients; although residing in a rural community does not consistently predict drop-out directly, barriers salient to rural communities such as longer travel times do, especially for clients seeking treatment for the first time (Edlund et al., 2002; Friedman et al., 2015). In rural settings race does not appear associated with treatment drop-out, despite evidence that people of color are generally at greater risk of drop-out compared to White clients (de Haan et al., 2017; Edlund et al., 2002; Larrison et al., 2004). Broadly, marginalized groups experience discriminatory and cultural barriers to staying in treatment, with stronger therapeutic alliance and ethnic matching of therapist and client predicting greater retention (de Haan et al., 2017). In terms of outcomes, when rural clients and economically marginalized clients are able to access treatment consistently, they have similar rates of symptom reduction as their urban and economically secure counterparts for common mental health concerns like depression (APA, 2019; Rost et al., 2002; Smalley et al., 2010). However, there is evidence that rural clients with serious mental illness, particularly in combination with substance use, experience worse treatment outcomes than urban clients (Rost et al., 2002). Overall, these findings suggest that the current disparities in mental health treatment for

clients in EMRCs are systematic, likely an issue of access to equitable care, rather than the individual's inability to benefit from treatment.

Recommendations

In light of the lack of empirical effort and educational emphases on culturally competent and oriented mental health services for EMRCs, specific shifts in the field are necessary. As such, the following recommendations are offered. These recommendations are drawn from this review of the literature that demonstrates community level factors can inform our approach to psychotherapy practice, training, and policies.

Recommendation for Policy and Professional Organizations
Develop and support:

1. legislation to prevent the defunding and de-privatization of social programming and community mental health agencies.
2. legislation that protects government funded or subsidized health insurance and programs, including the Veterans Affairs Hospital System, Medicare, and Medicaid.
3. legislation to increase reimbursement and funding for telehealth services.
4. incentives for providers to remain in or move to EMRCs (e.g., loan forgiveness programs, increasing insurance reimbursement, higher pay, etc.)
5. degree programs, practica, predoctoral internship sites, post-doctoral sites, and other training opportunities in EMRCs.

Recommendations for Practitioners Working within these Communities
Case Conceptualization and Treatment Planning

1. Attend to values and beliefs salient to EMRCs, such as self-reliance, stoicism, community, and distrust of public institutions or outsiders.
2. Include community level factors in client conceptualizations.
3. Explore clients' motivations and hope for seeking treatment, including what brought them into therapy now, and how they view you as a mental health provider.
4. Assess and reframe self-stigmatizing beliefs about mental health to improve hope and help-seeking.
5. Attend to opportunities to discuss personal and client social class and rural identity in session.

6. Attend to the intersection of race, gender, and other identities within the context of rural economic marginalization to better understand client reactions to stressors related to oppression and cultural differences.
7. Assess for comorbid medical and chronic physical illnesses and incorporate these experiences into case conceptualization and treatment planning.
8. Attend to client strengths; this may include community relationships and self-reliance.

Working collaboratively with the Community

1. Build connections with community leaders to develop community trust, identify community needs, and have a point of connection for referrals.
2. Be a visible and active part of the community by engaging with important community organizations such as schools, houses of worship, court-systems, primary care providers, and local non-profits.
3. Use engagement with community events and organizations as opportunities to submerse yourself in the community's culture, challenge personal biases or assumptions, and build meaningful relationships with community members.
4. Address the perception that mental health services are inaccessible during community outreach and when providing services with new clients.
5. Learn about the community's local history of racial and economic oppression to better understand modern day consequences for the community.

Addressing Barriers to Care

1. Consider telehealth delivered via phone or internet, bibliotherapy, and other treatment modalities that have been successfully used to increase care in isolated rural areas.
2. Advocate for and develop programs to increase clients' access to technology and internet to improve access to telehealth services.
3. Lessen concerns related to public-stigma by practicing from a space that is shared with other service providers, providing parking that is hidden or shared with other services, and similar efforts to protect client confidentiality in small communities.
4. Be aware of physical markers of cultural and social class differences within your therapy setting as these first impressions may influence clients' evaluation of the effectiveness of therapy and their ability to connect with you as a provider.
5. Be open to discussing cultural and social class differences and similarities with clients to address assumptions and build rapport.

Personal Development and Professional Support

1. Increase awareness of personal biases and assumptions related to social class, rural culture, and the intersection of these cultural identities.
2. Be aware of cultural differences between yourself and the community where you work and how you address these differences while building trust and preserving your relationship with the community.

3. Seek supervision, consultation, and continued education to improve your multicultural competencies and orientation when working with clients from EMRCs.
4. Seek mentorship and a network of clinicians working in similar communities to provide professional support for coping with the unique stressors of working within EMRCs (e.g., isolation, fewer resources, lower pay, large caseloads).

Recommendations for Practitioners Working outside of these Communities

1. Incorporate technologies, knowledge, and interventions relevant to EMRCs into training curriculum (e.g., telehealth, bibliotherapy, multicultural competencies)
2. Incorporate discussions on rural and economically marginalized communities in coursework, workshops, supervision, consultations and other training roles.
3. Become involved with organizations that mentor and support students and early career professionals from EMRCs.
4. Increase the representation of EMRCs within psychotherapy intervention and outcome research to inform evidence-based practice.
5. Attend to and uplift the experiences of marginalized groups within EMRCs in research and training.

Limitations and Future Directions

A significant limitation of this review is the dearth of literature on mental health treatment in EMRCs. Although researchers are developing literature to understand rural and economically marginalized communities separately, these groups continue to be underrepresented in research and more is needed to understand the unique experiences at the intersection of these communities (APA, 2019; Carpenter-Song & Snell-Rood, 2017). While some groups such as farmers and veterans are more consistently represented in research, marginalized groups (e.g., racial minorities, LGBTQ+, non-English speakers, illiterate and those living on indigenous sovereign lands) and the most severely isolated are the least represented in the literature (Barefoot et al., 2015; Koch & Knutson, 2016). Consequently, this review largely pulls from the separate literatures on rural communities and economic marginalization, integrating these literatures with a focus on shared community values. However, there is a need to substantiate these connections through research exploring the mental health treatment of clients in EMRCs. Specifically, larger representative

samples of these communities across different regions of the United States are needed to supplement existing qualitative work. Additionally, the connections between community level values, beliefs, policies, and resources and mental health treatment proposed in this paper are often based on correlational or qualitative data and there is a need for research to explore causal and longitudinal connections.

Conclusions

The community plays a significant role in mental health services for EMRCs. Understanding EMRC values and beliefs relevant to mental health treatment allows us to understand the differences in policies and resources for these communities. Subsequently, EMRC values, beliefs, policies, and resources provides context for understanding therapist multicultural competencies and orientation as well as client experiences in treatment in these communities. Ultimately, these community level factors relate to client beliefs about treatment, motivation, hope, and perceptions of the working alliance – processes relevant to treatment retention and outcomes. Although the APA has made progress in developing *Guidelines for Psychological Practice for Clients with Low Income and Economically Marginalization* (2019), this review demonstrated that the intersection of economic marginalization and rurality needs specific attention. In addition to addressing the role of community level factors in mental health treatment for EMRCs, this review also evidences that the field needs to do more to address the specific concerns and disparities experienced by these communities to improve client care.

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CHAPTER 2: DEVELOPMENT AND VALIDATION OF A SCALE MEASURING PSYCHOLOGISTS' PERCEIVED COMPETENCY WITH CLIENTS EXPERIENCING LOW INCOME OR ECONOMIC MARGINALIZATION

Abstract

The field of psychology is working to rectify decades of silence on issues of economic marginalization in psychotherapy research, practice, and training. Increasing attention to economic marginalization led the APA to publish the first *Guidelines for Psychological Practice for People with Low-Income and Economic Marginalization* in 2019. The purpose of this paper is to describe the results of two studies that developed and validated the Clinical Practice Competencies for LIEM (CPC-LIEM), a scale based on these guidelines that measures psychologists' clinical competence working with low-income and economically marginalized communities. In Study 1, I developed the initial scale through expert review and identified the scale factor structure using exploratory factor analysis. In Study 2, I gathered a second sample of psychologists to conduct a confirmatory factor analysis and validate the CPC-LIEM. The CPC-LIEM was associated with general multicultural counseling competence and clinician self-report of therapy processes with clients from low-income economically marginalized backgrounds, but not with class-related attitudes or general multicultural awareness. The final 14-item five-factor CPC-LIEM represents a novel way to measure and increase attention to LIEM-related clinical competencies for clinicians, supervisors, and researchers.

Introduction

Researchers and advocates in psychology are working to undo the silence contributing to health disparities and inequitable care for low income and economically marginalized (LIEM)

communities within the United States (American Psychological Association [APA], 2020; Bullock, 2019). Economic marginalization is associated with negative outcomes on mental and physical health, social inclusion, security, and access to care (APA, 2010; Santiago et al., 2012). It was not until 2019, however, that the APA published the first *Guidelines for Psychological Practice for People with Low-Income and Economic Marginalization* (2019). These guidelines offer a framework to bridge the gap between research and practice to improve mental health care for LIEM communities with specific competencies for clinicians. Now that the field has these guidelines, we can work to empirically substantiate them by examining the extent to which these LIEM cultural competencies can be useful for improving care. A scale assessing psychologists' compliance with these guidelines is therefore critical to further this line of research and the practical application of these guidelines. For clinical training, scales similar to this may be used to develop awareness of competencies and growth areas; for research, such a scale may be used to identify predictors of competency. Consequently, a scale assessing clinical competencies working with clients experiencing LIEM might lead to increased awareness of these competencies at an individual, organizational, and professional level. Therefore, the purpose of this research was to develop and validate a scale to assess clinical competencies working with clients experiencing LIEM based on the 2019 APA guidelines.

Framework and Theoretical Background

Defining Multicultural Counseling Competencies in Therapy

Multicultural counseling competencies (MCC) in therapy refer to a practitioner's ability to work effectively with clients with different cultural identities and backgrounds than their own (Sue et al., 2009). Originating from findings that clients with ethnically and racially marginalized

identities experience greater mental healthcare disparities (APA, 2003), the MCC movement has focused on how cultural mechanisms salient to psychotherapy processes necessitate different approaches based on client and clinician culture (Sue et al., 2009). Sue and colleagues (1982; 2009) proposed a tripartite model of multicultural competencies, which includes cultural awareness and beliefs, cultural knowledge, and cultural skills. Awareness refers to clinicians' sensitivity to their personal beliefs and biases and how those beliefs influence their interactions with the clients. Knowledge refers to clinicians' knowledge of cultural differences and similarities, worldviews, and expectations for the therapeutic relationship. Skills refer to clinicians' abilities to provide care in a culturally sensitive and relevant way.

Clinicians' multicultural counseling competencies predict therapy outcomes and processes, although findings are mixed regarding the size and subsequent significance of these effects (Griner & Smith, 2006; Huey et al., 2014; Tao et al., 2015). For example, although there is evidence that multicultural counseling competency appears to differ across clinicians and predict client engagement and outcomes, clinician self-reports do not consistently match up to observer-rating or client-reports (Huey et al., 2014; Tao et al., 2015). One of the most studied therapeutic processes in relation to multicultural counseling competencies is the working alliance, the relationship between clinician and client, with an average correlation between working alliance and measures of multicultural counseling competencies of $r = .61$ across 15 studies (Tao et al., 2015). These findings from Tao and colleagues' (2015) meta-analysis included both clinician and client ratings for clinicians' multicultural competency and suggest that the clinicians with the strongest working alliances with their clients also tend to be more multiculturally competent. As the working alliance is a robust predictor of therapeutic change (Flückiger et al., 2018), it remains critical to understand

how multicultural counseling competency across specific cultural domains correlates with working alliance and predicts client outcomes.

Criticisms of the MCC movement include the centering of specific knowledge and skill competencies, the idea that certain clinicians are more competent than others, difficulty addressing clients' unique intersectionalities, and the mixed research findings linking multicultural counseling competency with therapy outcomes (Davis et al., 2018). Alternatives of MCC, predominately the multicultural orientation framework (MCO; Davis et al., 2018; Owen et al., 2011), instead focus on interpersonal constructs that describe clinicians' ways of being with clients, such as cultural humility and cultural comfort. The constructs of the MCO framework are promising and useful ways to think about clinicians' processes with culturally different clients, especially as predictors of outcome (Davis et al., 2018). However, MCO constructs describe interpersonal processes salient to clinicians' work that are related to but separate from MCC. That is, general MCO interpersonal processes in therapy are a distinct construct from competencies specific to working with clients from LIEM backgrounds.

Cultural Competencies with LIEM Communities

Lacking in the psychotherapy literature is attention to cultural competency for clients with LIEM (APA, 2019). The purpose of the APA (2019) *Guidelines for Psychological Practice for People with LIEM* was to address this gap and inform how psychologists provide culturally competent care for these communities. Based on the review of the literature in these guidelines, culturally competent care for LIEM communities requires not only attention to financial and monetary barriers but also attention to material hardship, cultural capital, social class identity, and other experiences salient to these communities (APA, 2019). These guidelines are consistent with the I-CARE model proposed by Foss-Kelly and colleagues (2017) and similar guidelines for

supervision of trainees working with economically marginalized clients (Smith, 2009). Core features of the APA recommendations include the importance of reflecting on personal biases and social class identity, addressing treatment barriers, and attending to client strengths and the working alliance to improve client care.

Four domains organize the APA guidelines on LIEM (APA, 2019). The Training and Education domain describes guidelines for increasing awareness of biases about LIEM populations that impact training and the importance of seeking out continuing education, supervision, and other training opportunities to improve knowledge of LIEM and social class issues. The second domain, LIEM and Health Disparities, focuses on the role of psychologists in understanding the systemic issues contributing to health disparities for LIEM communities and their role in promoting equity in access to high quality healthcare. The third domain, Treatment Considerations, is the largest section of the guidelines. The Treatment Considerations domain includes guidelines for attending to the social class of both the client and clinician in treatment, understanding how economic marginalization and social class impact client presentation, tailoring treatment to fit the needs of clients experiencing LIEM, improving awareness of barriers to treatment, and alleviating barriers to improve access to treatment. The final domain, the Intersection of LEIM with Career Concerns and Unemployment, covers the importance of understanding the effects of economic marginalization and social class on academic and career concerns and outcomes, including conceptualization and treatment recommendations related to clients' unemployment/underemployment and psychologists' roles in improving employment access. Consistent with Sue's (Sue et al., 2009) tripartite model, across all four domains, the guidelines focus on developing awareness ("gain awareness of how their biases related to social class may impact the training and education they provide"), knowledge ("increase their knowledge and

understanding of social class issues"), and skills ("alleviate [LIEM-specific] barriers when providing psychological interventions"). The guidelines review the literature substantiating these areas of cultural competency for working with LIEM communities (APA, 2019).

The APA guidelines for competencies working with LIEM communities are necessary because LIEM communities are underserved, with lower access to health and mental health care overall—especially evidence-based care—and higher dropout rates in therapy (Krupnick & Melnikoff, 2012; Levy & O'Hara, 2010; Warnick et al., 2012). Many people with LIEM also experience discrimination based on race, gender, disability, ethnicity, immigration status, and other cultural identities that relate to their access to equitable mental health care (APA, 2019). In addition to the physical, financial, and psychological barriers to accessing mental health care, clients' interactions with their clinicians may contribute to these disparities (Krupnick & Melnikoff, 2012). Specifically, clinicians' biases and difficulties establishing working alliances with clients from LIEM backgrounds contribute to clients' difficulty engaging in therapy (Liu et al., 2013; Thompson et al., 2012; Trott & Reeves, 2018). Clinicians' role in perpetuating or dismantling these disparities start in their interactions with clients from LIEM backgrounds.

Focusing on empirically supporting practice guidelines and competencies for working specifically with LIEM communities, rather than solely attending to general multicultural practices, is necessary in this under-researched area of practice. Researchers attribute the lack of attention to LIEM communities in psychotherapy research to the field's discomfort with economic marginalization (APA, 2019; Smith, 2009); which results in an under-representation of LIEM communities in research samples, theory, and training (APA, 2019; Clark et al., 2018; Lee et al., 2013; Liu et al., 2004; Reimers & Stabb, 2015). To rectify decades of silence on LIEM topics within psychotherapy research, the field needs to intentionally and specifically attend to this

community. Like other scales assessing specific cultural competencies, the benefit of focusing on competencies specific to LIEM communities is to study predictors and moderators unique to clinicians' work with clients from LIEM backgrounds. Within training, these scales also bring specific attention to the work a clinician does to improve their ability to provide equitable and evidence-based care for this underserved client population. The need for specialized focus on LIEM communities is why the APA worked to publish guidelines that address specific evidence-based competencies for improving care for these communities. Without this culturally-specific attention, the silence surrounding economic marginalization in psychotherapy practice and research will likely continue.

Need for Measuring LIEM Competencies

Although a critical first step, the APA's LIEM guidelines can only increase mental health care access and effectiveness for LIEM individuals if clinicians enact these guidelines in their work. Therefore, developing assessments of the competencies outlined in the guidelines is critical to investigate their utility in training and clinical practice. In terms of training, there is evidence that both psychologists and trainees find competency scales helpful for identifying strengths and areas of growth, increasing awareness of different competency areas, and monitoring trainee development (Karel et al., 2012). Although self-report tools are influenced by social desirability biases, these tools can be an effective part of supervision in triangulation with other evidence (Fuertes et al., 2001). Because supervision is one of the most successful training tools for improving multicultural competencies (Pope-Davis et al., 1994), clinicians could benefit from purposefully attending to these competencies via supervisee assessment and reflection. Although similar scales exist to assess clinical competencies when working other marginalized groups (e.g., Counseling Women Competencies Scale, Ancis et al., 2008; Sexual Orientation Counselor

Competency Scale, Bidell, 2005) and to assess multicultural counseling competency more broadly (Multicultural Counseling Inventory, Sodowsky et al., 1994; the Cross-Cultural Counseling Inventory-Revised, LaFromboise et al., 1991; the Multicultural Counseling Awareness Scale, Ponterotto et al., 2002; and the Multicultural Awareness Knowledge Skills Scale; Kim et al., 2003), no assessments of clinical competencies with clients from LIEM backgrounds exists.

Competency assessments also benefit psychotherapy research. Despite the extensive research assessing cultural competencies with other specific groups, little research exists examining psychologists' internal processes and competencies when working with LIEM communities. This is consistent with the general lack of representation of economically marginalized communities in psychology research, including in samples, theory, and assessment tools. Although excellent research exists examining outcomes in therapy for clients with LIEM and providing qualitative descriptions of clinicians' experiences with clients from LIEM communities (e.g., Santiago et al., 2012; Smith et al., 2013; Thompson et al., 2015), quantitative research on clinicians' internal processes when working with this population has relied on proxy measures of competency or creative methodologies (Clark et al., 2017; Hutchison, 2011; Thompson et al., 2014; Toporek & Pope-Davis, 2005). For example, general multicultural competency measures have been used in conjunction with scales assessing poverty beliefs or behaviors to make inferences regarding clinical competencies working with economically marginalized clients (Clark et al., 2017; Toporek & Pope-Davis, 2005). Unfortunately, due to the lack of appropriate assessment tools, this practice continues despite researchers' concerns that social class and economic marginalization are not well integrated into general multicultural competency curriculums and trainings (Clark et al., 2017). A scale specific to LIEM competencies is needed to assess the impact of these competencies in treatment and would help researchers

collect data describing clinicians' internal processes when working with clients experiencing LIEM. In both training and research, accurate assessment tools improve the capacity to study, understand, and implement the guidelines for working with clients with LIEM.

The Present Research

To fill this gap in the literature and capitalize on the growing momentum in the field to address LIEM competencies, the aim of these studies was to develop and validate the Clinical Practice Competencies for LIEM (CPC-LIEM) scale, a self-report measure for psychologists about their competency working with LIEM communities. I developed this scale across two studies. In Study 1, I created an initial pool of items that a panel of experts reviewed and revised for content validity and conducted an exploratory factor analysis to reduce and refine the scale, removing items that loaded poorly or were redundant. In Study 2, I tested the refined scale's factor structure using confirmatory factor analyses and tested the scale's relation to therapy processes and class-related constructs to assess construct validity.

Study 1

The purpose of Study 1 was to develop and refine scale items based on the competencies identified in the APA's (2019) *Guidelines for Professional Practice for People with Low Income and Economically Marginalization* and the LIEM psychotherapy literature. From this review, I developed an oversaturated initial pool of 79 items reflecting different aspects of LIEM clinical competencies (see Appendix J for items). A panel of experts in social class and psychotherapy research further reviewed items for face validity and provided feedback which I used to refine the pool to 38 items (Appendix K). I then administered the 38 items to a sample of 389 psychologists and conducted an exploratory factor analysis.

Methods Study 1

Participants

The Study 1 sample consisted of 389 psychologists. Participants ranged in age from 24 to 83 years old (M = 50.67, SD = 12.94), with 11 not reporting age. For gender, 224 identified as a woman (57.58%), 10 as a cis-woman (2.57%), 136 as a man (34.96%), five as a cis-man (1.29%), two as genderqueer (0.51%), one as agender (0.26%), one as female nonconforming (0.26%), one as "it's complicated" (0.26%), one as "none" (0.26%), and one as "YY" (0.26%). Most of the sample identified as White (n = 332, 85.35%), with others identifying as Black/African American (n = 13, 3.34%), Hispanic/Latino(a) (n = 11, 2.83%), Asian/Asian American (n = 7, 1.80%), Arab/Arab American/Middle Eastern (n = 1, 0.26%), and Jewish (n = 3, 0.77%). Of the 20 who identified as multiracial, six identified as Hispanic/Latino(a) and White (1.54%), four as Arab/Arab-American/Middle Eastern and White (1.03%), four as Native American/American Indian/First Nation and White (1.03%), three as Asian/Asian American and White (0.77%), two as Black/African American and White (0.51%), one as Native American/American Indian/First Nation, Hispanic/Latino(s), and White (0.26%). Of the 350 who disclosed their household income, the average income was $180,830 (median and mode = $150,000; SD = $189,192; range $13,000 to $2,500,000) for households ranging in size from 1 to 18 people (M = 2.79; SD = 1.52). Of the 383 participants who described their social class using the MacArthur Scale of Subjective Social Status on a scale of 0 to 10, with 10 representing the highest status, participants on average ranked their social class in childhood at 5.36 (SD = 2.10, range 0-10) and currently at 7.53 (SD =1.20, range 2-10). Table 1 describes the professional characteristics and experience of the participants.

Table 1.

The Professional Characteristics of Samples 1 and 2.

	Sample 1	Sample 2
Highest Degree		
Ph.D.	261 (67.1%)	203 (59.5%)
Psy.D.	116 (29.8%)	92 (27.0%)
Ed.D.	2 (0.5%)	8 (2.3%)
Other	0	6 (1.8%)
Professional Identity		
Clinical Psychologist	297 (76.3%)	241 (70.7%)
Counseling Psychologist	57 (14.7%)	49 (14.4%)
Neuropsychologist	6 (1.5%)	2 (0.6%)
School Psychologist	5 (1.3%)	5 (1.5%)
Forensic Psychologist	5 (1.3%)	6 (1.8%)
Child/Pediatric Psychologist	4 (1.0%)	0
Industrial and Organizational Psychologist	1 (0.3%)	0
Clinical Health Psychologist	0	1 (0.3%)
Behavior Analyst	0	1 (0.3%)
Current Setting		
Private Practice	150 (38.6%)	118 (34.6%)
Medical Clinic/Hospital/Primary Care	49 (12.6%)	66 (19.4%)
Academic Faculty	31 (8.0%)	20 (5.9%)
VA Medical Center	29 (7.5%)	15 (4.4%)
Other	27 (6.9%)	16 (4.7%)
Community Mental Health	23 (5.9%)	25 (7.3%)
University or College Counseling Center	19 (4.9%)	12 (3.5%)
Forensic/Justice	16 (4.1%)	14 (4.1%)
Inpatient Psychiatric Hospital	16 (4.1%)	9 (2.6%)
Primary or Secondary School	6 (1.5%)	9 (0.9%)
Department Clinic	4 (1.0%)	5 (1.5%)
Residential/Group Home	3 (0.8%)	3 (0.9%)
Retired	3 (0.8%)	0
Child or Family Guidance Center	1 (0.3%)	1 (0.3%)
Clinical Activities		
Individual therapy	324 (83.3%)	262 (76.8%)
Diagnostic Assessment	246 (63.2%)	219 (64.2%)
Consultation	189 (48.6%)	179 (52.5%)
Supervision of other practitioners	182 (48.6%)	138 (40.5%)
Family or couples therapy	134 (34.4%)	97 (28.4%)
Other Assessment	118 (30.3%)	94 (27.6%)
Group therapy	111 (28.5%)	57 (16.7%)
Milieu therapy	15 (3.9%)	10 (2.9%)

Table 1 continued

Supervisory Trainer Roles		
Supervising licensed practitioners	140 (36.0%	91 (26.7%)
Supervising unlicensed trainees	197 (50.6%)	135 (39.6%)
Course instructor in a graduate clinical program	49 (12.6%)	33 (9.7%)
Course instructor in another type of program	41 (10.5%)	29 (8.5%)
Providing workshops/trainings for other practitioners	181 (46.5%)	119 (34.9%)
Providing workshops/trainings for non-practitioners	122 (31.4%)	73 (21.4%)
Other	45 (11.6%)	34 (10.0%)
None	68 (17.5%)	81 (23.8%)
Years in Practice	*M* = 22.40 (*SD* = 12.48, median = 20, *n* = 378)	*M* = 23.47 (*SD* = 12.32, median = 22, *n* = 302)
Number of Clients Last Year	*M* = 146.96 (*SD* = 232.21, median = 70, *n* = 350)	*M* = 120.93 (*SD* = 186.93, median = 60, *n* = 275)
Rurality of Setting (0 = very rural, 10 = very urban)	*M* = 6.87 (*SD* = 2.52, *n* = 378)	*M* = 6.93 (*SD* = 2.51, *n* = 302)
Percentage of Clients with LIEM Over Last Year	*M* = 44.2% (*SD* = 29.1%, *n* = 362)	*M* = 46.1% (*SD* = 28.7%, *n* = 193)
Percentage of Clients with LIEM Over Career	*M* = 53.66% (*SD* = 23.1%, *n* = 375)	*M* = 54.5% (*SD* = 24.4%, *n* = 307)

Measures

Demographics and Professional Experience. Participants reported their demographic information, such as race, gender, and age. They also reported their professional experience, including their education level, licensure level, profession (e.g., counseling psychologist, clinical psychologist, school psychologist, etc.), years of practice, current and past clinical settings (e.g., hospital, community mental health center, private practice, etc.), region of clinical practice (e.g., rural, urban), theoretical orientation, and client population (e.g., "what percentage of your clients would you characterize as LIEM?").

Subjective Social Status. Subjective social class in childhood and currently were separately assessed using the one-item MacArthur Scale of Subjective Social Status (Adler et al., 2000). Participants reported their subjective social class currently and retrospectively for their childhood social class. They ranked where they perceive themselves to stand relative to the U.S. population on a scale from 0 to 10 using the image of a ladder as a guide, with the top of the ladder indicating higher social status (with 10 representing the highest rank). Scores on the MacArthur Scale of Subjective Social Status moderately correlate with income (r = .39) and education (r = .37), indicating that subjective social status is distinct but related to objective measures of social class (Operario et al., 2004). Similarly, subjective social status predicts health and psychological outcomes above and beyond household income, further evidencing that subjective social class is a distinct construct from objective measures of social class (Cundiff et al., 2013; Operario et al., 2004). The MacArthur Scale of Subjective Social Status has been found to have adequate test-retest reliability over six months (r_s = .62; Operario et al., 2004).

Household Income and Size. Participants reported their household income and the number of members in their household.

Clinical Practice Competencies for LIEM (CPC-LIEM). Participants responded to the initial pool of 38 items using a five-point Likert-like scale ranging from *Strongly Disagree* (1) to *Strongly Agree* (5). See Appendix K for items.

Reactions to the CPC-LIEM Scale. Participants described what they believed the CPC-LIEM scale assessed in an open-ended item. Then, they were informed of the scale's purpose and asked to respond to items about (1) how helpful they believed this scale would be for supervision, training, and research, as well as (2) how likely they would be to use this scale after it is developed. Responses were rated using a 5-point response scale ranging from *1 = strongly disagree* to *5 =*

strongly agree. An additional open-ended item asked participants for general feedback on the scale. See Appendix L for items.

Procedure

Scale items for Study 1 were developed using deductive item generation methodology (Clark and Watson 1995; DeVellis, 2003). An initial item pool was generated based on the APA's practice guidelines with clients with LIEM and an intensive literature review. Specific competencies reflected in these items include self-awareness of personal biases, addressing barriers to treatment associated with social class, acknowledgement of social class in client care and supervision, and awareness of differences in how clients experiencing LIEM present in therapy (see Appendix J for initial item pool). Next, I contacted members of the APA task force who developed the practice guidelines for their feedback. None were available to review scale items, so three psychologists with expertise in either psychotherapy research with clients experiencing LIEM or social class research provided comprehensive feedback on individual items, resulting in the item pool being reduced and revised to better reflect the intended construct.

After I finalized the items and received IRB approval, I recruited participants to complete an online survey. I recruited psychologists using licensing board lists of all licensed psychologists in 17 states/districts in the United States. The 17 states/districts were selected due to 1) representing different regions of the US, 2) having publicly accessible lists of licensees, and 3) having email information for licensees. State/districts included Arkansas, District of Columbia, Kansas, Kentucky, Michigan, Minnesota, Nebraska, Nevada, North Carolina, North Dakota, New York, Ohio, Oregon, Rhodes Island, Utah, Wisconsin, and Wyoming. This sampling method invited a broad spectrum of practicing psychologists to participate. Half of the psychologists from each state/district were randomly selected for recruitment for Study 1 using a random numbers generator.

Psychologists were eligible to participate if they were licensed as a doctoral level psychologist within the United States, 18 years or older, and had any experience working with clients with LIEM backgrounds. After consenting to participate in the study, participants responded to the scale items, provided demographic, social class, and professional experience information, and reported their reactions to the initial pool of survey items.

Of the 521 participants who responded to the online survey, 76 did not answer any of the new scale items, 25 failed the validity check, and 15 skipped the validity check item. Another 16 participants skipped one or more items of the new scale, leaving a final sample of 389 participants who completed all items of the new scale and who passed the validity check. This sample size met the conservative criteria of ten participants per item to conduct an EFA (Worthington & Whittaker, 2006).

Analysis Plan

To explore the factor structure of the scale, I used participants' responses to the initial pool of items to conduct a parallel analysis and series of exploratory factor analyses (EFA) using principle-axis factoring and promax rotation because any potential factors are expected to be correlated. To test the number of factors using a parallel analysis, I used principle-axis factoring to be consistent with my plan for the EFA. For the principal axis parallel analysis, I used 1,000 random data sets and compared the eigenvalues for a potential factor within the participant data set with the eigenvalues from the random data set to determine the appropriate number of factors. For the EFA, I used the following criteria to eliminate items: factor loadings less than .40, factor loadings greater than .32 on multiple factors, communalities below .40, high correlations with other items, and low correlations with the total score (Worthington & Whittaker, 2006). I also

evaluated item factor loading during the EFA for conceptual consistency and content validity to eliminate items (Worthington & Whittaker, 2006).

Results

Exploratory Factor Analysis

The Kaiser-Meyer-Olkin measure was high, KMO = .903, suggesting the sample size was adequate for these analyses. Before conducting EFA, I removed items 31 and 37 due to their high correlations with other items (item 20 at r = .829 and item 38 at .794, respectively). The next highest correlation between any two items was less than r = .65. An EFA of the remaining items resulted in nine factors with eigenvalues over 1, accounting for 60.96% of the variance. Items 3, 7, 19, 20, 21, 28, 32, and 34 were removed due to factor loadings less than .40 and item 10 was removed due to cross loadings of greater than .32.

The second EFA resulted in seven factors accounting for 60.11% of the variance and item 11 was removed due to low factor loading and items 35 and 18 were removed due to cross loading on more than one factor. Item 14 was removed due to poor factor loading and item 17 due to cross loadings after the third EFA (six factors, 59.18% of the variance), item 22 was removed due to a poor factor loading after the fourth EFA (6 factors, 61.43% of the variance), and items 12, 25, 38, and 5 were removed in the fifth, sixth, and seventh EFAs due to low communalities. Despite communalities below .40, items 15, 16, 24, 26, and 27 were kept due to representing key aspects of the construct (self-reflection and practices that increase access to care), having strong factor loadings, and no cross loadings. This resulted in a five-factor solution accounting for 63.93% of the variance. To increase brevity and simplicity of the scale, the lowest loading items on the first factor (items 8, 9, and 29) were removed.

The final EFA on the remaining 14 items continued to show a five-factor solution, accounting for 69.16% of the variance (see Table 2). The five-factors represented Seeking Knowledge (factor loadings = .710-.854; α = .801), Addressing Social Class with Clients (factor loadings = .655-.804; α = .791), Providing Supervision and Training (factor loadings = .525-.962; α = .750), Increasing Access to Care (factor loadings = .582-.616; α = .629), and Self-Reflecting in Clinical Practice (factor loadings = .674-.744; α = .649). Principal axis parallel analysis using 1,000 random data sets with the 14 items corroborated the five-factor solution. All items had factor loadings at .525 or higher and no item had cross loadings above the .32 cut-off. Items 24, 26, 27 (factor four) had communalities below .40, but higher than .359. Although Worthington and Whittaker (2006) recommend a cut off criteria of .40 for low communalities, Child (2006) suggested a lower criteria of .20 for removing items. Because the three items in this factor appear to represent a salient aspect of LIEM competencies (increasing access to care) and given the mixed recommendations for identifying low communalities, these items were tentatively kept with the plan to further assess their utility in Study 2.

Participant Feedback

Several participants provided feedback in open-ended responses reporting confusion on how to respond to some items using the Strongly Agree to Strongly Disagree scale, with one participant explicitly recommending that the response scale be changed to a frequency scale (Never to Always). Given this feedback from participants, it is possible that response error contributed to the low communalities in some items.

When asked about the perceived utility of the scale, the majority reported it would be helpful as part of supervision (30.3% Strongly Agree, 46.8% Somewhat Agree, 12.9% Neither Agree nor Disagree, 4.9% Somewhat Disagree, 2.1% Strongly Disagree), clinical trainings (40.9%

Table 2

Final Item Loadings from Exploratory Factor Analysis

Factor Names and Items	Loadings				
	1	2	3	4	5
Seeking Knowledge					
1. I seek opportunities to learn about how to address economic barriers in treatment.	.854				
2. I seek opportunities to learn about classism in health care.	.721				
3. I seek opportunities to learn about evidence-based practices for working with clients seeking employment.	.710				
Addressing Social Class with Clients					
4. I discuss with clients how social class may influence decisions related to schooling or employment.		.804			
5. I discuss with clients how economic inequality affects their health.		.762			
6. I bring up classism with clients.		.655			
Providing Supervision and Training					
7. I discuss social class in my supervision or teaching materials.			.962		
8. I lead discussions to help trainees/supervisees understand classism.			.531		
9. I reflect on the ways that classism affects the training I provide.			.525		
Increasing Access to Care					
10. I provide pro-bono (free) services.				.616	
11. I provide flexible service hours.				.586	
12. I provide services to people who are uninsured through flexible pay scale options.				.582	
Self-Reflecting in Clinical Practice					
13. I reflect on my reactions to hearing about clients' experiences of poverty.					.744
14. I reflect on the assumptions I have made about clients based on their social class.					.674

Note: Exploratory factor analysis with principal axis factoring and promax rotation.

Strongly Agree, 43.7% Somewhat Agree, 7.5% Neither Agree nor Disagree, 4.9% Somewhat Disagree, 1.3% Strongly Disagree); and research (37.5% Strongly Agree, 35.7% Somewhat Agree, 13.9% Neither Agree nor Disagree, 3.1% Somewhat Disagree, 2.1% Strongly Disagree). When reflecting on their personal practice, the majority indicated that their supervision would benefit from this scale (28.3% Strongly Agree, 37.3% Somewhat Agree, 23.9% Neither Agree nor Disagree, 2.8% Somewhat Disagree, 2.1% Strongly Disagree) and the trainings they provide would benefit from including this scale (23.1% Strongly Agree, 28.5% Somewhat Agree, 30.8% Neither Agree nor Disagree, 8.0% Somewhat Disagree, 3.6% Strongly Disagree). In reflecting on if their personal research would benefit from including this scale, only 11.6% Strongly Agreed and 14.1% Somewhat Agreed, with the majority reporting Neither Agree nor Disagree (45.8%), Somewhat Disagree (8.2%), or Strongly Disagree (6.9%).

Study 2

The purpose of Study 2 was to confirm the factor structure of the scale using a unique sample and examine the validity evidence for the CPC-LIEM. In Study 2, I assessed the construct validity of the CPC-LIEM by examining the relation between scores on the scale and scales assessing attitudes related to social class and classism, multicultural counseling competency, and therapeutic processes with clients experiencing LIEM. The variables selected to assess the validity of the CPC-LIEM were informed by the social class worldview model because of the model's focus on psychologists' internal processes and beliefs. The social class worldview model (Liu, 2011, 2012; Liu et al., 2013) provides a theoretical basis for conceptualizing clinicians' internal processes when working with clients experiencing LIEM by attending to clinicians' subjective social class worldviews – the beliefs, values, and assumptions that shape how they understand social class. Individual attributions regarding the causes of poverty and downward classism are

constructs that are theoretically expected to be related to psychologists' work with economically marginalized clients (Liu, 2011; 2012). Additionally, I assessed objective and subjective measures of psychologists' social class and economic backgrounds as well as their experience working with clients experiencing LIEM to test for group differences in scores on the scale in development. Based on this information, I tested the following hypotheses related to the construct validity of this scale:

- Psychologists with lower scores on the LIEM competency scale will endorse greater classist attitudes and be more likely to attribute poverty to internal – rather than external – causes.
- Psychologists with higher scores on the LIEM competency scale will have greater experience working with clients experiencing and be more likely to report personal experience with low social class and low income.

In terms of therapy-specific internal processes, psychologists' self-reported hope for clients (Bartholomew et al., 2020) and their perceptions of working alliances with clients (Flückiger et al., 2018) are correlated with decreased symptom distress. Because of the strong relations between these therapeutic processes and client outcomes, these constructs will preliminarily assess the predictive validity of this scale for clinical competencies with LIEM in clinical practice, consistent with the methods used to validate other clinician scales (Bartholomew et al., 2020). Measuring general cultural competency also afforded an opportunity to assess the CPC-LIEM's construct validity. Because providers tend to present themselves in an overly positive light on similar self-report scales, psychologists' social desirability was also measured and controlled when testing validity (Kim et al., 2003). To further assess the scale's validity, I tested the following additional hypotheses:

- Because greater cultural counseling competencies will predict positive therapeutic processes, clinicians' scores on the LIEM competency scale will be positively related to working alliance and hope for clients experiencing LIEM.
- LIEM competencies will be associated with general multicultural counseling competency, but will account for variance in outcomes (e.g., working alliance, hope, and class related attitudes) above and beyond what is accounted for by general multicultural competency and social desirability.

Methods Study 2

Participants

The Study 2 sample consisted of 341 psychologists. Participants ranged in age from 25 to 85 (M = 52.85, SD = 13.74). The majority identified as women (n = 218, 63.93%), with six specifying cis-gender woman (1.76%), 105 identifying as a man (30.50%), one specifying cis-gender man (0.29%), one identifying as agender, one as genderqueer, and one as non-binary. As with the first sample, most psychologists identified as White (n = 281, 82.40%), with others identifying as Black/African American (n = 15, 4.40%), Hispanic/Latino(a) (n = 13, 3.81%), Asian/Asian American (n = 11, 3.23%), Arab/Arab American/Middle Eastern (n = 2, 0.59%), Pacific Islander (n = 1, 0.29%), Native American/American Indian/First Nation (n = 1, 0.29%), and unspecified other race (n = 2, 0.59%); of the 11 who identified as multiracial, two identified as Asian/Asian American and White, two as Hispanic/Latino(a) and White, three as White and unspecified other race, one as Arab/Arab American/Middle Eastern and White, one as Black/African American and Hispanic/Latino(a), one as Black/African American and White, and one as Native American/American Indian/First Nation and White. The average household income

was $194,518 (median = $169,000; *SD* = $134,812; range $12,000 to $1,500,000) for households ranging in size from 1 to 10 people (*M* = 2.73; *SD* = 1.33). Adjusted household income, household income divided by the square root of household size, was on average $122,908 (*SD* = 83,570). Participants described their subjective social class on a scale of 0 to 10, with 10 representing the highest status, as an average of 5.27 (*SD* = 2.05) in childhood and 7.58 (*SD* = 1.24) currently. Table 1 describes the professional characteristics and experience of the sample. All participants reported having seen clients in the last year (*M* = 120.93, *SD* = 186.93).

Measures

Demographics and Professional Experience. Participants responded to the same demographic and professional experience questions asked in Study 1.

Clinical Practice Competencies for LIEM (CPC-LIEM). Participants responded to the refined 14 items from the final EFA in Study 1. Based on participant feedback in Study 1, the anchors for the five-point Likert-type response scale was changed to 1 = *Never* to 5 = *Always* and a "Not Applicable" option was added to decrease error in participant responses.

Reactions to the CPC-LIEM Scale. Participants provided feedback using the same questions as Study 1.

Subjective Social Status. Just as in Study 1, subjective social class in childhood and currently was separately assessed using the one-item MacArthur Scale of Subjective Social Status (Adler et al., 2000).

Adjusted Household Income. Participants reported their household income and the number of members in their household. Adjusted household income was calculated by dividing the total household income by the square root of household size (Square Root Equivalency Scale; Cronin, et al., 2012).

Attributions to the Causes of Poverty. Two subscales of the Attributions to the Causes of Poverty Scale (ACPS; Cozzarelli et al., 2001) was used to assess the extent to which participants believe the causes of poverty to be external (e.g., "*prejudice and discrimination in hiring*") or internal ("*loose morals among poor people*"). Responses to 13 items are rated using a 5-point Likert-type response scale ranging from 1 = *not at all important as a cause of poverty* to 5 = *extremely important as a cause of poverty*, with higher scores representing greater endorsement of that factor as a cause of poverty. In the scale development study, greater endorsement of external attributions for poverty was associated with greater positive feelings towards people living in poverty, whereas endorsement of internal attributions was associated with negative stereotypes towards those living in poverty (Cozzarelli et al., 2001). Scale scores have acceptable internal consistency, for both external (α = .79) and internal (α = .75) attributions (Cozzarelli et al., 2001).

Classism. The Classism Attitudinal Profile (CAP; Colbow et al., 2016) is a self-report measure that assesses both downward classism (against lower social classes) and upward classism (against higher social classes), consistent with the social class worldview model (Liu, 2011). This scale consists of 12-items responded to using a 5-point Likert-type response scale (1 = *strongly disagree* to 5 = *strongly agree*). The CAP has two subscales, downward classism ("*People who are poor try to abuse the system*") and upward classism ("*More often than not, wealthy people are selfish*"), with 6-items for each subscale (Colbow et al., 2016). Participants were only asked to complete the downward classism subscale, due to this study's specific focus on working with clients experiencing economic marginalization. Evidencing the construct validity of the downward classism subscale, those reporting higher subjective social status have been found to report greater downward classism (Colbow et al., 2016). The CAP downward classism subscale has adequate

test-retest reliability after two weeks (r = .75) and internal reliability (α = .76 to .80; Colbow et al., 2016).

General Multicultural Counseling Competency. Participants responded to the Multicultural Awareness Knowledge Skills Survey–Counselor Edition–Revised (MAKSS-CE-R; Kim et al., 2003). The MAKSS-CE-R is a 33-item general measure of self-reported multicultural competency in therapy. Participants responded using a 7-point Likert-type response scale (1 = *not at all trust,* 7 = *totally true*), with higher scores indicating greater multicultural competency. The MAKSS-CE-R has three subscales in line with the three domains of competency (Sue et al., 1982): awareness (*"The human service professions, especially counseling and clinical psychology, have failed to meet the mental health needs of ethnic minorities"*), knowledge ("*At the present time, how would you rate your understanding of 'racism'*"), and skills ("*How would you rate your ability to effectively secure information and resources to better serve culturally different clients?*"). Respondents who have completed multicultural counseling graduate courses and have more experience counseling racially or ethnically different clients have been shown to score higher on the MAKSS-CE-R (Kim et al., 2003). MAKSS-CE-R scores also moderately correlate with other measures of multicultural competency, including the Multicultural Counseling Knowledge and Awareness Scale (r = .35-67), and the Multicultural Counseling Inventory, (r = .19-.60; Kim et al., 2003). Internal reliability statistics for the MAKSS-CE-R have been reported as adequate for the total score (α = .82) and all the subscales (awareness, α = .71; knowledge, α =.87; skills, α = .87; Kim et al., 2003).

Working Alliance. Participants were asked to think of a recent client experiencing LIEM that they worked with when responding to the Working Alliance Inventory-Short form Revised-Therapist version (WAI-SR-T; Hatcher & Gillaspy, 2006; Hatcher et al., 2019). The WAI-SR-T

assesses the therapists' perception of their relationship with the client using 12-items along two factors: goal/task and bond. Goal items assess agreement on therapy goals (e.g., "___ *and I have collaborated on setting goals for these sessions*"), task items assess collaboration on therapy tasks (e.g., " ___ *and I both feel confident about the usefulness of our current activity in therapy*"), and bond items assess the connection between therapist and client (e.g., "___ *and I respect each other*"). The use of the total score is supported by the bifactor structure of the scale and high explained common variance (ECV) estimate, with about 81% of the item variance attributable to a general working alliance dimension (Hatcher et al., 2019). Participants respond using a 5-point Likert-type response scale (1 = *seldom* to 5 = *always*), with higher scores representing a stronger perception of the working alliance with the client. The WAI-SR-T has been shown to perform just as well as other versions of the working alliance inventory for therapists (Hatcher et al., 2019). Internal reliability was evidenced to be adequate by a Cronbach's alpha of .91 for the total score, and Cronbach's alphas ranging from .85 to .90 for the subscales (Hatcher & Gillaspy, 2006; Hatcher et al., 2019).

Therapist Hope for Clients. Participants were asked to think of the same client that they worked with who had a LIEM background when they completed the WAI, when responding to the Therapist Hope for Clients Scale (THCS; Bartholomew et al., 2020). This measure was developed specifically to assess therapist hope in the context of therapy and has three factors: goals identification ("*I know what my client wants to work on in counseling*"), commitment to the client ("*I am motivated to help this client resolve their concerns through counseling*"), and belief in the client ("*I believe my client experiences the impact of counseling most days outside of sessions*"). The bifactor structure supports the use of the total score in addition to subscale scores (Bartholomew et al., 2020). The THCS consists of ten items responded to using an 8-point

continuous response scale (1 = *definitely false* to 8 = *definitely true*), with higher scores representing greater hope for the client. The validity of the THCS is supported by its ability to predict clinically relevant variables such as working alliance and therapists' self-efficacy above and beyond a general hope measure (Bartholomew et al., 2020). Internal reliability statistics reported in the initial validation study were α = .89 for the total score, α = .85 for goals identification, α = .80 for commitment to the client, and α = .82 for belief in the client (Bartholomew et al., 2020).

Estimate of Client Improvement. Participants estimated the improvement in therapy of the client they identified with a LIEM background using a single-item question "please estimate your client's change in therapy so far" (Hatcher & Gillaspy, 2006). Response options ranged -4 to 4 (-4 = *very much worse*, 0 = *no change*, 4 = *very much better*). The single-item measure has been shown to correlate with a longer 4-item measure assessing therapists' estimates of client improvement (r = .62-.74), and modestly correlate with client-reported working alliance (r = .17; Hatcher & Gillaspy, 2006).

Social Desirability. The 13-item Marlowe-Crowne Social Desirability Scale – Short Form C (MC-DSD; Reynolds, 1982) was used to assess participants' response style, specifically to assess if they responded in a way that presented themselves in an overly positive light. Participants rated statements (e.g., "I'm always willing to admit it when I make a mistake") as either true or false. The 13-item MC-DSD Short Form C correlates with the full 33-item scale (r = .93), and similar measures of response style, including the Minnesota Multiphasic Personality Inventory (MMPI) validity scales (L, r = .59; F, r = .-52; and K, r = .54; Reynolds, 1982; Robinette, 1991). Test-retest reliability correlation after six weeks was .74 (Zook & Sipps, 1985). The internal

reliability of the MC-DSD Short Form C was reported as adequate, with a Kuder-Richardson Formula 20 statistic of .76 (Reynolds, 1982).

Procedure

Study 2 used a separate, second sample of practicing psychologists to confirm the factor structure, assess internal consistency, evaluate group differences in responses, and test the construct and predictive validity of the scale. To collect a unique second sample for Study 2, I sent recruitment emails to the second half of the randomly selected licensees from each of the 17 state/district licensing board lists with the same eligibility criteria. All data were collected using online surveys. After consenting to participate in the study, participants completed the CPC-LIEM scale and provided information regarding their demographics and professional experiences. Participants then completed scales to assess construct validity. Participants were also asked to provide feedback on the CPC-LIEM scale. Of the 359 psychologists who responded to the survey, 11 failed the first validity check, three skipped the first validity check, and four failed the second validity check, leaving a final sample of 341 psychologists.

Analysis Plan

With the second sample, I conducted a confirmatory factory analysis (CFA) to find the best fitting factor structure using Mplus software (Muthén & Muthén, 2012). Specifically, I conducted a CFA with maximum likelihood estimation to test the correlated five factor structure identified in the EFA and then compare the factor structure with a one factor model, an orthogonal model, a bifactor model, and a higher order factor model. To assess the fit of the different factor structures, I used the following standards: root mean squared error of approximation (RMSEA) values less than .06, comparative fit index (CFI) values equal or greater to .95, standardized root mean square

residual (SRMR) values equal to or less than .08, and lower Akaiki's Information Criteria (AIC) values indicating a better fitting model (Hu & Bentler, 1999; Kline, 2005). To assess internal consistency, I used Cronbach's alpha and the Spearman-Brown coefficient for the two-item subscale.

To assess construct validity, I used analysis of variance (ANOVA) to examine the CPC-LIEM score differences across clinical setting, professional field, race, gender, and Pearson's correlations to examine the relation between CPC-LIEM scores and clinical experience with economically marginalized clients, personal social class, class-related attitudes, and general multicultural competency. To assess if CPC-LIEM scores account for variance in class-related attitudes (ACPC, CAP) and therapeutic processes (WAI, THCS, ECI) above and beyond what is captured by general multicultural competency and social desirability, hierarchical linear regressions was used to predict class-related attitudes and therapeutic variables, with the MAKSS-CE-R (assessing general multicultural competency) and the MC-DSD (assessing social desirability) entered in the first step, and CPC-LIEM entered in the second step.

Results

Preliminary Analysis

To reduce error in participants' responses, they were allowed to select "not applicable" to CPC-LIEM scale items and were instructed to only select this item if it was not possible for them to do what the item described given their professional role (e.g., offering flexible pay options if they work in a jail where clients do not pay for services). For analysis, "not applicable" responses were recorded as missing data (see Table 3 for Study 2 Item Descriptive Statistics). I assessed the data for patterns in missingness by creating a dummy variable identifying which participants were

missing data on the CPC-LIEM scale and found no differences on main study variables (demographics and validity measures) between those who were missing or not missing data. There was a significant difference in missingness based on current professional setting, $\chi^2(3) = 9.72$, $p = .021$, with only Academic Faculty having data missing at a lower rate than would be expected. However, in the results, current professional setting was only tested in the group difference tests and did not emerge as a significant independent variable. Consequently, I used maximum likelihood with robust standard errors (MLR) to calculate estimates in the CFA. Additionally, I tested correlations between the two-item factor (Factor 5) and other items, which is consistent with Worthington and Whittaker (2006) recommendations that two-item factors should have items that correlate well with each other (e.g., $r = .7$) and do not correlate strongly with other items; the two Factor 5 items correlated with each other at $r = .69$ and correlated with other items at $r = .00$-$.43$. For group difference comparisons, the medical clinic/hospital, VA hospital, and inpatient hospital were collapsed into "medical and hospital settings" and community mental health, child guidance center, department clinic, and university mental health centers were collapsed into "community settings." Additionally, psychologists who did not identify as Counseling or Clinical Psychologists (e.g., forensic psychologists, neuropsychologists) were collapsed into "other psychologists."

Table 3.

Study 2 Item Descriptive Statistics

Item	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Missing Count	20	16	43	12	8	6	67	73	57	53	31	60	7	8
M	3.32	3.18	2.70	2.98	3.07	2.93	3.69	3.20	3.69	2.72	3.60	3.19	3.76	3.61
SD	1.10	1.06	1.26	1.00	1.01	1.03	0.93	1.10	0.96	1.12	1.11	1.31	0.95	0.95
Skewness	-0.29	-0.12	0.20	0.09	-0.03	-0.01	-0.27	-0.25	-0.51	0.03	-0.51	-0.12	-0.60	-0.53
Kurtosis	-0.54	-0.32	-0.99	-0.28	-0.30	-0.47	-0.29	-0.54	0.06	-0.67	-0.42	-1.04	0.06	0.08

Confirmatory Factor Analysis

Table 4 summarizes the fit indices of the different models. The model identified in the EFA, the correlational five-factor model, evidenced good fit to the data, CFI = .959, RMSEA = .051, 90% CI [.037, 0.064], SRMR = 0.041, $\chi 2$ (67) = 125.49, $p < .001$, and AIC = 11,158.47. The higher order model also evidenced good fit, CFI = .959, RMSEA = .049, 90% CI [.035, 0.063], SRMR = 0.043, $\chi 2$ (72) = 129.93, $p < .001$, and AIC = 11,154.02. The higher order and oblique models, including factor loadings and factor correlations, are presented in Figures 2 and 3. The orthogonal and single factor models evidenced poorer fit and the bifactor model did not converge, even when trying several strategies to explore the cause of the issue, indicating it was not appropriate for the data.

The higher order model evidenced slightly better fit than the oblique model, with lower AIC values; however, the meaningfulness of these differences is likely negligible. Subsequently, evidence of validity for both subscale scores and the total score were tested to assess if a higher order factor is representing a meaningful aggregate construct of clinicians' competency working with clients from LIEM backgrounds. Cronbach's alpha for the total and subscales were Total α = .86; Seeking Knowledge α = .80; Addressing Social Class with Clients α = .83; Providing Supervision and Training α = .76; Increasing Access to Care α = .52; Self-Reflecting in Clinical Practice α = .81 and *Spearman-Brown coefficient* = .81.

Table 4

Comparison of Fit Indices for CFA Models

	RMSEA [90% CI]	CFI	SRMR	AIC	$\chi 2$	*df*
Five-factor – Orthogonal	.135 [.124-.146]	.663	.265	11621.75	554.53*	77
Five-factor – Oblique	.051 [037-.064]	.959	.041	11158.47	125.49*	67
General factor	.112 [.102-.123]	.767	.077	11466.45	407.56*	77
Higher order	.049 [.035-.062]	.959	.043	11154.02	129.93*	72

Note: using maximum likelihood and criteria for acceptable fit used were root mean squared error of approximation (RMSEA) values less than .06, comparative fit index (CFI) values equal or greater to .95, standardized root mean square residual (SRMR) values equal to or less than .08, lower Akaike's Information Criteria (AIC), and statistically significant chi-square { $\chi 2$) difference test.

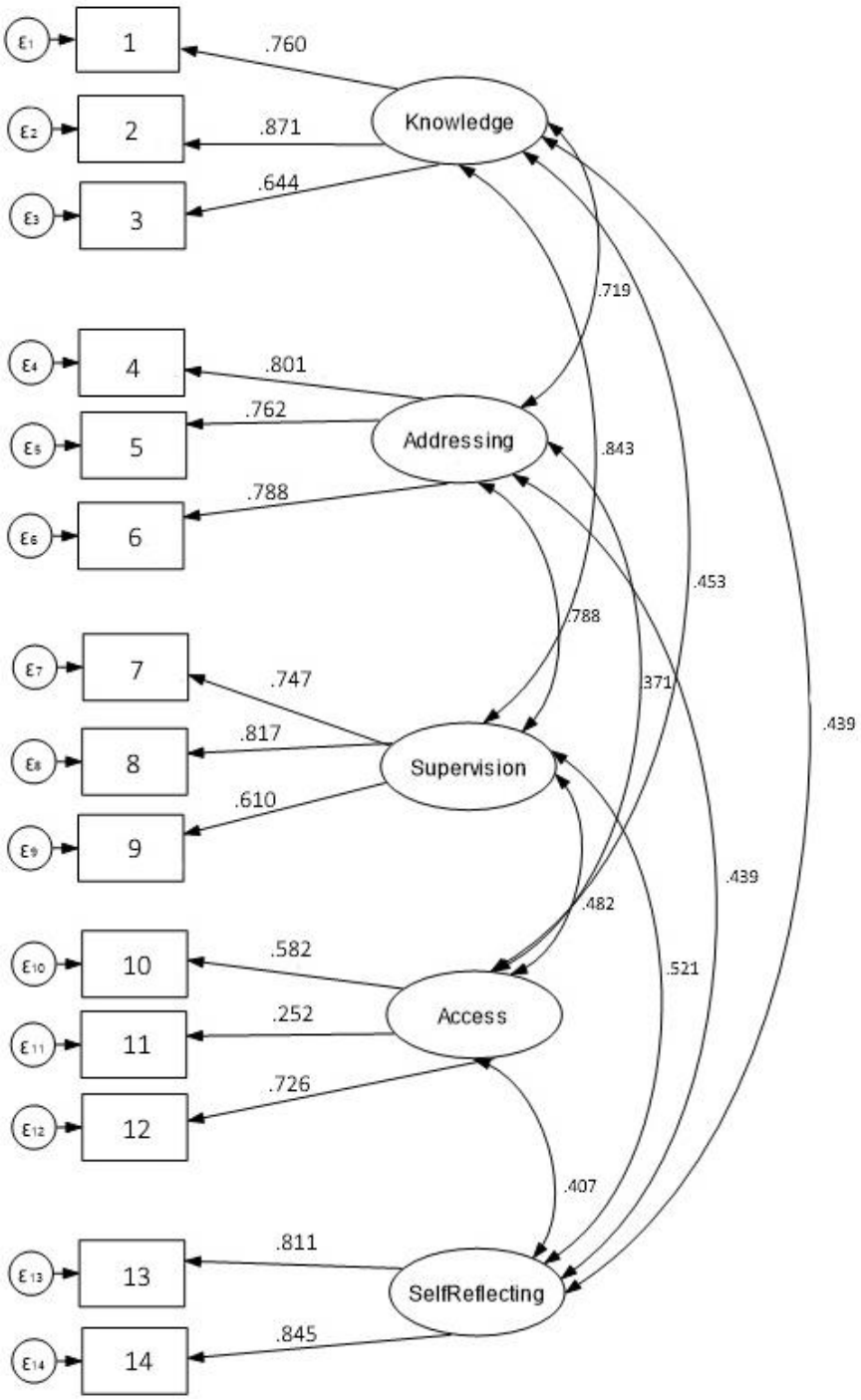

Figure 2. Correlational Five-Factor Model Tested in the CFA

Note: Correlational five factor model evidenced good fit to the data, CFI = .959, RMSEA = .051, 90% CI [.037, 0.064], SRMR = 0.041, $\chi 2$ (67) = 125.49, $p < .001$, and AIC = 11158.47. All reported figures are significant at $p > .001$.

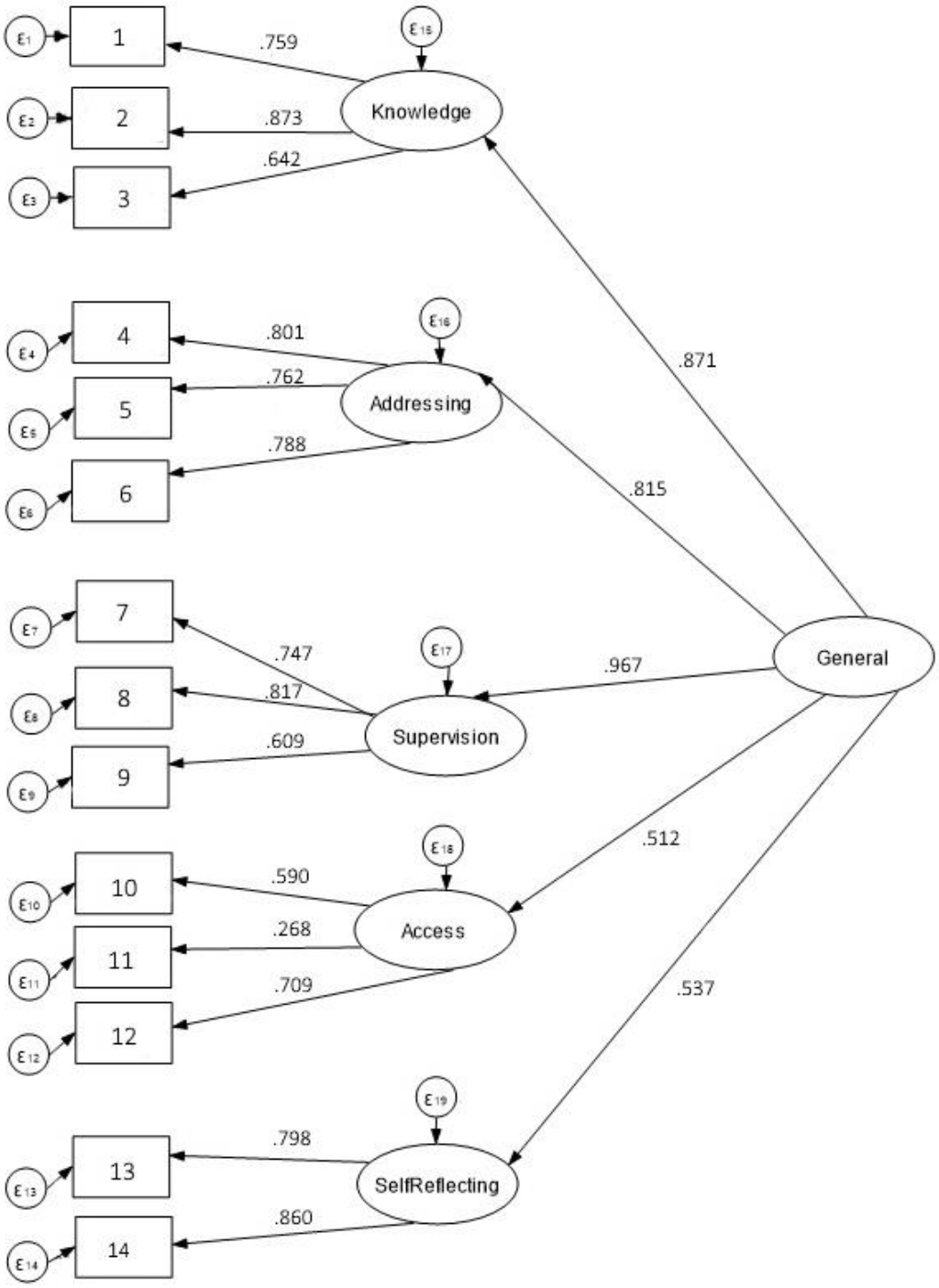

Figure 3. Higher Order Model Tested in the CFA

Note: The higher order model also evidenced good fit, CFI = .959, RMSEA = .049, 90% CI [.035, 0.063], SRMR = 0.043, $\chi 2$ (72) = 129.93, $p < .001$, and AIC = 11154.02. All reported figures are significant at $p > .001$.

Validity Analysis

Group Differences. To assess for differences in CPC-LIEM scores based on demographics or professional experience, I used t-tests, one-way ANOVAs, and Pearson's correlations. Average scores on Factor 3: Providing Supervision and Training differed between men (M = 3.36, SD = 0.85) and women (M = 3.62, SD = 0.79), $t(237,151) = 2.37$, p = .019, d = 0.32. No other mean scores differed by gender and the underrepresentation of other genders prevented analysis of gender through ANOVA.

In terms of differences in professional backgrounds, there were no significant differences in mean scores based on degree (PhD, PsyD, EdD). Mean scores on Factor 2: Addressing Social Class with Clients and Factor 5 Self-Reflecting in Clinical Practice differed by professional identity. Counseling Psychologists (M = 3.34, SD = 0.84) had higher average scores on the Addressing Social Class with Clients subscale than Clinical Psychologists (M = 2.94, SD = 0.84, p = .009, d = 0.48), and Other Psychologists (M = 2.42, SD = 0.78, p = .002, d = 1.14), $F(2,291) = 7.38$, $p < .001$, $\eta 2 = .05$. Similarly, Counseling Psychologists (M = 3.98, SD = 0.84) had higher average scores on the Self-Reflecting in Clinical Practice subscale compared to Clinical Psychologists (M = 3.62, SD = 0.85, p = .023, d = 0.43), $F(2,294) = 2.68$, p = .025, $\eta 2$ = .03.

There were significant differences based on where psychologists practiced for mean scores on Seeking Knowledge ($F(3,264) = 3.02$, p = .030, $\eta 2$ = .03), Increasing Access to Care ($F(3,234) = 4.82$, p = .003, $\eta 2$ = .06); and Self-Reflecting in Clinical Practice ($F(3,293) = 2.26$, p = .025, $\eta 2$ = .03) subscales. On the Seeking Knowledge subscale, psychologists working in private practice (M = 2.82, SD = 0.95) on average had lower scores than those working in community settings (M = 3.22, SD = 0.78, p = .034, d = 0.46). On the Increasing Access to Care subscale, those working in community settings (M = 3.34, SD = .88, p = .004, d = 0.62) and those working in private practice (M = 3.22, SD = 0.74, p = .011, d = 0.53) had higher scores than those working in medical

and hospital settings (M = 2.78, SD = 0.92). On the Self-Reflecting in Clinical Practice subscale, those working in medical and hospital settings (M = 3.88, SD = 0.78) had higher average scores than those working in community settings (M = 3.49, SD = 0.90, p = .018, d = 0.46). Correlations (e.g., with age, years of practice, and proportion of caseload being from LIEM backgrounds) are described in Table 5.

Table 5

Correlations and Descriptive for Subscale and Total Scores

	Seeking Knowledge	Addressing Social Class with Clients	Providing Supervision and Training	Increasing Access to Care	Self-Reflecting in Clinical Practice	CPC-LIEM Total Score	*M*	*SD*	α
Age	-.01	0.07	0.12	.22***	.08	.22**	52.85	13.74	-
Adjusted Household Income	-.05	-0.07	-0.05	-.08	.07	-0.12	122,908	83,570	-
Social Class - Current	-.02	-0.07	-0.05	0.004	0.10	-0.04	8	1.24	-
Social Class - Childhood	-.17**	-.22***	-.22***	-0.11	-0.01	-.23**	5.27	2.05	-
Years of Practice	.02	.07	.21**	.23***	.06	.25**	23.47	12.32	-
Percentage LIEM Clients - Last Year	.19**	.06	.04	.08	-.02	.13	46.14	28.72	-
Percentage LIEM Clients - Career	.25***	.16**	.17*	.09	.04	.25**	54.54	24.35	-
Social Desirability	-.12	-.16**	-.03	-.09	.03	-.08	0.56	0.24	.77
General Multicultural Counseling Competency - Total	.27***	.33***	.36***	.20***	.29***	.41***	2.89	0.27	.81
General Multicultural Counseling Competency - Knowledge	.26***	.35***	.29***	.22***	.27***	.35***	9.21	0.44	.88
General Multicultural Counseling Competency - Awareness	-.01	.06	.03	-.06	.04	-.08	2.63	0.36	.63
General Multicultural Counseling Competency - Skills	.27***	.28***	.30***	.29***	.27***	.43***	3.14	0.37	.73

Table 5 continued

Classist Attitudes	-.11	-.11	-.06	.01	-.20***	-.06	1.79	0.77	.87
Estimated Client Improvement	.20***	.12	.20**	.17*	.15*	.25**	1.80	0.93	-
Therapist Hope for LIEM Client	.19**	.23***	.28***	.23***	.15*	.31***	6.21	1.08	.92
Working Alliance with LIEM Client	.15*	.18**	.21**	.21**	.12	.28***	3.84	0.63	.92
Internal Attributions of Poverty	-.03	-.09	-.04	.06	-.15**	-.05	1.88	0.69	.85
External Attributions of Poverty	.18**	.19***	.09	-.04	.18***	.15	3.78	0.66	.77

Note: * Correlation is significant at the 0.05 level (2-tailed); ** correlation is significant at the 0.01 level (2-tailed); *** correlation is significant at the 0.001 level (2-tailed).

Convergent Validity. Correlations between main study variables and CPC-LIEM total and subscale scores are summarized in Table 5. Higher competencies working with clients from LIEM background were associated with higher general multicultural counseling competency, r = .20-.41. In examining specific domains of general multicultural counseling competency, knowledge (r = .22-.35) and skills (r = .27-.43), but not awareness, were positively associated with CPC-LIEM scores. Seeking Knowledge was higher for psychologists from lower social class backgrounds in childhood (r = -.17), those who work more often with clients with LIEM backgrounds in the last year and over the course of their year (r = .19 and .25), those who attribute poverty to external or systemic causes (r = .18), and those who perceive themselves as working well with a recent client from a LIEM background in terms of perceived client improvement (r = .20) and therapist hope for the client (r = .19). Higher scores on the Addressing Social Class with Clients subscale were associated with lower childhood social class (r = -.22), greater experience with clients with LIEM backgrounds (r = .16), endorsement of external or systemic causes to poverty (r = .19), and working well with a recent client from a LIEM background in terms of hope (r = .23) and alliance (r = .18).

Providing Supervision and Training competencies with LIEM communities were greater for psychologists with lower childhood social class (r = -.22), more experienced psychologists (r = .21), and those who worked well with a recent client from a LIEM background in terms of perceived client improvement (r = .20), hope (r = .28), and alliance (r = .21). Psychologists who reported more behaviors consistent with Increasing Access to Care for LIEM communities tended to be older (r = .22), more experienced (r = .23), and perceive themselves as having greater hope for (r = .23) and alliance with (r = .21) a recent client from a LIEM background. Higher scores on the Self-Reflecting in Clinical Practice subscale were associated with less classist attitudes (r = -.20), greater external attributions to the causes of poverty (r = .18), and less internal attributions to the causes of poverty (r = .18). And finally, greater CPC-LIEM total scores were associated with older age (r = .22), lower childhood social class (r = -.23), more clinical experience (r = .25), more clinical experience with LIEM communities over their career (r = .25), as well as greater perceived client improvement (r = .25), hope (r = .31), and alliance (r = .28). Current social class and adjusted household income were generally high in the current sample and were not associated with higher CPC-LIEM scores.

Incremental Validity. Hierarchical regressions tested the CPC-LIEM's utility in predicting class-related attitudes (ACPC, CAP) and therapeutic processes (WAI, THCS, ECI) above and beyond what is captured by general multicultural competency and social desirability (see Table 6). CPC-LIEM total score explained an additional 3.5% of the variance in therapists' hope for a recent client of theirs experiencing LIEM, ΔR^2 = .035, p = .03; an additional 4.3% of the variance in therapists' working alliance with a recent client experiencing LIEM, ΔR^2 = .043, p = .014; and an additional 3.5% of the variance in clinicians' estimate of how much a recent client experiencing LIEM had improved in therapy, ΔR^2 = .035, p = .038. CPC-LIEM subscales did not

predict therapy processes above and beyond general multicultural competency and social desirability. CPC-LIEM subscales of Social Class with Clients and Self-Reflecting in Clinical Practice accounted for additional 14.7% of the variance in external attributions to the causes of poverty, $\Delta R^2 = .147$, $p < .001$. CPC-LIEM total and subscale scores did not explain additional variance in classist attitudes, which is consistent with the small to non-existent correlations between these variables.

Table 6.

Hierarchical Linear Regression Models

	Regression Coefficients				Model Statistics		
Model/Variable	*b*	*SE*	*β*	*p*	*F*(*df*)	*MSE*	R^2
			Therapist Hope				
Step 1					7.98 (2,112)	1.01	.125
Constant	3.33	1.07					
Social Desirability	-0.88	0.39	-0.20	.026			
MAKSS-CE-R	1.15	0.36	0.29	.002			
Step 2					7.04 (3,111)	0.98	.160
Constant	3.07	1.06			$\Delta R^2 = .035$, $p = .03$		
Social Desirability	-0.82	0.38	-0.19	.036			
MAKSS-CE-R	0.81	0.39	0.20	.038			
CPC-LIEM	0.37	0.17	0.21	.033			
			Therapist Hope				
Step 1					7.98 (2,112)	1.01	.125
Constant	3.33	1.07					
Social Desirability	-0.88	0.39	-0.20	.026			
MAKSS-CE-R	1.15	0.36	0.29	.002			
Step 2					3.53 (7,107)	0.99	.188
Constant	3.29	1.09		.003	$\Delta R^2 = .063$, $p = .150$		
Social Desirability	-0.85	0.40	-0.19	.035			
MAKSS-CE-R	0.70	0.39	0.17	.075			
Seeking Knowledge	-0.15	0.14	-0.12	.269			
Addressing Social Class with Clients	0.09	0.15	0.07	.564			
Providing Supervision and Training	0.25	0.16	0.19	.120			

Table 7. Continued

Increasing Access to Care	0.15	0.11	0.13	.160			
Self-Reflecting in Clinical Practice	0.04	0.14	0.03	.763			
			Working Alliance				
Step 1					7.65(2,123)	0.37	.111
Constant	2.72	0.60		<.001			
Social Desirability	-0.68	0.23	-0.26	.003			
MAKSS-CE-R	0.50	0.20	0.21	.013			
Step 2					7.40(3,122)	0.35	.154
Constant	2.45	0.60		<.001	$\Delta R^2 = .043$, $p = .014$		
Social Desirability	-0.61	0.22	-0.23	.007			
MAKSS-CE-R	0.32	0.21	0.13	.135			
CPC-LIEM	0.24	0.09	0.22	.014			
			Working Alliance				
Step 1					7.65(2,123)	0.37	.111
Constant	2.72	0.60		<.001			
Social Desirability	-0.68	0.23	-0.26	.003			
MAKSS-CE-R	0.50	0.20	0.21	.013			
Step 2					3.69(7,118)	0.35	.180
Constant	2.43	0.61		<.001	$\Delta R^2 = .069$, $p = .085$		
Social Desirability	-0.62	0.23	-0.23	.008			
MAKSS-CE-R	0.27	0.21	0.12	.200			
Seeking Knowledge	-0.07	0.08	-0.10	.345			
Addressing Social Class with Clients	0.08	0.08	0.12	.330			
Providing Supervision and Training	0.07	0.09	0.10	.418			
Increasing Access to Care	0.09	0.06	0.13	.140			
Self-Reflecting in Clinical Practice	0.09	0.08	0.11	.239			
			Estimate of Client Improvement				
Step 1					1.82(2,118)	0.77	.030
Constant	1.81	0.87		.039			
Social Desirability	-0.63	0.33	-0.17	.062			
MAKSS-CE-R	0.09	0.29	0.03	.756			
Step 2					2.72(3,117)	0.75	.065
Constant	1.47	0.87		.096	$\Delta R^2 = .035$, $p = .038$		
Social Desirability	-0.53	0.33	-0.15	.112			
MAKSS-CE-R	-0.14	0.31	-0.04	.644			
CPC-LIEM	0.29	0.14	0.20	.038			

Table 8. Continued

Estimate of Client Improvement							
Step 1					1.82(2,118)	0.77	.030
Constant	1.81	0.87		.039			
Social Desirability	-0.63	0.33	-0.17	.062			
MAKSS-CE-R	0.09	0.29	0.03	.756			
Step 2					1.75(7,113)	0.75	.098
Constant	1.09	0.90		.225	$\Delta R^2 = .068$, $p = .141$		
Social Desirability	-0.64	0.34	-0.17	.065			
MAKSS-CE-R	-0.15	0.31	-0.05	.626			
Seeking Knowledge	0.12	0.11	0.12	.275			
Addressing Social Class with Clients	-0.13	0.12	-0.14	.293			
Providing Supervision and Training	0.07	0.13	0.07	.581			
Increasing Access to Care	0.10	0.09	0.11	.251			
Self-Reflecting in Clinical Practice	0.22	0.12	0.19	.060			
External Attributions to the Causes of Poverty							
Step 1					5.73(2,131)	0.45	.080
Constant	2.12	0.641		.001			
Social Desirability	0.65	0.241	0.225	.008			
MAKSS-CE-R	0.44	0.215	0.172	.042			
Step 2					4.93(3,130)	0.44	.102
Constant	1.96	0.64		.003	$\Delta R^2 = .022$, $p = .078$		
Social Desirability	0.69	0.24	0.24	.005			
MAKSS-CE-R	0.28	0.23	0.11	.222			
CPC-LIEM	0.18	0.10	0.16	.078			
External Attributions to the Causes of Poverty							
Step 1					5.73(3,131)	0.45	.080
Constant	2.12	0.64		.001			
Social Desirability	0.65	0.24	0.22	.008			
MAKSS-CE-R	0.44	0.21	0.17	.042			
Step 2					5.31(7,126)	0.39	.185
Constant	1.74	0.61		.005	$\Delta R^2 = .147$, $p < .001$		
Social Desirability	0.75	0.23	0.26	.002			
MAKSS-CE-R	0.30	0.22	0.12	.169			
Seeking Knowledge	0.13	0.08	0.16	.098			
Addressing Social Class with Clients	0.19	0.09	0.25	.029			
Providing Supervision and Training	-0.23	0.09	-0.28	.015			
Increasing Access to Care	-0.10	0.06	-0.14	.104			

Table 9. Continued

Self-Reflecting in Clinical Practice	0.23	0.08	0.25	.006			
			Classist Attitudes				
Step 1					4.93(2,127)	0.56	.072
Constant	4.00	0.72		<.001			
Social Desirability	-0.13	0.27	-0.04	.645			
MAKSS-CE-R	-0.75	0.24	-0.27	.002			
Step 2					3.34(3,126)	0.57	.074
Constant	3.95	0.73		<.001	$\Delta R^2 = .002$, $p < .652$		
Social Desirability	-0.11	0.28	-0.04	.683			
MAKSS-CE-R	-0.80	0.27	-0.28	.003			
CPC-LIEM	0.05	0.12	0.04	.652			
			Classist Attitudes				
Step 1					4.93(2,127)	0.56	.072
Constant	4.00	0.72		<.001			
Social Desirability	-0.13	0.27	-0.04	.645			
MAKSS-CE-R	-0.75	0.24	-0.27	.002			
Step 2					2.03(7,122)	0.57	.104
Constant	3.94	0.75		<.001	$\Delta R^2 = .032$, $p < .501$		
Social Desirability	-0.03	0.29	-0.01	.928			
MAKSS-CE-R	-0.80	0.27	-0.28	.003			
Seeking Knowledge	0.07	0.09	0.08	.473			
Addressing Social Class with Clients	0.04	0.11	0.04	.730			
Providing Supervision and Training	-0.12	0.11	-0.14	.283			
Increasing Access to Care	0.13	0.08	0.15	.101			
Self-Reflecting in Clinical Practice	-0.04	0.10	-0.04	.678			

Note: MAKSS-CE-R = Multicultural Awareness Knowledge Skills Survey–Counselor Edition–Revised. CPC-LIEM = Clinical Practice Competency for LIEM.

Participant Feedback

When asked about the perceived utility of this scale, the majority reported this scale would be helpful as part of supervision (37.8% Strongly Agree, 43.4% Somewhat Agree, 10.6% Neither Agree nor Disagree, 2.3% Somewhat Disagree, 1.8% Strongly Disagree); as part of clinical trainings (53.4% Strongly Agree, 33.1% Somewhat Agree, 6.7% Neither Agree nor Disagree, 2.6%

Somewhat Disagree, 1.2% Strongly Disagree); for research (51.6% Strongly Agree, 29.3% Somewhat Agree, 11.1% Neither Agree nor Disagree, 1.8% Somewhat Disagree, 1.2% Strongly Disagree). When reflecting on their personal practice, the majority indicated that their supervision would benefit from this scale (34.0% Strongly Agree, 25.8% Somewhat Agree, 12.0% Neither Agree nor Disagree, 2.1% Somewhat Disagree, 1.2% Strongly Disagree) and the trainings they provide would benefit from including this scale (25.2% Strongly Agree, 26.1% Somewhat Agree, 15.0% Neither Agree nor Disagree, 5.0% Somewhat Disagree, 1.5% Strongly Disagree). In reflecting on if their personal research would benefit from including this scale, 13.2% Strongly Agreed, 7.9% Somewhat Agreed, 11.4% Neither Agree nor Disagree, 5.0% Somewhat Disagree, and 1.8% Strongly Disagree.

Discussion

My goal in these studies was to develop and validate a self-reported measure of clinician's perceived competencies working with clients from LIEM backgrounds. This scale was developed based on the 2019 APA *Practice Guidelines for Psychological Practice for People with LIEM* and the current literature on effective clinical practices and approaches for clients with LIEM background. My intention was to focus on the assessment of clinical practices that are particularly salient to psychologists' work with LIEM communities, and psychologists' role in mental health systems (i.e., ranging from providing interventions to supervision of other practitioners). After revising the initial pool of 38 scale items based on feedback from a panel of three experts on this topic, I conducted an initial test of the factor analysis and reduction of items in Study 1, which resulted in a 14-item correlated five-factor scale. In Study 2, I tested the fit of different model structures and found that the correlational five-factor model and the higher order model had similarly good fit to the data. In Study 2, I also tested the CPC-LIEM's validity in terms of the

scale's predictive value in explaining differences in participants' perceptions of their work with a recent client and the relation between this scale and similar constructs.

CPC-LIEM Factor Structure and Characteristics

The final scale items represent behavioral indicators of psychologists' competencies with LIEM communities, with items reflecting attitudes, knowledge, or values from the initial pool failing to load in a meaningful way during the EFA process. The final items on the five subscales of the CPC-LIEM appear to represent unique constructs identified in the psychotherapy literature and APA guidelines for working with LIEM communities. Items from the Seeking Knowledge factor exemplify Guideline 2 of the APA practice guidelines: "Psychologists are encouraged to increase their knowledge and understanding of social class issues" (2019); the Providing Supervision and Training factor, Guideline 1: "Psychologists strive to gain awareness of how their biases related to social class may impact the training and education they provide" ; the Increasing Access to Care factor, Guideline 4: "Psychologists strive to promote equity in the access to, and the quality of, healthcare available for people from LIEM backgrounds"; and the Self-Reflecting in Clinical Practice factor, Guideline 5: "… Psychologists are encouraged to seek to a) understand how social class influences psychotherapists' ability to effectively engage clients in treatment…" (2019). The Addressing Social Class with Clients factor represents items that were not derived from a single guideline, but rather represent psychologists' capitalizing on opportunities to explicitly discuss social class with clients, which the APA guidelines encouraged throughout. This factor may also be consistent with the multicultural orientation framework's concept of *taking advantage of cultural opportunities* as a core strategy for improving psychotherapy outcomes for clients from underrepresented or marginalized backgrounds (Davis et al., 2018; Owen et al., 2011).

Notably, the final scale does not represent all constructs that are suggested to be important to psychologists' clinical roles working with LIEM communities. For example, psychologists' involvement in creating systemic change at the organizational or regional level (e.g., advocating for policy changes within their agency or supporting relevant laws or government services; APA, 2019; the I-CARE model, Foss-Kelly et al., 2017) did not meaningfully load with other items and were excluded from the final scale. Similarly, items representing specific knowledge, attitudes, or awareness were removed during the Study 1 EFA and item reduction process, despite these constructs being theoretically consistent with Sue's tripartite model of multicultural counseling competencies (Sue et al., 1982; 2009). Constantine and colleagues (2002), in their analysis of three self-report multicultural counseling competencies, found that the originally proposed tripartite factor structure (awareness, knowledge, skills) of these scales was not supported. The present study provides additional evidence of structural issues with using Sue's model to develop competency scales.

The CFA provided good evidence that the CPC-LIEM best fits either a correlational five-factor or higher order model. Conceptually, authors of other similar scales argue for the utility of both correlational factor structures representing correlated but distinct aspects of multicultural clinical competencies (e.g., the Multicultural Counseling Awareness Scale, Ponterotto et al., 2002; Sexual Orientation Counselor Competency Scale, Bidell & Whitman, 2013) as well as a higher order factor structure with a superordinate factor representing general multicultural clinical competency (e.g. MAKSS-CE; Kim et al., 2003; Multicultural Competencies Inventory; Sodowsky et al., 1994). The validity tests described in Study 2 suggest that both the total score and individual subscales are associated with theoretically related constructs and that the total score provides useful information in predicting psychologists' conceptualizations of clinical constructs

like alliance and hope. Because the total score was related to expected constructs and helps predict psychotherapy processes above and beyond social desirability and general multicultural counseling competencies, this suggests that the total score could meaningfully represent a superordinate factor of LIEM competencies, rather than a confounding construct like social desirability. However, more research is needed to assess the factor structure of the CPC-LIEM, with particular attention to testing the existence of a higher-order general competency.

Evidence of Reliability and Validity

The CPC-LIEM subscales differed in terms of their relation to certain hypothesized validity constructs related to personal and professional characteristics. Psychologists with lower childhood social class and greater experience working with LIEM communities over their career evidenced greater competencies in three of the five factors (Seeking Knowledge, Addressing Social Class with Clients, Providing Supervision and Training) as hypothesized. However, the two factors reflecting the extent to which psychologists endorsed behaviors consistent with increasing access to care (e.g., providing pay-scale options or flexible hours) or self-reflecting on their experiences working with clients from LIEM backgrounds were not associated with childhood social class or clinical experience as hypothesized. Potentially other experiences such as clinical training may be more important to predicting how clinicians engage in self-reflection or offer flexibility in their services.

For example, the present study found that participants who identified as Counseling Psychologists had significantly higher scores than participants who identified as Clinical Psychologists on the Self-Reflecting in Clinical Practice subscale, suggesting that their clinical training may have more strongly focused on developing these practices. These findings are consistent with the literature indicating that compared to other practicing psychology programs,

Counseling Psychology training faculty are typically more engaged in multicultural research and as a field, Counseling Psychologists can be identified by a shared value of diversity (Norcross et al., 2021). Similarly, competencies measured by the Self-Reflecting in Clinical Practice and Increasing Access to Care differed based on the setting where psychologists worked. This could be because psychologists in different settings either have more flexibility to engage in LIEM culturally competent behaviors (e.g., offering flexible hours and pay options in private practice) or may have more agency support or incentives for engaging in these behaviors (e.g., community care settings that may be structured around providing care for LIEM communities). Inconsistent with the hypotheses, current social class and adjusted household income did not relate to any CPC-LIEM scores. This may be due to ceiling effects – the samples had high social class and incomes of the participants relative to the U.S. general population, with the Study 2 sample reporting an average household income of $194,518 and on average identifying their current social class as 7.58 on a scale of 0 to 10, with 10 representing the highest status.

The CPC-LIEM total score appears to be useful in predicting clinicians' self-reported psychotherapy processes and outcomes when reflecting on their work with a recent client experiencing LIEM. Total CPC-LIEM scores predicted participants' working alliance, hope for client change, and estimated client improvement above and beyond what was accounted for by general multicultural counseling competencies and social desirability. Although the amount of additional variance in participant self-reported therapy processes and outcomes explained by total score LIEM-competencies was small (ranging from 3.0% to 4.3%), it doubled the amount of variance accounted for by general multicultural competencies alone. This evidence supports the rationale for psychologists to attend to LIEM-specific competency models and tools, such as the CPC-LIEM, rather than relying solely on general models. Group specific models and tools may be

particularly important for assessment of LIEM-related constructs, which researchers and the APA have identified as underrepresented in research, theory, and training (APA, 2019; Clark et al., 2018; Lee et al., 2013; Liu et al., 2004; Reimers & Stabb, 2015).

Although the CPC-LIEM total score predicted participants' perceptions of therapeutic processes above and beyond general multicultural competencies and social desirability, the CPC-LIEM subscales did not. One explanation for these differences is they may be due to the missing data caused by inclusion of a "Not Applicable" response option because anyone who chose this option was excluded from having a score calculated. Alternatively, the subscales may not have evidenced incremental validity in the same way the total score did because the shared variance between the five factors may be what meaningfully predicts therapeutic processes – rather than the unique manifestations of the underlying competency construct represented by each subscale. If so, this may support the higher order factor structure of the scale, with the higher order LIEM competency construct being more useful than the subscales in predicting therapy processes.

CPC-LIEM scores differed in their relation to attitudinal constructs related to LIEM. Notably, only one subscale (Self-Reflecting in Clinical Practice) was related to downward classism or internal attribution to the causes of poverty (i.e., blaming individuals for their experience of poverty). This likely reflects the shift in scale items from the initial pool tested in the EFA and the final scale tested in Study 2. Specifically, initial items related to attitudes, knowledge, and awareness were largely excluded from the final scale due to low factor loadings. Of the final subscales, only the Self-Reflecting in Clinical Practice subscale reflects the internal processes of psychologists (e.g., "I reflect on the assumptions I have made about clients based on their social class"), which may account for its relation to classist attitudes. The third attitudinal variable, external attributions to the causes of poverty (i.e., blaming systems or external factors for

individual's experience of poverty), was also only related to three subscales: Seeking Knowledge, Addressing Social Class with Clients, and Self-Reflecting in Clinical Practice. That is, psychologists who believed poverty is caused by external or structural factors (e.g., government policy, discrimination) reported seeking out more LIEM-relevant continuing education, self-reflecting on their own class-related client experiences, and initiating conversations about social class with their clients. This mirrors the growing literature on the importance of critical consciousness, the ability to recognize and challenge oppressive systems, to working effectively with clients who have experienced marginalization (Lee & Hill, 2022). Applied to the present findings, providers who recognize the external or structural oppressive systems causing poverty report attending to these factors more often in their clinical work.

Consistent with the mixed correlations between the CPC-LIEM scores and attitudinal measures, the hierarchical regressions suggested that the CPC-LIEM was helpful in predicting additional variance in external attributions to the causes of poverty, but not classism. Further, consistent with the lack of relation between the CPC-LIEM and classism, but contrary to initial hypotheses, general multicultural awareness was not associated with any CPC-LIEM score. This occurred despite general multicultural skills and knowledge being associated with all CPC-LIEM subscales and the total score. Collectively, this evidence suggests that the final CPC-LIEM scale assesses perceived behavioral indicators of competency, rather than theorized constructs of multicultural awareness or class-related attitudes. More research is needed to explore the relation between behaviors psychologists engage in as measured by the CPC-LIEM and the internal processes (e.g., classism) described by the social class worldview model (Liu, 2011, 2012; Liu et al., 2013).

Practical Implications

Largely, the 730 participants included across the two studies agreed that the CPC-LIEM scale is relevant to clinical practice, supervision, training, and psychotherapy research on psychologists working with LIEM communities. The vast majority of participants reported this scale would be helpful as part of supervision (81%), clinical trainings (87%), and research (81%). Even when reflecting on their own personal practice, 60% reported that their supervision would benefit from the CPC-LIEM, 51% reported that the trainings they provide would benefit, and 21% reported that the research they conduct would benefit. These findings are consistent with evidence that psychologists and trainees find competency scales helpful for guiding their clinical growth (Karel et al., 2012).

The CPC-LIEM was intentionally developed to assess a diverse range of psychologists' clinical roles (in interventions or assessment, providing supervision, and seeking continuing education) and reflect core behaviors identified in the psychotherapy literature for improving access to and outcomes for clients from LIEM communities. The diversity of the clinical roles represented in this scale is valuable due the unique and diverse skill set psychologists bring to mental health care. Even in the present two samples, although the vast majority of participants provided individual therapy (77-83%), many provided diagnostic assessment (63-64%), consultation (49-53%), supervision of other practitioners (41-49%), other types of assessment (28-30%), or workshops or trainings with other practitioners (35-47%) and in the community (21-31%). Because the CPC-LIEM items do not assume a specific type of clinical activity, the scale can be used to assess competencies for psychologists that primarily engage in a range of clinical roles, including intervention (individual, group, milieu, etc.), assessment, and supervision.

The CPC-LIEM also may help address the inattention to and difficulty assessing LIEM-related factors in psychotherapy research. The literature's reliance on proxy measures of LIEM

clinical competencies, such as through interpreting measures of general multicultural competency in combination with measures of poverty beliefs, and reliance on qualitative methods, may be due to the lack of empirically validated scales on this topic (Clark et al., 2017; Toporek & Pope-Davis, 2005). The development of tools focused on LIEM-related experience in clinical practice, such as the CPC-LIEM, improves researchers' abilities to study these constructs and may subsequently address disparities in the representation of LIEM samples and issues in psychotherapy literature.

Limitations and Future Directions

The development of this scale was limited by several factors. First, although the sample was collected from licensure lists to increase the representative of the sample, I was only able to access the lists of 17 states/districts. Notably, I was not able to obtain licensee lists from any territories of the U.S. or from several populous states like Texas and California, which limits the representativeness of the samples. Although the two samples mirrored the workforce of psychologists in terms of age and proportion of White psychologists, the two samples in this study disproportionately included men and multiracial psychologists and underrepresented Hispanic/Latino(a) psychologists (national workforce is 30% men, 7% Hispanic, and 2% other or multiracial, APA, 2020). Sample characteristics, such as nation of origin and sexual orientation, were not assessed in these studies and present another limitation to assessing the generalizability of these findings to specific subgroups of psychologists. Additionally, both samples were collected during the first two years of the COVID-19 pandemic, and it is not clear how changes in how psychologists provide care during the pandemic may have impacted their responses to scale items (e.g., telework, increased economic hardship experienced by clients, increased personal stress; Chenneville & Schwartz-Mette, 2020).

Another issue that needs to be further explored is that the factor loading of item 11 "I provide flexible service hours" in factor 4 (Increasing Access to Care) decreased from .59 on the EFA for Study 1 to .25 in the orthogonal model and .27 in the higher order model in the CFA. Subsequently, despite acceptable internal consistency across the other four subscales and total scores (α = .76-.86), the internal consistency of the Increasing Access to Care subscale was notably lower, α = .52. One difference between Study 1 and Study 2 that may account for this change is the addition of a "Not Applicable" response option. For item 11, 31 participants selected "Not Applicable." It is possible that participants overused this response option, preferring to say that it is not possible for them to provide flexible service hours, rather than selecting "never" on the frequency response scale. Hansen and colleagues (2006) also found that participants frequently chose "Not Applicable" on multicultural competency items when given the opportunity, which the authors proposed could be due participants' limited experience with marginalized client populations or "suboptimal multicultural competence" (p. 69). That is, clinicians may prefer to report that a multicultural competency behavior is not applicable to their practice rather than report that they do not engage in that behavior. It is also possible that the original scale tested in the EFA was impacted by error in participant responses due to the lack of inclusion of a "Not Applicable." Research is needed to clarify the reasons for the change in factor loadings. Researchers and clinicians using the CPC-LIEM may consider the appropriateness of administering the Increasing Access to Care subscale and other subscales based on the characteristics of the psychologists being assessed. For example, providing flexible service hours might not be relevant for clinicians working in schools or prison systems.

In terms of the scale structure, research is needed to further test the findings of the present study and explore the best fitting factor structure of the scale. For the present scale, I tried to

balance the development of a psychometrically sound scale with scale brevity to increase the usefulness of such a scale in research and clinical practice. In attempting to strike this balance, the number of items on each subscale presents a limitation to the subscale's reliability in future studies (Worthington & Whittaker, 2006). Specifically, the two-item factor of Self-Reflection was kept due to the theoretical importance of what these items measure, the initial EFA results, and the strong association between these two items (r = .69) relative to their relations with other items. However, the two-item subscale may be particularly susceptible to poor reliability in replication. Therefore, future research is needed to assess this. When comparing multiple factor models, both the higher order and correlational models evidenced good fit to the data and the bifactor model did not converge even when trying several strategies to explore the cause of the issue. Therefore, theoretical and empirical research is needed to continue to explore the factor structure of this scale and the construct of LIEM clinical competencies more broadly.

Importantly, this study also only assessed psychologists' conceptualizations of their working alliance, hope, and estimated client improvement. Despite including a social desirability measure to account for bias in participants' responses, self-report measures – especially provider self-report – are limited in the extent to which they reflect how useful this scale may be in assessing clinical outcomes. Future research is needed to assess the CPC-LIEM's usefulness in predicting client-reported therapy processes and outcomes, which are undeniably more important for addressing LIEM-related health disparities. Similarly, the CPC-LIEM is limited to only assessing psychologists' reported competencies, which based on similar measures, will likely differ from observer-ratings or client-reports (Huey et al., 2014; Tao et al., 2015). Future research is needed to address these limitations by expanding on the findings of the present studies to develop client-report or observer-rating scales of LIEM clinical competencies. Additionally, this scale was

developed using samples of licensed psychologists. As a result, it is not clear how other clinicians would respond to the measure. However, given that a range of clinicians (e.g., social workers, counselors) work with LIEM communities, future research may explore if such a scale could also be relevant for their work.

Conclusions

The CPC-LIEM provides a novel way to assess psychologist's perceived clinical competencies working with LIEM communities. The CPC-LIEM subscales represent specific guidelines identified by the APA's *Guidelines for Psychological Practice for People with Low-Income and Economic Marginalization* (2019) as well as constructs identified in the psychotherapy literature as salient to mental health care for LIEM communities (e.g., addressing treatment barriers and self-reflection on personal biases). The five-factor structure of the scale measures different facets of psychologists' unique responsibilities in clinical settings, including providing supervision, setting practice policies, and direct client contact. Practicing psychologists, supervisors, and trainees may find the CPC-LIEM useful in identifying clinical strengths as well as areas of growth. Researchers may extend the present studies to assess the CPC-LIEM's utility in predicting psychotherapy processes and outcomes as well as to address the limitations described to strengthen to CPC-LIEM's validity. Across psychotherapy research and practice, the CPC-LIEM represents an opportunity to increase our attention to improving psychologists' ability to provide effective and equitable care for LIEM communities.

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APPENDIX A

Demographics and Professional Experience

Demographics

What gender do you identify with?

□ Woman □ Man □ Trans-woman □ Trans-man

□ Non-binary □ Self identify _____

What is your racial background?

□ Arab, Arab American, Middle Eastern

□ Asian, Asian American

□ Black, African American

□ Hispanic, Latino(a)

□ Native American, American Indian, First Nation

□ Pacific Islander

□ White, Caucasian

□ Other _____

What is your age? _____

Clinical Experience

What the highest degree have you earned related to mental health practice?

□ Certificate program

□ BA, BS, other bachelors

□ MA, MS, other masters

□ PhD

□ PsyD

□ EdD

□ Other _____

□ I am currently in a training program

↘What degree are you currently working towards related to mental health practice?

□ Certificate program

□ BA, BS, other bachelors

□ MA, MS, other masters

□ PhD

□ PsyD

□ EdD

□ Other _____

How do you professionally identify? If you are currently in training, select which option describes your program of study.

□Clinical Psychologist

□Counseling Psychologist
□School Psychologist
□Other _____

How do you describe your orientation?

Adlerian
Behavioral/cognitive–behavioral
Cognitive
Constructivist
Eclectic
Family systems
Gestalt
Humanistic/existential
Interpersonal/object relations
Jungian
Psychoanalytic/psychodynamic
Reality therapy
REBT
Solution-focused
Transactional analysis
Other _____

Which category best describes your current professional setting?

Academic faculty (e.g., university or college)
Child Guidance Clinic
Community Mental Health
Department Clinic (Psychology clinic run by a department or school)
Forensic / Justice Setting (e.g.. jail, prison)
Inpatient Psychiatric Hospital
Medical Clinic/Hospital
Private Practice
Residential/Group Home
Primary or Secondary School
University or College Counseling Center / Student Mental Health Center
VA Medical Center
Other _____

Now, indicate ALL professional settings that you have ever worked in as a practitioner.

Academic faculty (e.g., university or college)
Child Guidance Clinic
Community Mental Health
Department Clinic (Psychology clinic run by a department or school)
Forensic / Justice Setting (e.g.. jail, prison)

Inpatient Psychiatric Hospital
Medical Clinic/Hospital
Private Practice
Residential/Group Home
Primary or Secondary School
University or College Counseling Center / Student Mental Health Center
VA Medical Center
Other _____

On a scale of 0-10, with 0 representing “very rural” and 10 representing “very urban,” how would you describe your current professional setting?

0-10

For how many years have you seen clients?

□ I have never seen a client
□ _____ (fill in _numbers only allowed)

Approximately how many different clients have you seen in the last year?

□ I have not seen a client in the last year
□ I have never seen a client
□ _____ (fill in _numbers only allowed)

Select all options that describe your work with clients in the last year.

□ Diagnostic Assessment
□ Group therapy
□ Individual therapy
□ Other Assessment
□ Supervision of other practitioners
□Milieu therapy
□Family or couples therapy
□ Consultation
□Other _____

Select all options that describe a roles you had as an educator/supervisor in the last year.

□ Supervising licensed practitioners
□ Supervising unlicensed trainees
□ Course instructor in a masters or doctoral level clinical program
□ Course instructor in another type of program
□ Providing workshops/trainings/orientations for other practitioners
□ Providing workshops/trainings/orientations for non-practitioners
□ Other roles as an educator/supervisor _____

Over the course of your career, what percentage of your clients would you characterize as low income or economically marginalized? 0% to 100%

In the last year, what percentage of your clients would you characterize as low income or economically marginalized? 0% to 100%

APPENDIX B

Social Class

Subjective Social Status

Think of this ladder as showing where people stand in the United States.

At the **top** of the ladder are the people who are the best off – those who have the most money, the best education, and the most respected jobs.
At the **bottom** are the people who are the worst off – who have the least money, least education, and the least respected job or no job.
The higher up you are on this ladder, the closer you are to the people at the top.; the lower you are, the closer you are to the people at the bottom.

Where would you place yourself on this ladder? 1 = bottom rung to 10 = top rung

Adjusted Household Income. Adjusted household income will be calculated by dividing the total household income by the square root of household size (Square Root Equivalency Scale; Cronin, et al., 2012).

How many people are living in your household?
What is your total household income? (That is, the combined income of all members of your household).

APPENDIX C

Attributions to the Causes of Poverty Scale

Participants respond to the following statements using this response scale: 1 = not at all important as a cause of poverty to 5 = extremely important as a cause of poverty

Factor 1: External Attributions

- Prejudice and discrimination in hiring
- Failure of industry to provide enough jobs
- A federal government which is insensitive to the plight of the poor
- Prejudice and discrimination in promotion and wages
- Being taken advantage of by the rich
- Not having the right "contacts" to help find jobs
- Not inheriting money from relatives

Factor 2: Internal Attributions

- Lack of effort and laziness by the poor
- No attempts at self-improvement
- Lack of thrift and proper money management
- Alcohol and drug abuse
- Loose morals among poor people
- A lack of motivation caused by being on welfare

APPENDIX D

Classism Attitudinal Profile

Participants respond using a 5-point response scale (1 = *strongly disagree* to 5 = *strongly agree*).

Downward items

People who are poor let their kids run around without supervision.

People who are poor lack proper communication skills.

Generally, people that are poor have problems with drugs or alcohol.

People who are poor are more violent than other groups of people.

People who are poor try to abuse the system.

People who are blue collar are less refined compared to most other groups.

APPENDIX E

Multicultural Awareness Knowledge Skills Survey–Counselor Edition–Revised (MAKSS-CE-R). Participants respond using a 7-point response scale (*1 = not at all trust, 7 = totally true*).

Skills-Revised

How would you rate your ability to effectively consult with another mental health professional concern1ng the mental health needs of a client whose cultural background is significantly different from your own?

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

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

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

How well would you rate your ability to accurately assess the mental health needs of persons

who come from very poor socioeconomic backgrounds?

How would you rate your ability to identify the strengths and weaknesses of psychological tests in terms of their use w1th persons from different cultural/racial/ethnic backgrounds?

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

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

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

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

Awareness-Revised

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

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

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

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

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

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

Racial and ethnic persons are underrepresented in clinical and counseling psychology.

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

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

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

Knowledge-Revised

At the present time, how would you rate your understanding of the following term? "ethnicity"

At the present time, how would you rate your understanding of the following term? "culture"

At the present time, how would you rate your understanding of the following term? "multicultural"

At the present time, how would you rate your understanding of the following term? "prejudice"

At the present time, how would you rate your understanding of the following term? "racism"

At the present time, how would you rate your understanding of the following term? "transcultural"

At the present time, how would you rate your understanding of the following term? "pluralism"

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

At the present time, how would you rate your understanding of the following term? "mainstreaming"

At the present time, how would you rate your understanding of the following term? "cultural encapsulation"

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

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

At the present time, how would you rate your understanding of the following term? "contact hypothesis"

APPENDIX F

Working Alliance Inventory -Short form Revised-Therapist version (WAI-SR-T; Hatcher & Gillaspy, 2006; Hatcher et al., 2019).

For the next questions, you will first need to identify **ONE** of your recent clients who experienced low income or economically marginalization. Only think about this one client when responding to the following questions.

Keeping in mind the **ONE** recent client you chose who experienced low income or economically marginalization, respond to the following statements. (*1 = seldom* to *5 = always)*

1. We are working towards mutually agreed upon goals.
2. As a result of these sessions ___ is clearer as to how he/she might be able to change.
3. ___ and I have collaborated on setting goals for these sessions.
4. We have established a good understanding of the kind of changes that would be good for ___.
5. ___ and I both feel confident about the usefulness of our current activity in therapy.
6. I feel confident that the things we do in therapy will help ___ to accomplish the changes that he/ she desires.
7. We agree on what is important for ___ to work on.
8. ___ believes that the way we are working with his/her problems is correct.
9. I believe ___ likes me.
10. ___ and I respect each other.
11. I appreciate ___ as a person
12. I respect ___ even when he/ she does things that I do not approve of.

APPENDIX G

Therapist Hope for Clients Scale (THCS; Bartholomew et al., 2019).

Keeping in mind the **ONE** recent client you chose who experienced low income or economically marginalization, respond to the following statements. (*1 = definitely false* to *8 = definitely true*).

1. I am motivated to help this client resolve their concerns through counseling.
2. I believe my client is aware of what she or he wants to accomplish through counseling.
3. My work with this client is energizing for me.
4. I believe my client experiences the impact of counseling most days outside of sessions.
5. I can identify many ways for my client to use counseling to reach clinical goals.
6. Even in times when my client is stuck, I energetically pursue our work together.
7. Even when we are stuck, I am confident my client remains motivated to reach their goals.
8. I sustain active participation with this client in counseling.
9. My client's goals for counseling are easily identified.
10. I know what my client wants to work on in counseling.

APPENDIX H

Estimate of Client Improvement

Keeping in mind the **ONE** recent client you chose who experienced low income or economically marginalization, please estimate your client's change in therapy so far (*-4 = very much worse, 0 = no change, 4 = very much better*).

APPENDIX I

Marlowe-Crowne Social Desirability Scale – Short Form

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is true or false as it pertains to you.

1. It is sometimes hard for me to go on with my work if I am not encouraged. True False
2. I sometimes feel resentful when I don't get my own way. True False
3. On a few occasions, I have given up doing something because I thought too little of my ability. True False
4. There have been times when I felt like rebelling against people in authority even though I knew they were right. True False
5. No matter who I'm talking to, I'm always a good listener. True False
6. There have been occasions when I took advantage of someone. True False
7. I'm always willing to admit it when I make a mistake. True False
8. I sometimes try to get even, rather than forgive and forget. True False
9. I am always courteous, even to people who are disagreeable. True False
10. I have never been irked when people expressed ideas very different from my own. True False
11. There have been times when I was quite jealous of the good fortune of others. True False
12. I am sometimes irritated by people who ask favors of me. True False
13. I have never deliberately said something that hurt someone's feelings. True False

APPENDIX J

Clinical Practice Competencies with LIEM (CPC-LIEM) initial items prior to expert review.

Therapists will respond to the initial pool of items using a five-point Likert-type scale ranging from 1 = Strongly Disagree to 5 = Strongly Agree.

DOMAIN 1: TRAINING AND EDUCATION
Guideline 1: Psychologists strive to gain awareness of how their biases related to social class may impact the training and education they provide.

- I am aware of how my social class affect the training/education I provide.
- My biases related to social class affect the training or education I provide.
- I am aware of the ways that classism affects the training or education I provide.
- I discuss social class in my role as an educator (e.g., supervisor, trainer, teacher).
- I address social class issues in my supervision or teaching materials.
- I take steps to minimize the financial costs that are required of my trainees/supervisees as part of their training
- My trainees/supervisees are required to pay for miscellaneous costs as part of their training.
- I am mindful of my trainees/supervisees financial and material resources when assigning tasks.
- I spend time providing support for economically marginalized trainees/supervisees.
- I lead discussions to help trainees/supervisees understand their own social class values and experiences.

Guideline 2: Psychologists are encouraged to increase their knowledge and understanding of social class issues, including poverty and wealth, through continuing education, training, supervision, and consultation.

- I seek out opportunities to learn about social class issues.
- I consult with other practitioners about issues related to social class.
- I engage in continuing education opportunities about issues related to social class.
- I seek out trainings to learn about issues related to social class.
- I seek out opportunities to improve my awareness of the unique stressors related to poverty.
- I use theories that address economic marginalization in clinical practice.
- I use theories that address economic marginalization in my role as an educator (e.g., supervisor, trainer, teacher).

DOMAIN 2: LIEM AND HEALTH DISPARITIES

Guideline 3: Psychologists strive to understand the contribution of economic and social marginalization to the substantial health disparities in our society.

- On average, my clients' health is related to their socioeconomic status.
- I am aware of the ways my client's health is related to economic marginalization.
- I discuss with my clients how economic marginalization affects their health.
- I provide psychoeducation on the effect of economic marginalization on health.
- I seek out educational opportunities to understand the role of economic marginalization to health disparities in our society.
- I try to understand how economic marginalization is related to health disparities.

Guideline 4: Psychologists strive to promote equity in the access to, and the quality of, healthcare available for people from LIEM backgrounds.

- I actively work to promote equity in access to quality healthcare for people experiencing economic marginalization.
- I engage in program development to promote equity in access to quality healthcare for people experiencing economic marginalization.
- I alter my intervention approach for clients experiencing economic marginalization.
- I assess for economic barriers that may interfere with my clients' ability to engage in services.
- I work with my agency/institution to address barriers to services for economically marginalized groups.
- I advocate for within-institution changes to address barriers to services for economically marginalized groups.
- I work within my community to address economic marginalization.
- I provide services to people who are uninsured through flexible pay scale options.
- I provide pro-bono (free) services.
- I provide flexible service hours.
- I encourage my trainees/supervisees to offer flexible service hours.
- I encourage my trainees/supervisees to offer pro-bono (free) services.
- I am aware of validity issues of interpreting certain assessments with clients who have a history of economic marginalization.

DOMAIN 3: TREATMENT CONSIDERATIONS

Guideline 5: Psychologists acknowledge the presence of social class as a variable that is present in mental health treatment settings. Psychologists are encouraged to seek to a) understand how social class influences psychotherapists' ability to effectively engage clients in treatment, and b) attend to ways that social class differences manifest and impact the experience of mental health treatment for clients

- I discuss social class with my clients in mental health treatment.

- I assess my clients' social class.
- I reflect on the ways social class influences my ability to engage with clients.
- My own social class influences my ability to engage with clients.
- I reflect on my reactions to hearing about my clients' experiences of economic marginalization.
- I attend to the ways that social class affects how clients experience mental health treatment.
- When treatment planning, I am mindful of my clients financial and material resources.
- I collaborate with clients to identify the best ways for them to engage in treatment given their economic constraints.
- I integrate social class into my conceptualizations of clients' distress
- My social class affects how I interpret clients' presenting concerns

Guideline 6: Psychologists aim to understand the barriers that prevent persons with low SES from better accessing mental health care and make efforts to alleviate these barriers when providing psychological interventions and/or creating mental health care delivery systems.

- I address barriers to mental health care for my clients experiencing economic marginalization
- I change how I provide mental health services to address barriers related to economic marginalization.
- I collaborate with professionals outside of my discipline to address barriers to mental health care experienced by my clients with economic marginalization
- When appropriate, I share my knowledge of the barriers faced by my clients experiencing economic marginalization with their other healthcare providers.
- I advocate for changes in my community to reduce the negative health consequences of economic marginalization.

Guideline 7: Psychologists strive to understand the common clinical presentations that may be more likely to occur among persons who are from LIEM populations and how best to address these in treatment settings.

- I learn about how clinical presentations differ due to economic marginalization.
- I am aware of clinical presentations that may be more likely to occur among clients with economic marginalization.
- I am aware of best-practices for addressing common clinical presentations for clients with economic marginalization.
- I consult with other practitioners about how to address economic marginalization in treatment planning.
- I seek out opportunities to learn about how clinical presentations differ due to economic marginalization.
- I seek out opportunities to learn about how to address economic marginalization in treatment.

DOMAIN 4: INTERSECTION OF LIEM WITH CAREER CONCERNS AND UNEMPLOYMENT
Guideline 8: Psychologists seek to understand the impact of social class on academic success, career aspirations, and career development throughout the lifespan.

- I educate myself about the effect of social class on academic success.
- I seek out opportunities to learn about the impact of social class on academic success.
- I have noticed how my own beliefs about social class influence my career advice.
- I have noticed how my own beliefs about social class influence my expectations of clients' academic or work life.
- When discussing employment and academic decisions,
- I discuss with my client the influence of social class on employment and academic decisions.
- I educate myself about the impact of social class on work experiences.
- I seek out opportunities to learn about the impact of social class on work experiences.

Guideline 9: Psychologists seek to understand the interaction among economic insecurity, unemployment, and underemployment and attempt to contribute to re-employment processes for individuals.

- I provide resources for people seeking employment in my community.
- In my community, I provide resources for people seeking employment.
- I am aware of the current resources in my community that help people seeking employment.
- I refer clients to employment resources.
- I am aware of the evidence-based practices for working with clients seeking employment.
- I am aware of the current resources in my community for those experience unemployment.
- I refer clients to resources that support people experiencing unemployment.
- I actively advocate for policies that financially support people experiencing unemployment.
- I actively advocate for policies that provide a living wage for workers.
- I, or the organization I work for, pay all employees a living wage.
- I offer trainings that address stigma in the hiring process.
- I provide services to support people seeking stable employment
- I help my unemployed or underemployed clients search for new jobs
- I provide my clients with employment resources when appropriate

APPENDIX K

Initial Item Pool of the Clinical Practice Competencies with LIEM (CPC-LIEM) administered during EFA

Therapists will respond to the initial pool of items using a five-point Likert-type scale ranging from 1 = Strongly Disagree to 5 = Strongly Agree.

1. I reflect on the ways that classism affects the training I provide.
2. I discuss social class in my supervision or teaching materials.
3. I take steps to minimize the financial costs that are required of my trainees/supervisees as part of their training.
4. I lead discussions to help trainees/supervisees understand classism.
5. I consult with other practitioners about issues related to economic inequality.
6. I discuss with clients how economic inequality affects their health.
7. I seek opportunities to learn about the role of public policy on class-based health disparities.
8. I engage in program development to promote access to healthcare for those with low-incomes.
9. I work with my agency/institution to address economic barriers to treatment.
10. I actively advocate for changes in my community to reduce negative health consequences of economic inequality.
11. I support laws that improve access to healthcare for those with low income.
12. I ask clients about their social class.
13. I bring up classism with clients.
14. I adapt my intervention approach for low-income clients.
15. Please select Strongly Disagree for this item.
16. I reflect on the assumptions I have made about clients based on their social class.
17. I reflect on my reactions to hearing about clients' experiences of poverty.
18. I am aware of how classism affects clients' experience of mental health care.
19. When treatment planning, I consider clients' financial and material resources.
20. I integrate social class into my conceptualizations of clients' distress.
21. I consider how clients' economic backgrounds may affect validity of scores on psychological assessments.
22. I ask clients about economic barriers that may interfere with their ability to engage in mental health services.
23. I change how I provide mental health services to address clients' economic barriers.
24. I seek opportunities to learn about how to address economic barriers in treatment.
25. I provide services to people who are uninsured through flexible pay scale options.
26. I know where uninsured clients can receive mental health services in my community.

27. I provide pro-bono (free) services.
28. I provide flexible service hours.
29. I collaborate with professionals outside my discipline to address clients' specific economic barriers.
30. I am aware of best-practices for addressing common clinical presentations associated with economic inequality.
31. I seek opportunities to learn about classism in health care.
32. I seek opportunities to learn about the impact of classism on work experiences.
33. I notice how classism influences my expectations of clients' academic or work life.
34. I discuss with clients how social class may influence decisions related to schooling or employment.
35. I am aware of the unique psychological toll associated with my clients' unemployment.
36. I know the resources in my community to support those experiencing unemployment.
37. I seek opportunities to learn about evidence-based practices for working with clients seeking employment.
38. I actively advocate for policies that financially support people experiencing unemployment.
39. I actively advocate for policies that provide a living wage for workers.

APPENDIX L

Reactions to the Competencies with Economically Marginalized Clients Scale

Therapists will be asked to report what they believed this scale assessed in an open-ended item. Then, they will be informed of the scale's purpose and respond to items asking how helpful they believed this scale would be for 1) supervision and 2) training, as well as how likely they would be to use this scale after it is developed. Responses will be rated using a 5-point response scale ranging from *1 = strongly disagree* to *5 = strongly agree.* An open-ended item will ask therapists for general feedback on the scale.

The purpose of this study was to develop a scale assessing therapists' competencies working with low income and economically marginalized communities. The items were based on the 2019 *APA Guidelines for Psychological Practice for Clients with Low Income and Economically Marginalization*. To aid in the development of this scale, we would appreciate your feedback regarding the scale. (Participants will be shown the scale items again).

(*1 = strongly disagree* to *5 = strongly agree)*

A scale like this would be helpful as part of supervision.
A scale like this would be helpful as part of clinical trainings
A scale like this would be helpful for research.
My supervisees would benefit from a scale like this.
The trainings I provide would benefit from a scale like this.
The research I conduct would benefit from a scale like this.

What suggestions do you have to improve the scale items? (open ended)

APPENDIX M

Clinical Practice Competencies with LIEM (CPC-LIEM) Final Scale

Reflect on your clinical work when you respond to the following statements. Please provide your honest, candid responses, rather than how you would like to be seen or how you might look in the future.

Rate how often you engage in the following actions. Select the option that best reflects how often you **actually** engage in each action, not how often you would like to.

Only select "Not Applicable" if it is not possible for you to engage in that action because of the nature of your work.

	1 = Never	2 = Rarely	3 = Sometimes	4 = Often	5 = Always	N/A
1. I seek opportunities to learn about how to address economic barriers in treatment.						
2. I seek opportunities to learn about classism in health care.						
3. I seek opportunities to learn about evidence-based practices for working with clients seeking employment.						
4. I discuss with clients how social class may influence decisions related to schooling or employment.						
5. I discuss with clients how economic inequality affects their health.						
6. I bring up classism with clients.						
7. I discuss social class in my supervision or teaching materials.						
8. I lead discussions to help trainees/supervisees understand classism.						
9. I reflect on the ways that classism affects the training I provide.						
10. I provide pro-bono (free) services.						

11. I provide flexible service hours.						
12. I provide services to people who are uninsured through flexible pay scale options.						
13. I reflect on my reactions to hearing about clients' experiences of poverty.						
14. I reflect on the assumptions I have made about clients based on their social class.						