

Fall 12-16-2016

The relationship between perceived multicultural disability competence, multicultural counseling coursework, and disability-related life experience

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The relationship between perceived multicultural disability competence, multicultural counseling coursework, and disability-related life experience

A Dissertation

Submitted to the Graduate Faculty of the
University of New Orleans
in partial fulfillment of the
requirements for the degree of

Doctor of Philosophy
in
Counselor Education

By

Melissa D. Deroche

B.A. University of New Orleans
M.Ed. University of New Orleans

December, 2016

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Dedication

I dedicate my dissertation to my parents, Earl and Cindy. To my Mom (in memoriam), I am grateful for your warm and giving spirit; your constant support and encouragement; and your belief in my abilities – all of which has given me the confidence to pursue my dreams. To my dad, thank you for making all of this possible and for traveling this doctoral journey with me.

Acknowledgements

To Dr. Herlihy, without your support and encouragement early in my graduate studies, I would not have had the confidence to pursue such a lofty goal of earning my doctoral degree. I truly value your wealth of knowledge, mentorship, patience, and constant professionalism. Your keen ability to know when I just needed your support and when I needed to be challenged have resulted in my doctoral journey ending with a “done dissertation.”

To Dr. Lyons, I sincerely appreciate your professionalism - always maintaining a pleasant and calm demeanor even when I was frantic, stressed, and unsure of myself. Your reassurance, confidence in my abilities, and insights helped me make it through the dissertation process.

To Dr. Bonis, there are no words that can fully and accurately describe my gratitude for the time and attention you gave to me throughout my dissertation process. No matter how long my list of questions, you always greeted me with kindness and patience. Your ability to present and explain complex statistical concepts in a digestible form is truly a gift you possess and that I appreciate.

To Dr. Angelocci, your friendship, mentorship, and expertise have been invaluable to me throughout this dissertation process. Thank you for always being available with a listening ear.

To Edina and Jenn, my friends and mentors, I am indebted to you for your wisdom, unwavering support, and encouragement. Thank you for always knowing when I needed a sounding board and knowing when I just needed you to be my cheerleader. I treasure you both.

To Anabel, Christine, Joan Ellen, Angie, and Adan, I am overwhelmed by your kindness and generosity. Thank you for helping make this a “done dissertation.”

To countless other family members and friends, thank you for always being there for me, your love and support are immeasurable.

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Abstract

The aim of this study was to explore the perceived multicultural disability competence of master's-level counseling students in CACREP-accredited programs given their disability-related life experience(s) and multicultural counseling course completion and to assess the extent to which the topic of ability/disability is addressed in multicultural counseling coursework. Participants (n = 285) were electronically surveyed using the *Counseling Clients with Disabilities Survey* (CCDS; Strike, 2001) and a researcher developed biographical questionnaire. Collectively, study results indicated that both disability-related life experience(s) and multicultural counseling course completion positively impacted participant perceived multicultural disability competence. However, disability-related life experience(s) seemed to have a greater level of impact and significantly predicted self-awareness, perceived knowledge, and perceived skills. Results of this study indicated that the topic of ability/disability or persons with disabilities is given less attention than other topics covered in multicultural counseling courses within CACREP-accredited programs.

Keywords: multicultural disability competence, multicultural training, cross-cultural contact

Chapter 1 Introduction

In this chapter, an overview of the study is presented. The foundations of multicultural counseling, disability as a component of multiculturalism, and multicultural disability competence related to training and cross-cultural contact are discussed. The purpose and significance of the study are presented, along with the research questions, limitations and delimitations and assumptions of the study. The chapter concludes with a list of defined terms pertinent to the study.

Background

Multicultural counseling leaders have been critical of the deficiencies in traditional counseling theories and the inequities of the mental health services delivery system for those who are culturally different from the dominant culture (Arredondo, Tovar, & Parham, 2008; Sue, 1978; Sue & Sue, 1977). These criticisms prompted a shift in the discourse of the counseling profession from a focus on the individual to the cultural, environmental, and systemic experiences of diverse populations (Crethar, Rivera, & Nash, 2008; Ratts, 2009; Sue, 1978; Sue & Sue, 1977). The foundation of multicultural counseling, therefore, is based on the premise that individuals who do not possess certain demographic, ethnographic, or status-relevant personal characteristics associated with the dominant culture are not afforded the same opportunities and privileges as those who do possess such characteristics (Petersen, 1990; Reynolds & Pope, 1991; Robinson, 1999).

The term multiculturalism has been viewed from multiple perspectives. Some authors have posited that all counseling is multicultural and that culture should be more broadly defined and inclusive of identities other than race/ethnicity (Speight, Myers, Cox, & Highlen, 1991; Steenbarger, 1993). This broadening process highlights the dynamic and complex nature of

cultural identity and cultural worldview (Pedersen, 1990; Speight et al., 1991) and its relevance to counselor multicultural competence. Other writers have made a distinction between the concepts of multiculturalism and diversity. Proponents of this distinction assert that multiculturalism focuses on race, ethnicity, and culture, whereas diversity refers to other personal identity differences such as ability or disability, age, gender, and sexual orientation (Arredondo et al., 1996).

Regardless of the position taken, proponents of both perspectives acknowledge that individuals possess multiple identities which can cut across demographic, ethnographic, or status-related personal characteristics (Reynolds & Pope, 1991; Robinson, 1999). These personal characteristics or multiple identities are social constructs that set the stage for a hierarchical and dichotomous society. The consequence is that individuals who possess valued traits are afforded unearned privileges whereas others experience oppression and marginalization based solely on their status in society (Black & Stone, 2005; Robinson, 1999).

Individuals with disabilities, like other minorities, are subject to the dominant discourses of the majority culture (Olkin, 2002; Reynolds & Pope, 1991; Robinson, 1999). The discourse often reduces persons with disabilities to a single dimension and view disability as a devalued, inferior, and undesirable trait, which contributes to disablement (Johnson, 2006; Masala & Petretto, 2008; Robinson, 1999). Disablement is not the result of impairment; rather, it is the product of negative attitudes and barriers to access (Masala & Petretto, 2008; Olkin, 1999; Smart, 2009a). For individuals with disabilities, disablement is represented in unemployment and underemployment, underrepresentation in professional fields and politics, inappropriate use and interpretations of tests, and even subtle and overt forms of discrimination in the workplace (Olkin, 1999; Olkin & Pledger, 2003; Snyder, Carmichael, Blackwell, Cleveland, & Thornton,

2010). Consequently, the prejudice, stigma, discrimination, and oppression experienced by individuals with disabilities are social and civil issues (Bampi, Neves, & Alvis, 2010; Hughes, 2010; Middleton, Rollins, & Harley, 1999; Smart, 2009a) that deserve greater attention in multicultural counselor training and research (D'Andrea, Skouge, & Daniels, 2006; Lofaro, 1982; Rawlings & Longhurst, 2011).

Whether disability is characterized as a component of multiculturalism or as an aspect of diversity in counseling, both training program standards (CACREP, 2009) and professional codes of ethics (ACA, 2014) clearly state that cultural competence is central to ethical practice. The multicultural competencies developed by Sue, Arredondo, and McDavis (1992) provide a framework for defining what it means to be a culturally competent counselor and describe these competencies from training and practice standpoints along three domains (self-awareness, knowledge, and skills). Most recently, the framework has been revised to include both multicultural and social justice counselor competencies. These revisions include the recognition of the impact of intersecting identities and the dynamics of power, privilege, and oppression within the counseling relationship and incorporate four developmental domains, including counselor self-awareness, client worldview, counseling relationship, and counseling and advocacy interventions (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015). The preamble of the *American Counseling Association Code of Ethics* (ACA, 2014) delineates as one of the core values of the counseling profession that counselors honor diversity and embrace a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts.

Although the multicultural counseling literature provides a basis for the inclusion of disability in multicultural/diversity issues in counseling, the topic of race/ethnicity dominates

the multicultural counseling literature to the detriment of a focus on non-racial aspects of multiculturalism (Arredondo, Rosen, Rice, Perez, & Tovar-Gamero, 2005; Pope-Davis, Ligiero, Liang, & Codrington, 2001). The minimal consideration given to the topic of disability in multicultural counselor training and research is disproportionate to the fact that individuals with disabilities comprise the largest minority group in the United States (Disability Funders Network, 2012). Multiple content analyses of counseling journals and multicultural counseling course syllabi have indicated that the topic of disability is underrepresented compared to the focus on racial/ethnic minorities (Foley-Nicpon & Lee, 2012; Lee, Roser, & Bums, 2013; Pope-Davis et al., 2001; Priester et al., 2008). Additionally, a content analysis of commonly used human behavior textbooks indicated that the topic of disability is underrepresented in comparison to other developmental concerns (Reed-Cunningham & Fleming, 2009). Similarly, training programs have subscribed to a narrow definition of diversity and typically have relegated the topic of disability to rehabilitation specialty programs (Green, Callands, Radcliffe, Luebbe, & Klonoff, 2009; Olkin, 2002). The inadequate attention given to the topic of disability in counselor training programs and the research literature is antithetical to the importance placed on a multicultural perspective (Arredondo et al., 1996; D' Andrea et al., 2006; Olkin, 2002; Reynolds & Pope, 1991; Robinson, 1999). Consequently, some researchers have argued that disability competence should be integrated into the multicultural and social justice frameworks (D' Andrea et al., 2006) and included within the three domains of multicultural competence (Foley-Nicpon & Lee, 2012; Strike, Skofholt, & Hummel, 2004).

Much of the existing research concerning domains of disability competence has focused on rehabilitation students' and rehabilitation professionals' attitudes toward individuals with disabilities (Rosenthal, Fong, & Livneh, 2006; Sciarra, Chang, McLean, & Wong, 2005;

Thomas, Curtis, & Shippen, 2011). Due to multiple demographic, contextual, and contact-related variables, these attitudinal studies have yielded mixed results (Pruett & Fong, 2006; Rosenthal et al., 2006; Strohmer, Grand, & Purcell, 1984; Yunker, 1988). However, Carney and Cobia (1994), examined counseling students' attitudes across different specialty programs and found that rehabilitation counselor trainees had the most positive attitudes toward individuals with disabilities, followed by school counselor trainees and community counseling trainees. They suggested that counseling area of emphasis may account, in part, for these differences in attitudes.

Rehabilitation specialists are no longer considered the only professionals who will encounter individuals with disabilities (Mcdougall, 2008; Olkin & Pledger, 2003). This is due, in part, to legislation such as the Americans with Disabilities Act (ADA) of 1990 and its amendments that has prompted greater inclusion of individuals with disabilities into mainstream society. Therefore, it is necessary for all counselors to be competent in working with individuals with disabilities. The recent merger between CACREP and the Council on Rehabilitation Education (CORE), recommendations for the inclusion of disability across the counseling curriculum, and a future unifying body of accreditation for all counseling programs further substantiate the need for greater inclusion of the topic of disability into multicultural counseling course curricula.

One method of examining counselors' competence to work with clients with disabilities is to measure their perceived multicultural disability competence using the domains of self-awareness, knowledge, and skills. Some researchers have identified disability-related life experience, exposure, and/or contact as important variables relevant to perceived multicultural disability competence and have used various methods and measures to examine these variables

(Hollimon, 2007; McDougall, 2008; McLennon, 2012; Strike et al., 2004). Disability-related life experience has been defined in terms of type (Hollimon, 2007; McLennon, 2012; Strike et al., 2004) and extent of exposure/contact (Diaz-Lazaro & Cohen, 2001; McDougall, 2008). Regardless of the definitions used in these studies (e.g., type or extent of exposure/contact), accumulated disability-related life experience resulted in higher levels of overall perceived multicultural disability competence (Diaz-Lazaro & Cohen, 2001; Hollimon, 2007; McDougall, 2008; McLennon, 2012; Strike et al., 2004).

Strike (2001) identified four main types of exposure/contact relevant to perceived multicultural disability competence. These categories included personal/interpersonal, work, training, and other-related disability experiences. Researchers have demonstrated that the operationalization of type of exposure/contact variables is relevant when investigating perceived multicultural disability competence (Hollimon, 2007; McLennon, 2012; Strike et al., 2004). For example, Strike et al. (2004) found that level of experience based on participants' cumulative personal/interpersonal, work, and training-related experiences yielded higher levels of perceived multicultural disability competence than their less experienced counterparts. Hollimon (2007), however, found that level of closeness based on participants' personal/interpersonal -related experiences resulted in higher levels of reported perceived multicultural disability competence than participants' who reported no contact or only training-related experience.

Diaz-Lazaro and Cohen (2001) built their study on the assertion that prior accumulated cross-cultural contact through life experience(s), completion of a multicultural counseling course, and the implementation of cross-cultural contact experiences within a multicultural course are relevant factors in promoting counselor multicultural competence. They found that a prior accumulated experience with persons with disabilities was significantly related to self-

reported awareness and skills but not knowledge. However, completion of a multicultural counseling course significantly increased overall knowledge and skills but not awareness as measured by the Multicultural Awareness, Knowledge, and Skills Survey (MAKSS). Using qualitative data, the researchers also suggested that a multicultural counseling course with a strong cross-cultural contact component is effective in augmenting trainees' overall multicultural competence.

Existing research lends support to the idea that completion of a multicultural counseling course and prior accumulated cross-cultural contact are important variables to consider when examining multicultural counselor competence (D'Andrea, Daniels, & Heck, 1991; Diaz-Lazaro & Cohen, 2001; Malott, 2010). More specifically, disability-related life experience, whether defined in terms of personal/interpersonal, work, or training-related experience, has demonstrated relevance to perceived multicultural disability competence (Diaz-Lazaro & Cohen, 2001; Hollimon, 2007; McDougall, 2008; McLennon, 2012; Strike et al., 2004). The significance of multicultural counseling coursework and cross-cultural contact on counselor multicultural competence, combined with the limited amount of research regarding counselor multicultural disability competence, gives credence to further investigation. Therefore, an examination of multicultural disability training and personal/interpersonal and work-related experience with persons with disabilities warrants attention.

Significance of the Study

The topic of disability traditionally has been viewed as a subspecialty in the fields of counseling and psychology. However, due to the increased participation in mainstream society of people with disabilities (Olkin & Pledger, 2003), it is critical for all counselors, regardless of specialization, to become competent in counseling individuals with disabilities. Introductory

multicultural counseling and diversity courses provide a potential context for training to develop this competence, as persons with disabilities are the largest minority group in the United States (Disability Funders Network, 2012). The results of this study provide information about the current state of integrating ability/disability into multicultural counselor instruction and the impact that disability-related life experience and instruction have on perceived multicultural disability competence. This study fills a gap in the research by informing counselor training programs and counselor educators about the need to more clearly address ability/disability as a distinct topic in multicultural counseling coursework and to consider using exposure/contact-related instructional strategies to help increase master's-level counseling students' multicultural disability competence.

Purpose of the Study

The intent of this study was to expand upon the existing research literature that demonstrates the efficacy of multicultural counselor training and cross-cultural contact experiences on multicultural counselor competence by applying these conditions to counselor multicultural disability competence. The main objective of this study was to examine relationships between master's-level counseling students' perceived multicultural disability competence and their disability-related life experience(s) and completion of a multicultural counseling course. A second objective was to determine whether there are significant group differences in perceived multicultural disability competence based on master's-level counseling students' multicultural counseling course completion and reported disability-related life experience(s). A third objective of this study was to determine how well completion of a multicultural counseling course and disability-related life experience(s) predicted self-awareness,

perceived knowledge, and perceived skills. A fourth objective was to identify to what extent the topic of disability is being integrated into multicultural course curricula.

This study was based on the rationale that disability is a relevant component of multicultural training and that completion of a multicultural counseling course and cross-cultural contact experiences have demonstrated efficacy with regard to multicultural counselor competence generally and to multicultural disability competence specifically (D'Andrea et al., 1991; Diaz-Lazaro & Cohen, 2001; McDougall, 2008; Strike et al., 2004). This researcher, however, examined these variables using a national sample of master's-level counselor trainees in CACREP-accredited programs. Additionally, disability-related life experience was operationalized differently from previous studies and multicultural counseling course completion (i.e., training) was considered a separate variable.

Conceptual Framework

A multicultural counseling model is based on the premise that the worldviews of both the counselor and client are shaped by the historical and sociopolitical climates in which they live and their cultural experiences and perspectives (Robinson, 1999; Sue, 1978; Sue et al., 1982; Sue et al., 1992). Consequently, their worldviews are vital components to the counseling process and therapeutic relationship (Katz, 1985; Sue et al., 1992). The multicultural and social justice counseling competencies (MSJCC) are described as a revised version of the original multicultural counseling competencies developed by Sue et al. (1992). The MSJCC framework is said to offer counselors a set of guidelines and standards for implementing multicultural and social justice counseling competencies into counseling theories, practices, and research (Ratts et al., 2015).

The MSJCC framework includes several constructs that form the backbone of the competencies. First, the importance of intersecting identities and the impact of power, privilege, and oppression on the counseling relationship are recognized and integrated throughout the competencies. Second, there are four developmental domains that reflect the different layers that provide a path to multicultural and social justice competency, including counselor self-awareness, client worldview, the counseling relationship, and counseling and advocacy interventions. The first three developmental domains are described in terms of aspirational competencies that include attitudes and beliefs, knowledge, skills, and actions. The fourth developmental domain, counseling and advocacy interventions, is explained using a socioecological model in which counselors advocate on behalf of clients on intrapersonal, interpersonal, institutional, community, public policy, and international/global levels (Ratts et al., 2015). The integration of intersecting identities and the constructs of power, privilege, and oppression throughout the competencies; the developmental domains; aspirational competencies; and the socioecological model described within this framework are all components that help provide an understanding of counselor multicultural disability competence.

Research Questions

The following research questions were investigated in this study:

1. What is the relationship between perceived multicultural disability competence and prior disability-related life experiences among master's-level students in CACREP-accredited counseling programs?
2. What is the relationship between perceived multicultural disability competence and completion of a multicultural counseling course among master's-level students in CACREP-accredited counseling programs?

3. Are there significant group differences in perceived multicultural disability competence between students who have neither disability-related life experience(s) nor have completed a multicultural counseling course, students who have disability-related life experience(s) but have not completed a multicultural counseling course, students who have completed a multicultural counseling course but have no disability-related life experience(s), and students who have disability-related life experience(s) and have completed a multicultural counseling course?
4. What amount of variance do the two independent variable sets, disability-related life experience and completion of a multicultural counseling course, contribute to the prediction of the outcome domains of self-awareness, knowledge, and skills?
5. To what extent do master's-level students in CACREP-accredited counseling programs report that the topic of disability or persons with disabilities was covered as a distinct aspect of multiculturalism/diversity in their multicultural counseling courses?

Overview of Methods

A quantitative research design was most appropriate for examining the identified research questions in this study. The Counseling Clients with Disabilities Survey (CCDS; Strike, 2001) and a researcher-developed questionnaire were used for the purposes of data collection. The five research questions were analyzed using descriptive statistics and correlational and multivariate methods.

Limitations and Delimitations

This study was delimited to masters'-level counseling students enrolled in CACREP-accredited counseling programs. Therefore, a limitation was that the results cannot be

generalized to trainees enrolled in non-CACREP-accredited programs. A second limitation was the use of self-report measures. The use of self-report measures has been criticized for the subjective nature of participant responses and the propensity of participants to respond in socially desirable ways (Fleming, 2012). Third, an online data collection program was used to gather data. These data collection procedures might introduce selection bias and a reduced response rate due to lack of access or lack of comfort using computer technology (Granello, 2007). Finally, the correlational nature of this study did not allow the researcher to make causal inferences.

Assumptions of the Study

The researcher assumed that participants met the criteria for the study and responded honestly to survey questions. Second, the researcher assumed that the participants in this study were representative of master's-level students in CACREP-accredited counseling programs.

Definition of Terms

Disability-related life experience(s): Direct interpersonal or work-related interactions between master's-level counseling students and persons with disabilities or someone who has a disability.

Diversity: Individual differences that refer to personal characteristics by which someone may choose to self-define. These characteristics may include age, gender, sexual orientation, religion, and physical or mental ability (Arredondo et al., 1996).

Multicultural disability competence: A construct that is represented by the connection between the tripartite framework of the self-awareness/knowledge/skills structure of the multicultural competencies and standards and the minority model of disability and as measured by the Counseling Clients with Disabilities Survey (CCDS). (Strike et al., 2004).

Multicultural competencies: A set of guidelines used to describe culturally skilled counselors along three domains, including self-awareness, knowledge, and skills (Sue et al., 1992).

Multicultural counseling: The working alliance between a counselor and client that considers the personal dynamics of the counselor and client, alongside the cultural dynamics of both of these individuals (Lee & Park, 2013)

Person with a disability: A physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment (American's with Disabilities Act, 1990).

Chapter 2 Literature Review

The literature review provides an understanding of multicultural counseling and its relevance to persons with disabilities. The chapter contains five main sections. In the first section, the researcher discusses the tenets and evolution of multicultural counseling. In the second section, the ways in which disability is defined and conceptualized, and the demographic variables associated with persons with disabilities are presented. In the third section of this chapter, the researcher covers the experience of persons with disabilities, including the sociopolitical history, response to disability, disability identity, everyday experiences, and multiple minority status of persons with disabilities. In the fourth section, the researcher describes multicultural training counselor competencies, multicultural training and preparation, and pedagogical instructional strategies, intergroup contact and exposure, and ethical and legal issues. In the final section, the researcher provides information about multicultural disability competence that includes the self-awareness/beliefs/attitudes, knowledge, and skills of counselors to work with clients with disabilities.

Multicultural Counseling and Disability

Over the past 60 years, a paradigm shift has occurred in the fields of counseling and psychology. This paradigm shift has coincided with the historical and sociopolitical climate of the United States in which culturally diverse minorities have demanded access, equality, and social inclusion (Lee et al., 2009; Middleton et al., 1999). The consequence has been the emergence of a theory of multiculturalism that exists alongside psychodynamic, cognitive behavioral and existential-humanistic theories and has been coined the “fourth force in counseling” (Pedersen, 1991).

Tenets of multicultural counseling. The multicultural counseling movement has resulted in the recognition that the underlying assumptions, theories, and values held by the profession were rooted in Eurocentric, middle class and male values that are representative of the dominant culture. These views failed to account for cultural differences and were insufficient in addressing the needs of culturally diverse clients (Katz, 1985; Sue & Sue, 1977; Vontress, 1969). A multicultural perspective, therefore, acknowledges the inherent complexities of human nature and human development and values the relevance of culturally diverse perspectives in counseling (Pedersen, 1990).

These culturally diverse perspectives take into consideration the intersecting identities of an individual, such as ability/disability, age, gender, racial or ethnic background, sexual orientation, socioeconomic status, religious affiliation, spiritual beliefs, and education, and how these cultural variables are affected by the dominant discourses in society (Reynolds & Pope, 1991; Robinson, 1999). The dominant discourses determine the level of status or value associated with a particular identity which, in turn, results in the attainment of unearned privileges or the experience of social exclusion and marginalization (Reynolds & Pope, 1991). In essence, multicultural counseling takes into consideration the impact of the personal dynamics and cultural experiences of both the client and counselor and the interplay of these contextual factors within a therapeutic relationship (Lee & Park, 2013).

Evolution of multicultural counseling. The 1960s and 70s were turning points during which the importance of culture and cultural differences was acknowledged as important to counseling and the counseling relationship (Sue, 1978; Sue & Sue, 1977; Vontress, 1969, 1970). The recognition and appreciation of cultural differences, specifically race and ethnicity, became central to the counseling discourse and led to the understanding that psychological stressors, such

as social exclusion and racial tension, are integral to the lives of those who are culturally different from the dominant culture (Smith, 1977; Sue, 1978; Sue & Sue, 1977).

Over time, scholars began to define multiculturalism more broadly to include aspects of human diversity which acknowledged the significance of multiple or intersecting identities (Constantine, 2002; Robinson, 1993). These differing views have created controversy over whether multiculturalism should be narrowly defined in terms of race, ethnicity, and culture or viewed more broadly to include other aspects of human diversity such as ability/disability, gender, sexual orientation, and social class (Daas, 1995; Patterson, 1996; Spate et al., 1991). Although there has been debate regarding the definition of multiculturalism, the counseling profession has endorsed the relevance of multiculturalism and human diversity in codes of ethics, program standards, and counselor competencies (ACA, 2005, 2014; CACREP, 2009; Sue et al., 1992).

More recently, greater consideration has been given to the idea that identities are socially constructed in society by way of discourses (Robinson, 1999). The dominant discourses of society create a system in which certain identities are valued, while others are not. This new approach to discussing aspects of multiculturalism has allowed scholars to explore the ways in which power and privilege contribute to the experience of marginalization and oppression in society (Black & Stone, 2005; Reynolds & Pope, 1991; Robinson, 1999). Robinson (1999) asserted that it is not the identities themselves that lead to oppression; rather, it is the socially constructed practices that result in prejudice and discrimination (e.g., racism, sexism, heterosexism, classism, and able-body-ism). Therefore, it is essential that counselors are aware of the dominant discourses and how they interact and intersect with their own identities.

Disability as an aspect of multicultural counseling. The historical and sociopolitical underpinnings of the civil rights movement for persons with disabilities run parallel to the experiences of other minority groups. Persons with disabilities are subject to the prevailing dominant discourses of society. These discourses, determined by the majority culture, view disability as an undesired or devalued trait (Olkin, 1999; Robinson, 1999), placing persons with disabilities in a position that holds little power or privilege based on their associated status in society. Therefore, these discourses contribute to the stigma, prejudice, and discrimination experienced by persons with disabilities and are seen throughout society. For example, the negative images of disability depicted in the media, pressure to assimilate into the majority culture, underrepresentation in professions and politics, and comparatively higher rates of unemployment and underemployment are forms of oppression and marginalization (Erickson, Lee, & Von Schrader, 2014; Olkin, 2002). These realities are similar to those experienced by other cultural minorities; therefore, persons with disabilities fit within the framework used to describe multiculturalism.

Landscape of Disability

Defining disability. Defining disability is a complex task as its meaning is based on a myriad of factors which are often socially constructed (Bampi et al., 2010; Hughes, 2010; Smart, 2009a) but can also be a result of self-definition (Gill, 1997; Olkin, 1999). Socially constructed definitions, however, are based on the dominant cultures perception of normalcy (Smart, 2009b; Smart, 2013) and are further complicated by the blurry distinction between the concepts of health/illness and disability (Olkin, 1999). Defining disability may be impossible without including both health/illness and disability (Olkin, 1999). The reason is that some disabilities

can lead to secondary health conditions, and some serious health conditions can result in loss of functioning (i.e., disability) (Olkin, 1999).

Several classification systems and categorical labels have been used to define and describe disability. For example, the International Classification of Functioning (ICF) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) are classification systems used to define disability. These systems, along with disability laws, describe disability in terms of a diagnosis, system affected, onset, severity, and function loss (Olkin, 1999; Smart, 2009b). Additionally, disabilities can be categorized as congenital or acquired, or visible or hidden, and be considered as physical, cognitive, or psychiatric. These perspectives are not exhaustive; however, they do illustrate the complexities in and contextual nature of defining and describing disability.

Frameworks. The above perspectives on defining disability also can be seen within more developed frameworks. The four broad models of disability discussed in the following sections include the moral, biomedical, functional/environmental, and sociopolitical models. These models are frameworks used to define, describe, and discuss disability. Each of these models provides a different definition of disability, describes the source of the problem of disability (i.e., causal attribution), and identifies who is responsible for the solution (i.e., responsibility attribution) (Olkin, 1999; Smart, 2009a). Therefore, models of disability contribute to the understanding of the disability experience, impact the language used to discuss disability, guide treatment and intervention strategies, and help shape the self-identities of persons with disabilities (Bampi et al., 2010; Smart, 2009a). Each of these models has its strengths and limitations, and no model provides a comprehensive understanding of the disability experience. Nevertheless, these models have the capacity to impact policies and legislation,

training and education, and professional practice and research (Smart 2009a; Smart, 2009b). The reality is that models are “powerful tools” that can greatly impact the lives of persons with disabilities (Smart, 2009a).

Moral model. The moral model of disability is the oldest model of disability. It contends that disability is a defect that results from moral lapse or sin, is a failure or test of faith, or is punishment for wrong doings (Olkin, 1999). From this standpoint, people are morally responsible for their own disability and bring shame to both themselves and their families. There is also the myth that as disability impairs one sense, it heightens another, and the solution is to adjust to or transcend the disability or impairment (Olkin, 1999).

Biomedical model. Although the biomedical model removes moral lapse or sin as the cause of disability, it replaces it with the premise that disability is a medical problem or condition that requires medical rehabilitation, amelioration, or cure. From the perspective of the biomedical model, disability is viewed as a pathology, abnormality, or defect that is located within an individual. This medicalization of disability has resulted in a standardized diagnostic system that classifies the severity of a disability, the level of impairment, and the treatment protocol or interventions used for rehabilitation (Olkin, 1999; Smart, 2009b). Persons with disabilities are, therefore, expected to avail themselves to the expertise of medical professionals. Even when medical stabilization is reached, the solution to the problem of disability is for persons with disabilities to adjust to their disabilities and the environment (Olkin, 1999).

The biomedical model has received much criticism because it pathologizes disability, places people in categories, and gives them diagnostic labels based on presumed objective criteria (Olkin, 1999; Smart & Smart, 2006). This medicalization of disability results in the use of prescriptive treatment plans that do not acknowledge the social and environmental factors

contributing to disablement; fails to recognize the differences in individuals' needs, resources, assets, cultural values and experiences; and subscribes to the notion that medical practitioners are the experts on disability (Smart, 2009b; Smart & Smart, 2006). The risk in using this classification system is that persons with disabilities can be viewed as groups or categories (e.g., "the blind" or "the mentally ill"), thereby ignoring their unique multiple identities (Allston & Bell, 1996; Drummond & Brodman, 2014; Harley, Nowak, Gassaway, & Savage, 2002).

Although the biomedical model has received considerable criticism, it has made some important contributions to understanding the experience of disability and improving the lives of people with disabilities. Most notably, the diagnostic/definitional system of the biomedical model has been formalized into law (e.g., ADA) and applied to the acquisition of services (e.g., educational and work-related accommodations and eligibility for governmental programs and benefits). Additionally, the biomedical model recognizes the biological realities of disability, is informed by medical and technological advancements, and provides an organized system for the general public to understand disability (Smart, 2009b).

Functional and environmental models. The functional and environmental models of disability are both interactional models that warrant a side-by-side discussion. These models describe disability as a complex phenomenon that takes into account the individual, his/her disability, the role or function needing to be performed, and the environment. Disablement, therefore, varies depending upon the function or role expected of the individual, the physical accessibility or inaccessibility of an environment, and negative societal attitudes about persons with disabilities (Smart, 2013; Smart & Smart, 2006). Because the problem of disability is conceptualized as residing external to the person with a disability, the solution to disablement is, at least in part, the responsibility of society. This translates to providing accommodations and

adaptations (e.g., assistive technology, hearing aids, and wheelchairs) and making physical, social, and environmental changes that reduce prejudice and discrimination (Smart, 2013).

Adherence to this model allows the opportunity for persons with a disability to be seen as more than their disability and as whole persons who have multiple identities and a range of skills, talents, and abilities (Robinson, 1993; Smart & Smart, 2006).

Nevertheless, there are two primary limitations of the functional and environmental models. First, the general public has difficulty conceptualizing the idea that lack of accommodations contributes to disablement. Second, the functional model is often referred to as the “economic model,” placing an emphasis on the value of persons with disabilities based on their ability to work or contribute to the economy (Smart, 2009a).

Sociopolitical or minority group model. The sociopolitical model is the newest model of disability described in the literature; it has also been referred to as the minority group model (Olkin, 1999, 2002; Wertlieb, 1985). It represents a paradigmatic shift in the understanding of the disability experience and is said to have greater explanatory power in describing the day-to-day lives of persons with disabilities (Smart, 2009a). What sets the sociopolitical model apart from the moral, biomedical, and functional/environmental models is that it acknowledges the importance of self-identification and self-determination for persons with disabilities (Saleeby, 2012; Smart & Smart, 2006).

The greatest contribution of the sociopolitical model is that it shifts the focus away from disability as a medical diagnosis or biological inferiority and contends that disability is a natural and common part of the human experience (Smart, 2009b). As a result, disability is no longer identified as the “problem,” and neither individuals nor their disabilities are the focus of treatment or intervention. From a sociopolitical perspective, disablement is the product of

negative societal attitudes, architectural barriers, lack of accommodations, and the failure of government protection; therefore, disability is both a social and civil concern that requires collective actions (Bampi et al., 2010; Hughes, 2010; Olkin, 2002; Smart, 2009a; Smart, 2009b).

Demographics of disability. Disability has been described as a universal phenomenon and an equal opportunity condition (Smart, 2009b). In other words, no one is immune to the possibility of acquiring a disability or being born with a congenital disability. However, demographic factors increase one's likelihood of having a disability. Of the estimated 53 million persons with disabilities in the United States, older adults (65+) and racial/ethnic minorities (e.g., African Americans and Native Americans) tend to have higher rates of disabilities than individuals of traditional working age or Whites (Erickson et al., 2014). However, overall rates of disability seem to be relatively similar for both males and females regardless of other demographic variables (Erickson et al., 2014).

Individuals who have personal characteristics that place them within a minority group are often compared to the majority culture. For persons with disabilities, the American Community Survey (ACS) provides a basis for tracking any differences in the lives of persons with disabilities compared to individuals who are non-disabled. In general, there have been some improvements in employment rates, education attainment, and political participation for persons with disabilities, yet significant gaps remain between persons with and without disabilities in a number of areas (National Organization on Disability, 2010). What is most disappointing is that since the passage of the Americans with Disabilities Act (ADA), there has been limited to no progress in the following areas: household income, access to transportation, health care, socializing, going to restaurants, and overall life satisfaction for persons with disabilities

(National Organization on Disability, 2010). These data suggest that persons with disabilities continue to experience barriers to access and equal opportunities.

The Disability Experience

Sociopolitical history of persons with disabilities. Historically, persons with disabilities have been subjected to forced institutionalization, sterilization, and eugenic practices (Mackelprang & Salsgiver, 2009). Over the past 50 years, however, significant progress has been made regarding the civil rights for persons with disabilities. The disability rights movement began with the collective actions of persons with disabilities. These activists were members of the disability community who believed that the challenges they encountered were not medical but were political, economic, and social (Olkin, 1999).

These leaders paved the way for the independent living movement in which Independent Living Centers (ILCs) provided services that helped increase the number of persons with disabilities living independently within their communities. The independent living movement, along with the Civil Rights Act of 1964, provided the foundation for enhancing the civil rights, independence, education, and employment for persons with disabilities (Middleton et al., 1999).

Several landmark legislative acts have helped shaped the civil rights of persons with disabilities; to date, the most comprehensive is the Americans with Disabilities Act (ADA) which was signed into law on July 26, 1990. The ADA was modeled after the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973 and created the language, policies, and practices that have promoted greater inclusion of persons with disabilities into mainstream society (Middleton et al., 1999). The ADA has been called the “equal opportunity” law for persons with disabilities and describes five areas in which persons with disabilities have legal

rights, including employment, public services, public accommodations, telecommunications, and miscellaneous (U.S. Department of Justice, n.d.).

Response to disability. A person's response to disability often has been described using the terms adjustment, adaptation, and/or acceptance of the disability and has been applied to a series of psychological stages or crises through which one has to progress before reaching psychological adjustment (Livneh, 1980; Livneh & Antonak, 2005; Smart, 2009b). This stage model approach described adjustment, adaptation, and/or acceptance as a linear process with a beginning and an end and has been equated with the stages of loss (Smart, 2009b). These same stage models have also been viewed as flexible with persons recycling, repeating, or skipping stages (Kendall & Buys, 1998; Smart, 2009b). According to Kendall and Buys (1998), adjustment to an acquired disability is a "unique process characterized by continual peaks and troughs as individuals seek to redefine themselves in the face of new challenges and unfamiliar circumstances" (p. 18). These fluctuations may occur within any or all of the following phases: (1) shock, (2) anxiety/fear, (3) bargaining, (4) denial, (5) mourning or grief, (6) depression, (7) withdrawal, (8) anger, (9) hostility/aggression, (10) acknowledgement, (11) acceptance, and (12) adjustment (Livneh, 1980).

These stage models provide guidelines for understanding and predicting the course and outcome of the response process, have been experienced and expressed by persons with disabilities, and have been viewed as normative (see Crisp, 1993; Smart, 2009b). However, scholars have also criticized stage models, stating that they are inadequate in explaining the disability experience (Parker, Schaller, & Hansmann, 2003). Stage models are silent on the impact of prejudice and discrimination; ignore the ongoing continuous nature of response to disability, especially for individuals who have gradually deteriorating conditions; do not consider

the time of onset, coping strategies, and environmental resources; and do not account for the impact of cultural/linguistic/ethnic variables and identity (Graf, Marini, & Blankenship, 2009; Livneh & Antonak, 2005; Smart, 2009b). Another criticism is that outsiders, persons without disabilities, have primarily been the ones to describe the response process (Olkin, 1999).

The term response to disability, rather than adjustment, adaptation, or acceptance, has been cited as a more preferable term to describe one aspect of the disability experience (Smart, 2009b). A person's response to disability is a complex, multifactorial process that entails behavioral, cognitive, and affective reactions (Smart, 2009b). This response is influenced by multiple factors, including prognosis, age of onset, reactions from family and friends, societal attitudes, degree of prejudice and discrimination experienced, sense of personal responsibility, encounters with barriers to access, level of integration, access to role models, and coping strategies (Crisp, 1993; Livneh & Antonak, 2005; Olkin, 1999; Phillips, 1990; Smart, 2009b). This list, though not exhaustive, demonstrates the complex nature of the response process.

Smart (2009b) alluded to a different response process for children with congenital disabilities, pointing out that they might not recognize stigma until they enter school. Additionally, the response process is not applicable only to the individual with a disability; there are also meaning and ramifications for the entire family, whether the disability is congenital or acquired (Alston & Turner, 1994; Olkin, 1999). It is this personal meaning ascribed to the disability that has been viewed as part of the response process and been equated with the idea of transcendence (Smart, 2009b). Disability, therefore, is not a single event; rather, it is a process that is influenced by personal, interpersonal, and societal variables (Graf et al., 2009; Olkin, 1999; Smart, 2009b) that has the potential to enable or disable (Tate & Pledger, 2003).

Everyday experiences of persons with disabilities. The daily lives of persons with disabilities have been equated with the minority group experience (Bell, 2013; Olkin, 1999; Phillips, 1990). This minority group experience has been described as an interlocking relationship among stigma, stereotypes, prejudice, and discrimination (Corrigan & Lam, 2007; Overton & Medina, 2008). Stigma is the product of stereotypes, prejudice, and discrimination (Corrigan & Lam, 2007). Negative stereotypes lead to prejudice, and prejudice is the result of cognitive and affective responses to stereotypes. Prejudice, then, leads to discrimination, and discrimination is a behavioral response to emotions and beliefs resulting from prejudice (Overton & Medina, 2008). Although these are all common experiences among persons with a range of disabilities, a stigma hierarchy associated with different categories of disabilities has been described in the literature. In general, there is greater acceptance of persons with physical disabilities than persons with sensory disabilities, and persons with sensory disabilities generally experience less stigma than persons with emotional/psychological or cognitive disabilities (Goodyear, 1983; Overton & Medina, 2008; Smart, 2009b).

Despite these differences, the dominant discourse regarding persons with disabilities is that disability is a tragedy (Hevey, 1993; Olkin, 1999). It is this discourse that has contributed to the misconceptions, negative attitudes, and stereotypes about disability and persons with disabilities (Smart, 2009b). These negative perceptions or individual forms of prejudice and discrimination are experienced by persons with disabilities in the following ways: (1) treated as perpetual children; (2) viewed as an object of pity; (3) assumed to have additional impairments or to be unintelligent or incompetent (disability spread); (4) experienced feeling invisible or ignored or felt an invasion of privacy; and (5) seen as brave, courageous or superhuman (Olkin, 1999; Phillips, 1990; Smart, 2009b). Persons with disabilities repeatedly express encountering

misconceptions and the negative attitudes of others as more disabling than the impairment itself, and these experiences have been characterized as microaggressions (Bell, 2013; Graf et al., 2009; Olkin, 1999).

Structural forms of prejudice and discrimination are felt by persons with disabilities on organizational, institutional, and systems levels (Corrigan & Lam, 2007). These structural forms of prejudice and discrimination are encountered through environmental and architectural barriers and by rules, policies, and procedures that limit the opportunities of persons with disabilities and have been described as unintentional or intentional forms of prejudice and discrimination (Corrigan & Lam, 2007). Unintentional structural forms of prejudice and discrimination result from environmental and architectural barriers. For example, barriers exist when buildings are not equipped with wheelchair entrances and have only stairs, when elevators are not labeled with Braille, when the housing environment impedes independent living, and when the lack of reasonable accommodations inhibits academic and occupational goals and productivity (Dunn, 1990; Friedman, 1993; Milsom, 2006; Olkin, 1999). Intentional structural forms of prejudice and discrimination, on the other hand, are represented in state laws that limit the marriage and custody rights of people with mental health disorders (see Corrigan & Lam, 2007). Whether subtle or overt, negative attitudes, stereotypes, prejudice, and discrimination affect the lives of persons with disabilities.

Disability identity. Disability identity is a multifaceted construct that has been conceptualized as encompassing both personal and social identities (Beart, Hardy, & Buchan, 2005; Olkin, 1999). Arguably, one of the most tenuous aspects of discussing disability identity is the question: “who defines a person as having a disability?” This question can be answered in two primary ways: (1) a person self-identifies as having a disability or (2) society (i.e., majority

culture) labels a person as disabled. Personal disability identity requires self-definition, whereas social disability identity is a social construct in which the majority group defines who has a disability (Beart et al., 2005; Olkin, 1999). In her Ted Talk, Amy Mullins (2010), who is an athlete, actress, and activist clearly communicated the distinction between personal and social disability identity when she stated:

There is an important difference and distinction between the objective medical fact of my being an amputee and the subjective societal opinion of whether or not I'm disabled. And, truthfully, the only real and consistent disability I've had to confront is the world ever thinking that I could be described by those definitions [referring to dictionary definitions of disability].

It seems that Amy chooses to self-identify as an amputee, while rejecting the notion that she is disabled as defined by societal standards. This distinction between personal and social disability identity has been challenged. The opposing view is that personal and social identities are inseparable because individuals derive their identities from social interactions and by the salience of the identity at a particular time (see Beart et al., 2005; Olkin, 1999; Smart, 2009b).

Scholars have conceptualized disability identity as a process of minority identity development that exists along a continuum, and that has been associated with political activism (Gill, 1997; Olkin, 1999; Putnam, 2005). Gill (1997) likened disability identity development to other minority identity development models, asserting that disability identity development follows a similar trajectory but does so based on four different types of integration. It is unclear whether Gill (1997) viewed disability identity development as a fluid process since she refers to types of integration, rather than describing a traditional stage model approach. Nonetheless, she

presents her framework as a discussion of how persons with disabilities describe who they are (i.e., identification) and where they belong.

The first type is described as integrating or assimilating into the majority culture (“coming to feel we belong”). The second type includes those who choose to integrate with a disability community (“coming home”). The third type describes those who experience internal conflict in which they must contend with valuing the part of the self that is not valued by the majority culture (“coming together”). The fourth type describes those who experience a sense of freedom in being oneself without internal conflict or social discomfort (“coming out”). “Coming out” means that there is congruency between the private and public selves (Gill, 1997).

Accepting or rejecting a disability identity is represented in Olkin’s (1999) conceptualization of disability identity as occurring along a continuum and including three main groups of people that range from non-disabled to disability activist. Persons who reject having a disability identity may do so for a number of reasons, including but not limited to the use of denial as a defense mechanism (Beart et al., 2005; Smart, 2008b). Some individuals may have a hidden impairment or disability, so they can “pass” as non-disabled (e.g., learning or mental disabilities), while others may refuse to accept the socially constructed definition of disability (Dunn & Burcaw, 2013; Olkin, 1999).

Another interpretation is that disability identity may be activated based only on contextual factors (e.g., activation based on an inaccessible building versus collaborating on a presentation with a colleague) (Dunn & Burcaw, 2013). Each of these scenarios presents different personal narratives, meanings, and subjective realities of disability identity (Dunn & Burcaw, 2013; Hallberg & Carlsson, 1993; Morris, 1992).

Regardless of the conceptualization used to describe disability identity, the literature suggests several variables associated with positive disability identity development. Disability self-concept, disability identity, and self-efficacy have all been identified as important variables associated with life satisfaction (Bogart, 2014). Affirmation of disability identity has resulted in lower levels of depression and anxiety, has been associated with age of onset, has predicted refusal of treatment, and has been presented as one dimension of a political disability identity (Bogart, 2014; Darling & Heckert, 2010; Hahn & Belt, 2004). Moreover, disability identity may be influenced by the response process, the visibility of the disability, and most significantly, societal perceptions or judgments (Smart, 2009b).

Multiple minority statuses for persons with disabilities. The idea of multiple identities among persons with disabilities is a relatively new aspect of the discourse within disability studies and the multicultural literature. In general, persons with disabilities have been viewed as unidimensional beings, defined solely by one aspect of their identity. Although a singular disability identity may be useful in some contexts (e.g., for political and definitional purposes), this perspective fails to acknowledge the multiple identities of persons with disabilities, including gender, gender expression, class, race/ethnicity, and sexual orientation (Harley et al., 2002; Henry, Fuerth, & Figliozzi, 2010; Ostrander, 2008). Consequently, some scholars have challenged the segmented and categorical identity perspective and have asserted that identities need to be conceptualized as “intersections” and “overlaps” (Erevells & Minear, 2010; Higgins, 2010; Reynolds & Pope, 1991; Robinson, 1993, 1999).

The complexity and salience of multiple identities for persons with disabilities is impacted by contextual, situational, and environmental factors, as well as social roles and cultural norms and values (Drummond & Brodman, 2014; Higgins, 2010; Huang & Brittain,

2006; Whitney, 2006). Many identity development models focus on only one aspect of identity and are not sufficient to explain or understand multiple minority statuses (Allston & Bell, 1996; Henry et al., 2010; Huang & Brittain, 2006; Whitney, 2006).

For instance, inattention to the sexuality of persons with disabilities portrays individuals with disabilities as asexual, and thereby immune to the prejudice and discrimination experienced by sexual minorities (Schulz, 2009). However, persons with disabilities who identify as queer, lesbian, gay, bisexual, or transgender must negotiate these identities in a society that values able-bodiedness and heterosexism. The narratives of sexual minorities with disabilities illustrate that the nature, onset, and visibility of the disability, as well as the level of acceptance within the majority culture and non-heterogemonic community impact the integration of these identities into the overall self-concept (Henry et al., 2010; Whitney, 2006).

A similar scenario holds true for persons with disabilities and the gender role expectations held by society (Huang & Brittain, 2006; Ostrander 2008). Meekosha (2002) communicated the inherent complexities of negotiating multiple minority identities when she stated, “our identities are constantly in tension, as we are defined by others and redefined by ourselves” (p. 67). Morris (1992) contended that inclusion of feminist theory and methodology into disability research may allow persons with disabilities to take ownership of the definition of oppression, provide a translation of their subjective realities, and empower and liberate persons from all social groups.

Multicultural Counselor Training, Preparation, and Competence

Multicultural counselor competencies and standards. The multicultural counselor competencies are drawn from almost 30 years of proactive leadership and advocacy, development of culture-specific organizational initiatives, and shifts from monoculturally-

focused to multiculturally-focused counselor preparation and research (Arredondo et al., 2008; Irvin & Pedersen, 1995; McRae & Johnson, 1991; Robinson, 1999; Sue, 1978; Sue et al., 1982, 1992; Sue & Sue, 1977). These actions helped to create a climate for the introduction of guidelines and recommendations relevant to culturally competent counseling (Sue et al., 1982). Sue et al. (1992) developed a multicultural counselor competency framework that was later adopted by the Association for Multicultural Counseling and Development (AMCD) and the American Counseling Association (ACA). This landmark framework paved the way for the implementation of multicultural competencies into professional codes of ethics and standards of practice (ACA, 2009, 2014) and training and accreditation standards (CACREP, 2009, 2016).

The conceptual framework developed by Sue et al. (1992) described a matrix of three characteristics by three domains, with 31 competencies. According to this framework, culturally competent counselors possess the following characteristics: (1) an awareness of their own cultural values and biases, (2) an awareness of the client's worldview, and (3) use of culturally appropriate interventions and strategies. These three characteristics occur across three domains of competence: beliefs and attitudes (i.e., self-awareness), knowledge, and skills.

This model has provided an initial framework for facilitating multicultural counselor training. It has also resulted in publications that have expounded upon these competencies and introduced new concepts and domains related to multicultural counselor competence. For example, Arredondo et al. (1996) elaborated on the original competencies by making distinctions between multiculturalism and human diversity, including the personal dimensions of identity (PDI) into the framework, and suggesting that organizations use the competencies as an evaluation tool. Furthermore, the initial 31 competencies were clarified and defined in 119 explanatory statements which provided the groundwork for culturally-based learning objectives

and teaching strategies and techniques (Arredondo et al., 1996; Arredondo & Arciniega, 2001). Toporek and Reza (2001) went a step further and developed the multicultural counseling competency assessment and planning model (MCCAP) with the intent of expanding upon the work of Sue et al. (1992) and Arredondo et al. (1996). They acknowledged the dynamic and life-long process of becoming multiculturally competent. According to the MCCAP model, multicultural competence occurs within three different contexts (personal, professional, and institutional), across three modes of learning and change (cognitive, affective, and behavioral), and entails an assessment and planning process.

Most recently Ratts et al. (2015) have revised the original multicultural counseling competencies developed by Sue et al. (1992) to include social justice advocacy competencies. The structure of the multicultural counseling and social justice counseling competency (MSJCC) framework is based on several constructs that connect to the competencies. The construct of intersecting identities and the impact of power, privilege, and oppression on the counseling relationship are integrated throughout the entire framework. Four developmental domains represent different levels of competency; these domains include counselor self-awareness, client worldview, the counseling relationship, and counseling and advocacy interventions. Embedded in the first three developmental domains are the aspirational competencies of attitudes and beliefs, knowledge, skills, and actions. The counseling and advocacy domain, however, is described in terms of a socioecological model. This translates to counselors advocating on behalf of clients on intrapersonal, interpersonal, institutional, community, public policy, and international/global levels (Ratts et al., 2015). These additional contributions illustrate that the multicultural counselor competencies are a living document that will be amended as the

counseling profession increases its understanding of the needs of a culturally diverse and pluralistic society.

Multicultural counselor training and preparation. The pertinence of multicultural counselor training has been described throughout the counselor education literature (Arredondo, et al., 1996; D'Andrea et al., 1991; Dinsmore & England, 1996; Locke & Kiselica, 1999; Sue, et al. 1982, 1992) and has been reflected in accreditation standards (CACREP, 2001, 2009) and in professional codes of ethics (ACA, 2005, 2014). Additionally, researchers have described core elements of multicultural training that promote counselor multicultural competence, including a required multicultural counseling course and infusion of multicultural counseling throughout program curriculum (D'Andrea & Daniels, 1991; Hartung, 1996); curriculum content and instructional strategies (Bluestone, Stokes, & Kuba, 1996; Coleman, 2006; Constantine & Ladany, 1996); minority faculty and student representation (Dinsmore & England, 1996; Ponterotto, Alexander, & Grieger, 1995; Ponterotto & Kasas, 1987); multicultural clinical training and supervision (Allison, Crawford, Echemendia, Robinson, & Knepp, 1994; Ponterotto et al., 1995); and learning environment (Dickson & Jepsen, 2007; Dickson, Jepsen, & Barbie, 2008).

In general, training programs have adopted one of three models to deliver multicultural training: (1) a required multicultural counseling course, (2) infusion of multicultural content throughout the curriculum, or (3) a combination of the two (D'Andrea & Daniels, 1991; Dinsmore & England, 1996). D'Andrea and Daniels (1991) described these programs as operating at a conscientious level regarding multicultural training, and Dinsmore and England (1996) reported that a large percentage of CACREP-accredited programs fit into the conscientious level. Within this single course framework, researchers have introduced multiple

training models and instructional methods (D'Andrea et al., 1991; Irvin & Pedersen, 1995; Malott, Paone, Maddux, & Rothman, 2010).

Evidence suggests a single multicultural counseling course positively impacts variables associated with multicultural competence, such as awareness, knowledge, skills, and racial identity development and attitudes (Brown, Yonker, & Parham, 1996; Castillo, Broassart, Reyes, Conoley, & Phoummarath, 2007; Coleman, Morris, & Norton, 2006; D'Andrea et al., 1991; Diaz-Lazaro & Cohen, 2001; Seto, Young, Becker, & Keselica, 2006). The challenge, however, resides in the limitations inherent in the use of self-report measures, research methodologies, small sample sizes, and the conceptualization of multicultural competence within the assessment instruments (Diaz-Lazaro & Cohen, 2001; Malott, 2010).

Despite these limitations, students have expressed finding value in completing an introductory multicultural counseling course (Tomlinson-Clark, 2000) and have indicated an increased awareness, openness, and interest in multicultural issues resulting from course completion (Heppner & O'Brien, 1994). Castillo et al. (2007) also demonstrated that a multicultural counseling course was superior in increasing self-awareness and decreasing implicit racial bias in comparison with a counseling foundations course, thereby providing evidence that a multicultural counseling course is beneficial in promoting aspects of multicultural competence.

Studies examining introduction to multicultural counseling course syllabi and educators', students', and counselors' assessments of course objectives, curriculum content and pedagogical strategies have produced some valuable data (Bluestone et al., 1996; Constantine & Ladany, 1996; Dickson & Jepsen, 2007; Green et al., 2009; Heppner & O'Brien, 1994; Malott et al., 2010; Priester et al., 2008). For example, the self-awareness and knowledge domains of the

multicultural competencies tend to be emphasized more than the skills domain (Malott et al., 2010; Priester et al., 2008). Although multicultural training has begun to shift its focus beyond race/ethnicity, other aspects of multiculturalism and human diversity are not covered as thoroughly (Bluestone et al., 1996; Priester et al. 2008). These findings are consistent with the self-reported overall training experiences and multicultural competence of both trainees and practitioners (Allison et al., 1994; Green et al., 2009; Holcomb-McCoy & Myers, 1999).

Some scholars suggest developing multicultural training and competence requires more than a single multicultural counseling course (D'Andrea & Daniels, 1991; Dickson & Jepsen, 2007; Ponterotto et al., 1995; Ponterotto & Casas, 1987; Tomlinson-Clark, 2000). Additional elements of multicultural training include infusion of multicultural content across the training curriculum, the learning environment, clinical and supervision training experiences, minority representation of students and faculty, and research considerations (Allison, Echemendia, Crawford, & Robinson, 1996; Bluestone, et al., 1996; Coleman, 2006; Dickson & Jepsen, 2007; Dickson et al., 2008; Kennedy, Neifeld Wheeler, & Bennett, 2014). These elements have not only been associated with counselor multicultural competence, but they have also been used to evaluate the multicultural competence of academic training programs (Allison et al., 1996; Coleman, 2006; Constantine & Ladany, 1996; Green et al., 2009).

Although students and practitioners view multiculturalism and human diversity as important components of their training, they report inadequate coverage of and dissatisfaction with the breadth of diversity training in coursework, clinical practice, and research (Allison, et al., 1994; Green et al., 2009; Holcomb-McCoy & Myers, 1999; Sewart, 2014). Similarly, students expressed feeling underprepared to address issues such as privilege and oppression, as they reported insufficient academic and clinical training in these areas (Hayes, Dean, & Chang,

2007). In addition, professional counselors have reported less than adequate multicultural training experiences, yet they perceive themselves as multiculturally competent in areas that are inconsistent with reported training experiences (Allison et al., 1994; Holcomb-McCoy & Myers, 1999).

Clinical practicum and supervision training experiences and program cultural ambience and learning environment have been identified repeatedly as important components of multicultural training and competence when compared with other training experiences (Allison et al., 1996; Dickson & Jepsen, 2007; Dickson et al., 2008; Manese, Wu, & Nepomuceno, 2001). With regard to the learning environment, perceived credibility of the instructor, psychological safety in the classroom, racial climate, and classroom diversity have all been cited as important to multicultural training and competence (Hayes et al., 2007; Kennedy, 2014; Ramsey, 2000; Sewart, 2014; Tomlinson-Clark, 2000). Moreover, clinical training and supervision experiences have been identified as two of the most effective training experiences relevant to providing services to culturally diverse populations and have predicted self-reported multicultural competence with specific culturally diverse groups (e.g., African Americans, sexual orientation, economic disadvantage, and motor and sensory impairment) (Allison et al., 1994; Allison et al., 1996).

Currently, most scholars, researchers, and practitioners recognize that multiculturalism extends beyond race, ethnicity, and culture and includes other aspects of human diversity (Arredondo et al., 1996; Fukuyama, 1990; Reynolds & Pope, 1991; Sue et al., 1992). This broader definition of multiculturalism is represented in accreditation standards and professional codes of ethics (ACA, 2014; CACREP, 2009). However, this broader perspective of cultural diversity has not yet been demonstrated in course curriculum, minority faculty and student

representation, and in clinical and supervision training experiences (Allison et al., 1994; Bluestone et al., 1996; Foley-Nicpon & Lee, 2012; Pope-Davis et al., 2001; Priester et al., 2008).

Pedagogical and instructional strategies. Counselor education has not yet developed a clear and concise pedagogy to guide instruction and has received criticism for lacking a comprehensive and evidenced-based model for teaching and learning (Fong 1998; Malott, Hall, Sheely-Moore, Crell, & Cardaciotto, 2014; Nelson & Neufeldt, 1998). Despite these limitations, scholars have proposed a range of pedagogical practices for teaching in the counselor education curriculum, both in general and in multicultural counselor training specifically. For instance, some pedagogical approaches described in the literature are rooted in both traditional and postmodern counseling theories, including didactic, experiential, participatory, and feminist strategies and methods (Enns, Sinacore, Ancis, & Phillips, 2004; Granello, 2000; Henriksen, 2006; Smith-Adcock, Ropers- Huilman, & Choate, 2004). Of these pedagogies, feminist principles and practices have been directly and indirectly linked to multiculturalism (Crethar et al., 2008; Enns et al., 2004; Ramsey, 2000; Smith-Adcock et al., 2004). Feminist and multicultural pedagogies challenge traditional teaching practices. They parallel and intersect with one another based on a shared focus on inclusive and diverse content and curricular models; recognize multiple identities and their impact on teaching and learning; attend to power in relationships; and explicitly address oppression, privilege, and power (Enns et al., 2000; Smith-Adcock et al., 2000).

Traditionally, didactic teaching strategies have been at the forefront of multicultural counselor training with an emphasis on increasing counselor knowledge of racial/ethnic groups (Priester et al., 2008). Cultural knowledge is undeniably an important element of multicultural competence, yet the use of didactic teaching strategies has received much criticism, including:

(1) the focus has been on others rather than the self, (2) the knowledge domain of competency has concentrated on the cognitive aspect of learning, and (3) affective and behavioral aspects of learning have been neglected (Kim & Lyons, 2003; Malott, 2010; McRae & Johnson, 1991). Alternatives entail giving greater attention to trainees' cultural background and its impact on their competency (McRae & Jonson, 1991; Sue et al., 1992), implementing participatory and experiential instructional strategies (Arredondo et al., 1996; Arredondo & Arciniega, 2001), and giving greater attention to the awareness and skills domains of competency (Burnett, Hamel, & Long, 2004; cook et al., 2012; Heppner & O'Brien, 1994; McRae & Johnson, 1991).

Experiential instructional methods have been recommended as pedagogical tools to enhance multicultural counselor competence and to address the affective and behavioral components of learning (Arredondo & Arciniega, 2001; Author & Achenbach, 2002). Tyler and Guth (1993) posited that using different forms of media provides educators with the opportunity to develop experiential classroom activities that are process-oriented and promote a greater impact on behavior. Authors of conceptual articles have recommended various experiential methods of instruction including the use of interactive drama (Tromski & Domston, 2003), real life scenarios with complementary lectures (Brinson et al., 2008), and games and simulations (Benns-Sutter, 1993; Kim & Lyons, 2003). Many of these experiential activities are described as in-class exercises and typically focus on race and racism (Brinson et al., 2008; Cook et al., 2012; Kim & Lyons, 2003).

Service learning activities and cross-cultural immersion experiences outside the classroom environment have also revealed, through self-reflection writing, positive outcomes (Burnett et al., 2004; Hipolito-Delgado et al, 2011; Mio, 1989). When students were given the opportunity to evaluate the effectiveness of multiple instructional strategies within a

multicultural counseling course, they most often referred to cross-cultural contact (e.g., presentations by culturally different guest speakers) as the most important component of the course and noted cognitive, affective, and behavioral aspects of learning as a result of these experiences (Diaz-Lazaro & Cohen, 2001; Heppner and O'Brien 1994). Although these exposure-based methods of instruction have yielded positive results, instructors are encouraged to carefully consider ways to highlight differences and strengths within subgroups of culturally diverse populations as a means to counteract any stereotypes (Malott, 2010).

Counselor educators have a myriad of experiential teaching strategies to consider when developing multicultural course content and curriculum. When selecting these strategies, they should consider: (1) the purpose, timing, and structure of the activity or assignment; (2) its impact and effectiveness relative to the desired outcomes; (3) the learning styles and needs of all students; and (4) the responsible and ethical implementation of these instructional strategies (Author & Achenbach, 2002). Although instructors who teach in a distance education learning environment face different challenges when selecting appropriate instructional methods to promote cultural competence, Ancis (1998) posited that instructional adaptations can be made within the distance learning environment. For instance, videotaped assignments; affect checks in the form of journal writing and reflection papers; use of electronic mail, web-based listserves, and websites; and multimedia projects can be implemented.

The multicultural training and instruction literature has provided counselor educators with basic knowledge on the use of specific instructional strategies to facilitate multicultural competence. Instructional methods typically have been classified as didactic, experiential, or participatory and have been used within the classroom learning environment and in activities and assignments outside the classroom (Arredondo & Arsiniega, 2001; Cook et al., 2012; D'Andrea

et al., 1991; Diaz-Lazaro & Cohen, 2001; Hipolito-Delgado et al., 2011; Kim & Lyons, 2001). A challenge for researchers is the lack of consistency in the language used to describe specific instructional methods. For example, scholars have described instructional activities and assignments as participatory, self-exploration, self-reflection, service learning, and immersion, which makes it difficult to classify and compare instructional methods. The existing literature provides a foundation for multicultural training and instruction, but future research studies should address limitations in the current literature (see Malott, 2010).

Intergroup contact and exposure. The concept of intergroup contact was developed on the premise that direct face-to-face contact between culturally different groups helps to reduce intergroup prejudice and hostility and to produce positive attitudes between groups (Allport, 1954; Amir, 1969; Pettigrew, 1998). Intergroup contact theory initially was developed for racial and ethnic encounters. However, it has shown applicability to other groups (Pettigrew & Tropp, 2006) and has been examined in a variety of social contexts, under certain conditions (e.g., equal group status within the situation, intergroup cooperation, and common goals) and through direct and indirect methods of contact (Addison & Thorpe, 2004; Hewstone & Swartz, 2011; Strohmer, Grant, & Purcell, 1984; Wittig & Grant-Thompson, 1998).

The examination of the effect of intergroup contact on attitudes has extended to research concerning persons with disabilities. Contact with persons with disabilities by persons without disabilities has been defined and measured from several vantage points, including type, frequency, and extent of contact; social context; quality of contact; and proximity and social distance (Addison & Thorpe, 2008; Alexander & Link, 2003; Gaier, Linkowski, & Jacques, 1968; Negri & Briante, 2007). Given the lack of consistency in defining intergroup contact, it is difficult to make comparisons across contact conditions. However, direct personal contact and

accumulated contact with persons with disabilities repeatedly have been shown to positively impact attitudes toward persons with disabilities in different participant populations (Addison & Thorpe, 2004; Alexander & Link, 2004; Yunker & Hurley, 1987). Contact with persons with disabilities measured within a range of social contexts and methods also has been associated with multicultural competence. However, inconsistencies in results regarding the impact of contact on self-awareness, knowledge, and skills may result from how contact is measured and the methodology used in the studies (Diaz-Lazaro & Cohen, 2001; Strike et al., 2004). For example, Strike et al. (2004) found group differences, based on level of experience, to be greatest for perceived skills, followed by perceived knowledge, and self-awareness. Diaz-Lazaro and Cohen (2001), on the other hand, reported significant associations between accumulated cross-cultural contact and perceived self-awareness and perceived skills but not perceived knowledge.

Ethical and legal implications. Professional counselors are legally and ethically bound to provide competent services to persons with disabilities. These professional obligations have been formalized within several legislative acts and in professional codes of ethics. The ADA (1990), which has been referred to as the civil rights act for persons with disabilities, prohibits discrimination and mandates public access, accommodations, and services for persons with disabilities. Professional counselors, as providers of a public service, are therefore required to provide non-discriminatory and accessible care to persons with disabilities (Strike, 2001). Non-discriminatory behavior is also required by the *ACA Code of Ethics* which explicitly prohibits non-discrimination of persons with disabilities (ACA, 2014 C.5). These mandates are applicable to all professional counselors regardless of specialization or professional setting.

The *ACA Code of Ethics* explicitly states that multicultural counseling competency is required across all counseling specialties and is applicable to a diverse client population (ACA,

2014, C.2.a). Although persons with disabilities are not specifically mentioned in this standard, the code states that “counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population” (ACA, 2014, C.2.a). Given compelling evidence that persons with disabilities are included within the multicultural family, it is critical for counselor training programs to equip future practitioners with competencies to work with persons with disabilities (D’Andrea et al., 2006; Erickson-Cornish, Gorgens, Monson, Olkin, Palombi, & Abels, 2008). If persons with disabilities are considered part of the multicultural counseling family, and if all counselors are not receiving appropriate training, then counselors are faced with practicing beyond their level of competence and violating ethical guidelines requiring multicultural competence for a diverse client population.

Multicultural Counselor Training, Competence, and Disability

Multicultural training and disability. Few researchers have directly examined the impact of training on counselor multicultural disability competence. Disability-related concerns are either absent from training or underrepresented in curriculum content (Allison et al., 1994; Bluestone et al., 1996; Priester et al., 2008; Smith et al., 2008). There is, however, evidence that training experiences positively impact self-reported multicultural disability competence (Hollimon, 2007; McLennon, 2012; Strike et al., 2004). Allison et al. (1996) found that the number of trainee therapy cases predicted self-reported competence for working with clients who have motor and sensory impairments, while quality of supervision predicted self-reported competence for clients with motor impairments.

Multicultural disability competence. Multicultural disability competence is based on the tripartite model of multicultural counselor competence (Sue et al., 1992), the minority group

model of disability, and the merging of these theoretical frameworks by Strike (2001). This merged model translates to professional counselors acquiring the necessary self-awareness, knowledge, and skills to work competently with persons with disabilities. Based on this multicultural disability competency framework, scholars have identified a variety of perspectives regarding important aspects of these competencies. For instance, counselor self-awareness requires an evaluation of attitudes, beliefs, stereotypes, and biases regarding persons with disabilities. Counselor self-awareness also means understanding the impact of being disabled or non-disabled (Strike, 2001; Strike et al., 2004). Counselor knowledge refers to factual information about disability and disability-related concerns (e.g., employment and language), whereas counselor skills entail assessment and case conceptualization skills (Strike, 2001; Strike et al., 2004).

Self-awareness/beliefs/attitudes toward persons with disabilities. Within the multicultural competency literature, counselor self-awareness has been inextricably linked to attitudes and beliefs and the need to check biases and stereotypes regarding culturally different groups (Arredondo et al., 1996; Strike et al., 2004; Sue et al., 1992). Counselor self-awareness regarding persons with disabilities is essential because attitudes are shaped by a wide range of factors, including previous contact, information about the disability, social context, level of education, use of language and labels, and type and severity of the disability (Diaz-Lazaro & Cohen, 2001; Granello & Gibbs, 2015; Kaplan, 1994; Olkin, 1999; Thomas et al., 2011). Attitudinal research regarding persons with disabilities is extensive and falls into two general areas: (1) attitudes of the nondisabled toward persons with disabilities, and (2) attitudes of rehabilitation professionals and students toward persons with disabilities (Kaplan, 1984; Olkin & Pledger, 2003; Rosenthal et al., 2006; Wong, Fong, Da Silva Cardoso, Lam, & Miller, 2004).

Although rehabilitation professionals receive specialized training to work with persons with disabilities, results of attitudinal research studies indicate inconsistencies with regard to attitudes (Kaplan, 1984; Rosenthal et al., 2006; Strohmer et al., 1984). Differences in attitudes toward persons with disabilities seem to emerge by professional specialization (Carney & Cobia, 1994; Thomas et al., 2011).

Olkin (1999) identified three interlocking factors that affect attitudes toward persons with disabilities: information about the disability, beliefs, and prior contact. She asserted that beliefs are impacted by information about the disability, and information about the disability, therefore, is impacted by exposure and contact (e.g., attitudes of significant others, education, and mass media). One component of this interlocking relationship is supported by a study conducted by Addison and Thorpe (2004) in which accuracy of knowledge was, in part, related to more favorable attitudes toward persons with mental illness.

The multidimensionality of exposure/contact and its impact on counselors' and psychologists' attitudes toward persons with disabilities and their perceived level of self-awareness have been examined from different perspectives and in a variety of contexts. Exposure/contact within academic training and through personal/interpersonal and work-related experiences have all demonstrated some level of positive impact on attitudes and perceived multicultural disability competence (Allison et al., 1996; Hollimon, 2007; Strike et al., 2004). Exposure/contact in academic training environments has been described in terms of coursework, practicum/internship experiences, and supervision (Allison et al., 1996; Diaz-Lazaro & Cohen, 2001), while non-academic contact has been conceptualized based on personal, interpersonal, and work experiences (Hollimon, 2007; Strike, 2001). In general, helping professionals (e.g., counselors, psychologists, and disability specialists) who have exposure/contact with persons

with disabilities rate themselves with higher levels of self-awareness than those who have limited to no exposure/contact (Diaz-Lazaro & Cohen, 2001; Hollimon, 2007; Strike et al., 2004). However, Hollimon (2007) found no differences in attitudes toward persons with disabilities between those who had close versus limited to no contact with persons with disabilities. The results of these studies demonstrate the complexities of the effects of exposure/contact on attitudes toward persons with disabilities and perceived self-awareness.

Level of knowledge regarding persons with disabilities. Knowledge about disabilities and persons with disabilities can encompass a diverse range of topics. Some professional counselors and counselor trainees may question the need for such knowledge because rehabilitation professionals specialize in working with persons with disabilities. The fact is that greater inclusion of persons with disabilities into mainstream society increases the likelihood that counselors working in a variety of settings will encounter persons with disabilities (Beecher, Rabe, & Wilder, 2004; Olkin & Pledger, 2003; Rawlings & Longhurst, 2011). Consequently, counselors need to have basic knowledge of disability laws (e.g., ADA, IDA, and Section 504 of the Rehabilitation Act of 1973), disability-related concepts (e.g., disability, handicapped, and ableism), the sociopolitical history of persons with disabilities, models of disability, and developmental concerns and challenges for those persons with disabilities who have multiple minority group statuses (Erickson Cornish et al., 2008; Hosie, Patterson, & Hollingsworth, 1989; Rawlings & Longhurst, 2011; Strike, 2001; Strike et al., 2004).

The knowledge domain of multicultural competence is generally associated with coursework and/or didactic teaching strategies. The topic of disability or persons with disabilities often is not included in the counselor education curriculum, including multicultural counseling coursework (Rawlings & Longhurst, 2011; Reid-Cunningham & Fleming, 2009;

Priester et al., 2008). Although little is known about counselors' level of knowledge about disability, school counselors' preparation to work with students with disabilities has been examined with respect to coursework and practicum experiences (Milsom, 2002; Milsom & Akos, 2003; Romano, Paradise, & Green, 2009). School counselors in these studies felt somewhat unprepared to work with students with disabilities and anxious about performing tasks related to Section 504 accommodations; however, they indicated that receiving information about students with disabilities (e.g., completion of coursework or attending workshops) made them feel more prepared to do so (Milsom, 2002; Romano, 2009).

Level of skills regarding persons with disabilities. Basic counseling skills are important when working with any client population; however, some additional skill sets may increase counselor efficacy when working with clients with disabilities. These skills include: (1) assessment and case conceptualization skills; (2) language used to describe disability; (3) communication guidelines for interacting with persons with different types of disabilities, and (4) consultation and advocacy skills (Beecher et al., 2004; Erikson Cornish et al., 2008; Strike, 2001; Strike et al., 2004). Assessment and case conceptualization skills are necessary for working with any client(s); however, some additional considerations exist for counselors when working with clients with disabilities. First, the guidelines in the *ACA Code of Ethics* (ACA, 2014) call for counselors to develop cultural sensitivity and to consider historical and social prejudices when diagnosing clients with mental disorders (E.5.b., E.5.c.). Counselors must also consider the selection and administration procedures of assessments and the interpretation of results given a person's ability/disability status (E.7.a., E.7.b, E.8). For counselors who are inexperienced in selecting, administering, and interpreting assessment results, consultation skills and relationships with other professionals who have expertise in working with clients with disabilities are crucial.

Counselors also need to include questions about ability/disability status during routine intake assessments, especially since many disabilities and medical conditions are not apparent or visible (Erikson Cornish et al., 2008; Goad & Robertson, 2000).

In comparison with perceived self-awareness and knowledge, professionals consistently have reported lower levels of multicultural disability competency skills (Hollimon, 2007, McDougall, 2008, Strike et al., 2004). These lower ratings are congruent with the identified barriers to mental health services for persons with physical disabilities (Pelletier, Rogers, & Dellario, 1985) and the case conceptualization skills of professionals who lack training to work with clients with disabilities (Kemp & Mallinckrodt, 1996). Kemp and Mallinckrodt (1996) found that untrained therapists were more likely to focus on extraneous issues, less likely to focus on appropriate themes of a sexual abuse survivor with a disability, and more likely to be distracted by the fact that the client had a disability. Counselor biases, either through errors of omission or errors of commission, can result in an overemphasis on the disability or neglect of relevant disability concerns, which can lead to further marginalization or invalidation of the person with a disability (Kemp & Mallinckrodt, 1996).

Additional skills relevant to working with clients with disabilities include the use of language and concepts to describe disability and disability etiquette (Olkin, 1999). The use of person-first language is widely accepted as it focuses on the whole person and not just the disability (APA, 2010). While the use of first-person language is the professional standard, the use of politically correct, politically incorrect, and ultra-correct language had no effect on counselor credibility regardless of disability status (Arokiasamy, Strohmer, Guice, Angelocci, & Hoppe, 1994). Arokiasamy et al. (2004) suggested that persons with disabilities have adjusted to and can succeed despite lack of sensitivity regarding the use of language. However, these results

do not mean that language is unimportant; rather, they point to the relevance of describing disability in a way that is free of bias and reflects how the person with a disability self-identifies (Harley & Brodwin, 1988; Olkin, 1999).

Implications for counselors. The paucity of training that counselors receive regarding persons with disabilities, combined with negative pathologizing images and messages of disability, place counseling professionals at risk of counseling clients with disabilities from a culturally incompetent stance (Olkin, 2002). Cultural incompetence may be unintentional, but it can result in harmful outcomes similar to those cited when counseling racial/ethnic minorities (Arredondo et al., 1996; Sue et al., 1982; Sue et al., 1992). For example, counselors who do not possess the necessary self-awareness, knowledge, and skills to counsel clients with disabilities may further stigmatize and marginalize their clients with disabilities through: (1) inappropriate use and interpretation of assessments, (2) failure to acknowledge the multiple identities of the client, (3) focusing solely on the disability when it is not the presenting concern, (4) viewing disability from the perspective of the dominant discourse, and (5) lacking an understanding of the day-to-day experiences of persons with disabilities (Kemp & Mallingckrodt, 1996; Olkin, 2002; Phillips, 1990).

From a legal perspective, counselors also need to be familiar with disability legislation, such as the policies in the ADA and its amendments, to effectively advocate for persons with disabilities. In order to facilitate counselor multicultural disability competence, counselor educators and researchers need to recognize and value that the experiences of persons with disabilities are similar to and different from other minority groups and, therefore, merit increased attention in counselor training and research. By embracing this perspective, counseling, as a profession, will be less prone to mirror the marginalization and oppression that persons with

disabilities experience in society (Olkin, 2002). This would seem to support Olkin's (1999) comment: "We can not make the mistake of thinking that people who choose helping professions, special education, nursing, rehabilitation, and so on, have more positive attitudes than do others" (p. 66).

Summary of findings. Multicultural disability competence has received limited attention in the research literature. It has been examined indirectly through the use of attitudinal research and by using other variables related to knowledge and skills competencies, such as use of language and case conceptualization (Arokiasamy et al., 1994; Kemp & Malinckrodt, 1996). When directly examined, multicultural disability competence has been shown to be positively associated with attitudes and contact with persons with disabilities (Hollimon, 2007; McDougall, 2008; McLennon, 2012; Strike et al., 2004). However, the multidimensionality of exposure/contact, combined with the tripartite multicultural competency framework, creates a complex picture which has not yet been examined among master's-level counseling trainees.

Chapter 3 Methodology

In this chapter, the methodology used in the research study is presented. This includes a description of the purpose of the study; study design, including dependent and independent variables and sample selection; and a review of the research questions and the instruments used. Data collection and data analysis procedures are also presented.

Purpose of the Study

The primary purpose of this study was to explore the perceived multicultural disability competence of master's-level students in CACREP-accredited counseling programs. Perceived multicultural disability competence was investigated based on students' multicultural counseling course completion and disability-related life experience(s). A second purpose was to determine whether perceived multicultural disability competence differed by multicultural counseling course completion and disability-related life experience(s) and to explore how well these variables predicted self-awareness, perceived knowledge, and perceived skills.

Survey Method

A quantitative methods research design was best suited to answer the research questions identified in this study. Quantitative methods are most appropriate when using objective data, examining associations between variables, identifying group differences, and assessing the relevance of predictor variables.

A web-based survey research design was used to collect data for this study, and the Qualtrics™ website and software was selected for this purpose. This type of research design was chosen for several reasons. First, it provided the ability to easily access a large number of students who are geographically spread across the United States. This, in turn, helped increase the generalizability of the research results. Second, a web-based research design offered

participant anonymity which may have contributed to participants' willingness to respond truthfully (Leedy & Ormrod, 2009). Finally, web-based data collection methods helped reduce the time and cost associated with data collection. These same methods provided greater flexibility and researcher control over survey format, and eliminated the need for data entry, thereby decreasing potential errors (Granello & Wheaton, 2004).

Variables

The dependent variable used in this study was perceived multicultural disability competence and was measured using the Counseling Clients with Disabilities Survey (CCDS) (Strike, 2001). The independent variables included participant completion of a multicultural counseling course and disability-related life experience(s). These independent variables were assessed using items on a biographical questionnaire developed by this researcher.

Correlational and multivariate statistics were used to examine the dependent and independent variables. A correlational design was used to study the relationship between perceived multicultural disability competence and disability-related life experience(s) and perceived multicultural disability competence and completion of a multicultural counseling course. Multivariate analyses were employed to investigate group differences and to assess the impact of predictor variables. Group differences in perceived multicultural disability competence were examined based on participants' responses regarding disability-related life experience(s) and multicultural counseling course completion. Disability-related life experience(s) and multicultural counseling course completion were used to assess how well they predicted self-awareness, perceived knowledge, and perceived skills.

Research Questions

1. What is the relationship between perceived multicultural disability competence and prior disability-related life experiences among master's-level students in CACREP-accredited counseling programs?
2. What is the relationship between perceived multicultural disability competence and completion of a multicultural counseling course among master's-level students in CACREP-accredited counseling programs?
3. Are there significant group differences in perceived multicultural disability competence between students who have neither disability-related life experience(s) nor have completed a multicultural counseling course, students who have disability-related life experience(s) but have not completed a multicultural counseling course, students who have completed a multicultural counseling course but have no disability-related life experience(s), and students who have disability-related life experience(s) and have completed a multicultural counseling course?
4. What amount of variance do the two independent variable sets, disability-related life experience and completion of a multicultural counseling course, contribute to the prediction of the outcome domains of self-awareness, knowledge, and skills?
5. To what extent do master's-level students in CACREP-accredited counseling programs report that the topic of ability/disability or persons with disabilities was covered as a distinct aspect of multiculturalism/diversity in their multicultural counseling courses?

Participants

The target population selected for this study was master's-level students in CACREP-accredited counseling programs. Selection of this sample was based on the premise that CACREP-accredited programs have met specific accreditation standards. Most relevant to this

research study are the standards requiring programs to include social and cultural diversity issues and trends as part of the counseling core curriculum (CACREP, 2009, p. 8; II.G.2.).

According to the CACREP Vital Statistics Survey Report, 36,959 master's-level students were enrolled in CACREP-accredited counseling programs in 2014 (CACREP, 2014).

G*Power3 statistical analysis program was used to calculate the required sample size based on the type of statistical analysis performed, the effect size, power, and level of confidence (Faul, Erdfelder, Lang, & Buchner, 2007). According to a Qualtrics report, a total of 349 surveys were started with 285 surveys being completed, indicating an 85% completion rate.

Instruments

Counseling Clients with Disabilities Survey. Strike (2001) developed the *Counseling Clients with Disabilities Survey* (CCDS) as a self-report instrument used to measure professionals' competence in working with clients with disabilities. The CCDS is a 60-item Likert scale survey with a demographic section plus space provided for additional comments. It is the only known instrument that measures multicultural disability competence. The CCDS was developed based on the tripartite multicultural competency framework and the minority model of disability (Strike, 2001; Strike et al., 2004). The CCDS is copyrighted by Diane L. Strike (2001) and is not provided as part of this manuscript (see Appendix A).

The survey contains a total of 60 items with 3 subscales (20 items per subscale) representing the competency domains of self-awareness, perceived knowledge, and perceived skills. The self-awareness subscale of the CCDS measures the respondents' beliefs and attitudes about the impact of disability and persons with disabilities (Strike, 2001). Sample items include "I consider people with disabilities to be a minority group" and "It is difficult for me to understand how disability could be a source of pride for people with disabilities" (Strike, 2001,

p. 75). The perceived knowledge subscale measures respondents' factual knowledge about disability and disability-related concerns from the perspective of prior exposure or training (Strike, 2001). Example items from this subscale include "I believe that unemployment/underemployment is common among people with disabilities in the United States" and "I think English is the native language of Americans who are deaf from birth" (Strike, 2001, p. 78). The perceived skills subscale measures both skills and behaviors that are desirable when working with persons with disabilities (Strike, 2001). Some sample items from this subscale include "I could take a client's disability into account when interpreting the results of assessment instruments" and "I am not aware of how disability may interact with human sexuality (e.g., family planning)" (Strike, 2001, p. 83). Thirty-five percent of the 60 items are reversed-worded.

The CCDS was designed using a 6-point Likert scale format that requires respondents to report their level of agreement or disagreement: 1 = strongly disagree, 2 = disagree, 3 = slightly disagree, 4 = slightly agree, 5 = agree, and 6 = strongly agree. An overall competency score ranges from 20-360 with subscale scores ranging from 20-120. A high total score indicates greater self-reported competence, and a low total score indicates less competence. It is not appropriate to conclude that a respondent has high or low competence based on a response to an individual item or scale (D. Strike, personal communication, March, 24, 2015).

The CCDS is a relatively new instrument and has been used in only a few studies; therefore, information on its psychometric properties is limited. In Strike's (2001) original study, she employed statistical procedures to compute the internal consistency reliability of the CCDS and its three subscales. The Cronbach's alpha for the total scale was .94. The internal consistency reliability statistics for the subscales were as follows: self-awareness = .67,

perceived knowledge = .87, and perceived skills = .90. Correlational analyses were performed and indicated a positive relationship between the subscales: self-awareness and perceived knowledge scales (.70), self-awareness and perceived skills scales (.69), and perceived knowledge and perceived skills scales (.81).

Comparable reliability statistics have been reported in other research studies. Holliman (2007) and McLennon (2012) reported Cronbach alpha total scale scores of .87 and .78, respectively. McDougall (2008), reported internal consistency reliability subscale scores similar to Strike (2001) (i.e., self-awareness = .60, perceived knowledge = .86, and perceived skills = .89). However, McLennon (2012) reported Cronbach alpha subscale scores that were lower than in other studies; subscale scores ranged from .46 for self-awareness to .62 for perceived skills. The self-awareness subscale had the lowest reported internal consistency reliability score in three studies (McDougall, 2008; McLennon, 2012; Strike, 2001). McDougall (2008) removed three items on the self-awareness subscale and increased the internal consistency reliability subscale score to .70.

Strike (2001) described procedures she used to establish validity of the CCDS. She employed a process of extensive literature review and ongoing professional and expert review to establish construct, content, and face validity. These expert reviewers specialized in the areas of multicultural counseling, disability studies, and survey research. College educated persons who used English as a first language and English as a second language reviewed the CCDS to enhance its readability and to estimate the time needed to complete the survey (Strike, 2001).

Biographical questionnaire. The biographical questionnaire used in this study contained two items from the demographic portion of the CCDS, along with six additional researcher-developed items. The questionnaire consisted of seven items that were designed to

provide descriptive data and information regarding the independent variables, disability-related life experience and multicultural course completion, identified in the research questions. These items prompted participants to respond to questions about counseling area of emphasis, ability/disability status, disability-related life experience, multicultural counseling course completion, and the integration of ability/disability into their multicultural counseling courses. Space was also provided for participants to comment on any additional experiences they believe have contributed to their multicultural disability competence. The biographical questionnaire can be found in Appendix B.

Data Collection Procedures

Permission was obtained to conduct this study from the University of New Orleans (UNO) Committee for Protection of Human Subjects in Research (IRB). A copy of the approval letter is included in Appendix C.

The researcher used the CACREP directory website at www.cacrep.org/directory to obtain information needed to access potential participants. Criteria for inclusion in the study included colleges or universities with a master's-level counseling program. A search of the directory revealed 72 colleges and universities who met these criteria, and these institutions collectively offer 716 different counseling programs within the United States. These institutions were classified as public or private colleges or universities; some had multiple sites. These counseling programs offer master's degrees with concentrations in mental health counseling, community counseling, school counseling, student affairs and college counseling, marriage, couple, and family counseling/therapy, clinical rehabilitation counseling, addictions counseling, career counseling, and gerontological counseling.

Email addresses of the CACREP liaisons were collected using the program links provided in the CACREP directory or through a self-directed search when an error message was received using the provided links. An initial email request was sent to all CACREP liaisons for whom email addresses were located, which included 327 individual email addresses. The message included a request for participation with a description of the purpose of the study and a link to a web-based survey (see Appendix D). CACREP liaisons were asked to disseminate the information to their master's-level counseling students currently enrolled in the institution's CACREP-accredited counseling program(s).

The initial email request for participation was sent to 327 CACREP liaisons. Of the 327 emails sent, four CACREP liaisons reported that their individual universities required IRB approval from that university. Five "out of office" replies were received stating that the CACREP Liaison was on sabbatical. Three of these liaisons provided additional contacts, and the researcher sent these individuals an email message requesting their assistance to distribute the request for participation. Nine email messages were returned as undeliverable.

Two weeks later, a second round of email messages with a request for participation was sent to the original list excluding those universities requiring their own IRB approval. The 323 email requests included rechecking the nine emails that were returned as undeliverable, making corrections, and identifying additional contacts for the two CACREP Liaisons on sabbatical who did not provide alternative contacts. In addition, the researcher sent email requests for participation to 14 newly CACREP-accredited programs. Only one of the 337 was returned as undeliverable.

To help increase access to participants, the researcher also contacted counselor educators and doctoral students she knows and who are associated with CACREP-accredited counseling

programs and forwarded the request for participants to those who responded. Additionally, the researcher posted a request for participation to the AMCD graduate student Facebook group and the AMCD community listserv (see Appendix E). These groups were selected for two main purposes: (1) members interest in multicultural counseling and (2) these groups were open to registered members of AMCD only.

One month into data collection, the researcher posted a request for participation to the CESNET-L listserv and followed-up with a second post one and a half weeks later (see Appendix F). During this period of time, a follow-up request for participation was also sent to the AMCD Community list. Six weeks into data collection, a request for participation was posted to the COUNSGRAD listserv which is an unmoderated listserv for graduate students in counselor education and was reposted to the listserv on two more occasions (See Appendix G). Additionally, a second e-mail request was sent to the 14 CACREP Liaisons of newly accredited counseling programs. Lastly, the researcher created flyers with information about her study and distributed these flyers to interested individuals at the 2016 American Counseling Association Conference (see Appendix H). 349 participants initiated taking the surveys, but only 285 of these surveys were included in the final analyses.

Participants choosing to take the survey were first presented with an informed consent that explained the purpose of the study, the voluntary nature of the study, measures taken to ensure anonymity, and information regarding any known risks and/or benefits associated with participating in the study. The informed consent document can be found in Appendix I. Contact information for the researcher and her dissertation co-chairs were also provided. Once participants agreed to the consent, they were presented with the biographical questionnaire and

the competency scale of the CCDS. Participants were given the opportunity to submit their email addresses for the chance to win one of five \$20 amazon.com gift cards.

Data Analysis Plan

Data analysis procedures included descriptive statistics, Spearman rho correlations, analysis of variance (ANOVA), and multiple linear regression tests. Cronbach's alpha statistics were calculated to determine the internal consistency reliability of the CCDS and its subscales. All statistical tests were performed using the SPSS statistical package version 24.

Research question 1. What is the relationship between perceived multicultural disability competence and prior disability-related life experiences among master's-level students in CACREP-accredited counseling programs?

Hypothesis 1. There will be a statistically significant positive relationship between perceived multicultural disability competence and disability-related life experience(s) among master's level students in CACREP-accredited counseling programs.

Data analysis. A Spearman's rho correlational analysis was conducted to determine the nature of the relationship between participants reported disability-related life experience(s), as measured by item four of the biographical questionnaire and participants' total perceived multicultural disability competency scores on the CCDS.

Research question 2. What is the relationship between perceived multicultural disability competence and completion of a multicultural counseling course among master's-level students in CACREP-accredited counseling programs?

Hypothesis 2. There will be a statistically significant positive relationship between completion of a multicultural counseling course and perceived multicultural disability competence among master's-level students in CACREP-accredited counseling programs.

Data analysis. A Spearman's rho correlational analysis was conducted to determine the nature of the relationship between participants' completion of a multicultural counseling course, as measured by item 5 on the biographical questionnaire and participants' total perceived multicultural disability competence scores on the CCDS.

Research question 3. Are there significant group differences in perceived multicultural disability competence between students who have neither disability-related life experience(s) nor have completed a multicultural counseling course, students who have disability-related life experience(s) but have not completed a multicultural counseling course, students who have completed a multicultural counseling course but have no disability-related life experience(s), and students who have disability-related life experience(s) and have completed a multicultural counseling course?

Hypothesis 3a. Students who have reported disability-related life experience(s) and multicultural counseling course completion will report statistically significant different perceived multicultural disability competency scores than students who reported disability-related life experience(s) but have not completed a multicultural counseling course, students who reported no disability-related life experience but have completed a multicultural counseling course, and students who reported neither disability-related life experience nor multicultural counseling course completion.

Hypothesis 3b. Students who reported disability-related life-experience(s) and non-completion of a multicultural counseling course will report significantly different perceived multicultural disability competency scores than students who completed a multicultural counseling course but have no disability-related life experience and students who reported neither disability-related life experience nor multicultural counseling course completion.

Data analysis. A one-way analysis of variance (ANOVA) was conducted to determine whether there are group differences in perceived multicultural disability competence scores based on student disability-related life experience(s) and completion of a multicultural counseling course.

Research question 4. What amount of variance do the two independent variable sets, disability-related life experience and completion of a multicultural counseling course contribute to the prediction of the outcome domains of self-awareness, knowledge, and skills?

Hypothesis 4. The two independent variables (disability-related life experience(s) and multicultural counseling course completion) will contribute to the outcome domains of self-awareness, knowledge, and skills.

Data analysis. Three multiple linear regression models were calculated to determine whether the independent variables of disability-related life experience(s) and multicultural counseling course completion (items 4 and 5 of the biographical questionnaire) contributed to the prediction of self-awareness, perceived knowledge, and perceived skills as measured by the three subscales of the CCDS.

Research question 5. To what extent did master's-level students in CACREP-accredited counseling programs report that the topic of ability/disability or persons with disabilities was covered as a distinct aspect of multiculturalism/diversity in their multicultural counseling courses?

Hypothesis 5. Master's-level counseling students in CACREP-accredited programs will report that the topic of ability/disability is not covered to the same extent that other topics are covered in a multicultural counseling course.

Data analysis. Descriptive statistics were computed for item 7 on the biographical questionnaire.

Chapter 4 Results

The purpose of this study was to explore the relationship between multicultural disability competence, multicultural counseling coursework, and disability-related life experience(s) among master's-level students in CACREP-accredited counseling programs and to describe the extent to which the topic of ability/disability is being integrated into multicultural course curriculum. In this chapter, the results of this study are presented in three sections. In the first section, frequencies for sample characteristics are given and descriptive and reliability statistics on the CCDS and its subscales are also provided. In the second section, analysis of the five research questions and the one open-ended qualitative question are presented. In the final section, the findings are summarized.

Descriptive statistics

Of the 285 participants who completed the survey, the most prevalent counseling area of emphasis reported was community/clinical mental health counseling ($n = 128, 44.9\%$). The second most common counseling area of emphasis reported by participants was school counseling ($n = 91, 31.9\%$), followed by marriage, couple, and family therapy/counseling ($n = 21, 7.4\%$). These top three counseling areas of emphasis correspond with the CACREP 2014 vital statistics report (CACREP, 2014). The frequencies for remaining counseling areas were each less than 5% of the sample (see Table 1).

Table 1

Participants' Counseling Area of Emphasis by Frequency (n = 285)

Area of Emphasis	N	Percentage (%)
Community, Clinical Mental Health Counseling	128	44.9%
School Counseling	91	31.9%
Marriage, Couple, and Family Therapy/Counseling	21	7.4%
College, Student Affairs Counseling	10	3.5%
Substance Abuse, Addictions Counseling	9	3.2%
Rehabilitation Counseling	14	4.9%
Career Counseling	1	0.4%
Other	11	3.9%

Frequencies were also computed for the independent variables: completion of a multicultural counseling course, and disability-related life experience. A total of 76.8% ($n = 216$) of participants reported completing a multicultural counseling course, and 23.2% ($n = 66$) reported not completing a multicultural counseling course. Disability-related life experience was measured based on type of experience(s), which were categorized as personal, interpersonal, and/or work-related experiences; and how helpful (i.e., not at all, somewhat, and very helpful) these experiences were viewed as being, in enhancing one's ability to effectively counsel persons with disabilities. For type of disability-related life experience(s), participants selected all choices relevant to their own experiences. Based on the three main categories associated with type of disability-related life experience(s), the most prevalent responses were: 11.6% ($n = 33$) of participants reported having a disability (personal), 42.5% ($n = 121$) reported having a family

member or close friend with a disability (interpersonal), 40.7% ($n = 116$) reported having work experience (within the past five years) involving disability (work) (see Table 2). A total of 277 or 97.2% of participants reported some type of disability-related life experience and rated how helpful these experiences in enhancing their ability to effectively counsel persons with disabilities. Participants indicated level of helpfulness as follows: 2.1% ($n = 6$) not at all helpful, 31.6% ($n = 90$) somewhat helpful and 63.5% ($n = 181$) very helpful (see Table 3).

Table 2

Participants' Disability-Related Life Experience by Frequency ($n = 285$)

Disability-Related Life Experience	N	Percentage (%)
I have a disability	33	11.6
I have a medical condition (not a disability)	46	16.1
A member of my immediate family or a close friend has a disability	121	42.5
A member of my extended family, a co-worker, or an acquaintance has a disability	119	41.8
I have recent work experience involving disability (within the last five years)	116	40.7
I have past work experience involving disability (five or more years ago)	58	20.4
Other	12	4.2
None	43	15.1

Table 3

Participants' Perceptions of Helpfulness of Disability Life Experiences by Frequency (n = 285)

Perceptions of Helpfulness	N	Percentage (%)
Not at all helpful	6	2.1
Somewhat helpful	90	31.6
Very helpful	181	63.5

Reliability statistics

To estimate the reliability of the CCDS in this study, Cronbach's alpha coefficients were calculated for the CCDS and its subscales. For the 60 items of the CCDS, a high internal consistency reliability was found: Cronbach's alpha = .907. Internal consistencies for each individual subscale yielded the following results: self-awareness/beliefs/attitudes subscale $\alpha = .696$, perceived knowledge subscale $\alpha = .81$, and perceived skills subscale $\alpha = .851$ (see Table 4). Correlations were calculated between the self-awareness/beliefs/attitudes and the perceived knowledge subscales ($r_s = .543$), self-awareness/beliefs/attitudes and perceived skills subscales ($r_s = .429$), and perceived knowledge and perceived skills subscales ($r_s = .746$), indicating moderate to high correlations between the three scales on the CCDS. The means and standard deviations for the CCDS and its subscales were: CCDS ($M = 235.54$, $SD = 89.101$), self-awareness/beliefs/attitudes ($M = 87.52$, $SD = 8.94$), perceived knowledge ($M = 79.01$, $SD = 11.201$), and perceived skills ($M = 69.01$, $SD = 13.573$) (see Table 5).

Table 4

Internal Consistency of the Counseling Clients with Disabilities Survey (CCDS) and its Subscales

CCDS Subscales	Cronbach's Alpha/ α	Number of Items
Self-Awareness Subscale	.696	20
Perceived Knowledge Subscale	.810	20
Perceived Skills Subscale	.851	20
Total	.907	60

Table 5

CCDS Subscales Scores by Means, Standard Deviations, and Ranges (n=285)

CCDS Subscales	M	SD	Range
Self-Awareness Subscale	87.52	8.940	64-112
Perceived Knowledge Subscale	79.01	11.201	49-111
Perceived Skills Subscale	69.01	13.573	33-114
Total	235.54	89.101	158-233

Analysis of the Research Questions

G*Power3, a statistical analysis program, was used to estimate the sample size needed based on type of statistical analysis (Faul, Erdfelder, Lang, & Butchner, 2007). The estimated sample size for each statistical analysis was computed given a pre-determined effect size, alpha level, and power. For research questions 1 and 2, a G*Power analysis with an effect size of .3,

an alpha level of .05, and a power of .95 indicated that a sample size of 111 participants was required.

Research question 1. Research question 1 examined the relationship between perceived multicultural disability competence and disability-related life experience(s) among master's-level counseling students in CACREP-accredited programs. Perceived multicultural disability competence was measured using the 60-item competency scale of the CCDS. Disability-related life experience(s) was measured using item four of the biographical questionnaire, which allowed participants to rate the level of helpfulness of these experiences in enhancing their ability to effectively counsel persons with disabilities using a 3-point Likert-type scale (i.e., not at all, somewhat, and very helpful).

Hypothesis 1 stated that there would be a statistically significant positive relationship between perceived multicultural disability competence and disability related life experience(s). This means that higher scores of multicultural disability competence on the CCDS would be associated with higher levels of helpfulness on item four of the biographical questionnaire. A one-tailed Spearman's rho correlation test was conducted to calculate the relationship between participants' perceived multicultural disability competence and the level of helpfulness of their reported disability-related life experience(s) in enhancing their ability to competently counsel clients with disabilities. Results supported the hypothesis and indicated a statistically significant moderately positive relationship between perceived multicultural disability competence and level of helpfulness of disability-related life experience(s) ($rs = .378, p < .001$). (See Table 6.)

Research question 2. Research question 2 examined the relationship between perceived multicultural disability competence and completion of a multicultural counseling course among master's-level students in CACREP-accredited counseling programs, as measured by the

competency scale of the CCDS and item five of the biographical questionnaire, which prompted participants to indicate whether they had completed a required multicultural counseling course.

Hypothesis 2 stated that there would be a statistically significant positive relationship between participants' perceived multicultural disability competence and their completion of a multicultural counseling course (i.e., completed or not completed). This means that higher scores of perceived multicultural disability competence would be associated with completion of a multicultural counseling course. A one-tailed Spearman's rho correlation test was conducted to determine the relationship between participants' perceived multicultural disability competence and their completion of a multicultural counseling course. Results supported the hypothesis and indicated a statistically significant positive, but weak, relationship between participants' perceived multicultural disability competence and their completion of a multicultural counseling course ($r_s = .184, p = .001$) (see Table 6).

Table 6

Spearman Correlation Matrix for Variables - Perceived Multicultural Disability Competence (PMDC), Disability-Related Life Experience, and Completion of Multicultural Counseling Course

	PMDC
Disability-Related Life Experience	.378*
Completion of Multicultural Counseling Course	.184*

* $p < .001$

Research question 3. Research question 3 examined whether group differences existed in students' perceived multicultural disability competency scores based on their disability-related

life experience(s) and completion of a multicultural counseling course. Perceived multicultural disability competence was measured using the composite score on the CCDS, and disability-related life experience(s) and multicultural counseling course completion were determined by responses on items 4 and 5 of the biographical questionnaire, respectively. A G*Power3 analysis with an effect size of .25, an alpha level of .05, and a power of .95 indicated that a sample size of 285 participants was needed to detect group differences (Fault et al., 2007). Participants were grouped according to their responses concerning disability-related life experience(s) and multicultural counseling course completion, resulting in a total of four groups. Group 1 included participants with neither disability-related life experience(s) nor multicultural counseling course completion; group 2 included participants who reported completing a multicultural counseling course only; group 3 included participants who reported having disability-related life experience only; and group 4 included participants who reported both disability-related life experience and multicultural counseling course completion.

A one-way between subjects ANOVA was conducted to compare the four identified group conditions on perceived multicultural disability competence. All assumptions for conducting an ANOVA were met, including independence of observations, sample normality, and homogeneity of variances. The test of homogeneity of variances indicated a p value of .130 with a Levine's statistic of 1.899, concluding that the variances are homogeneous. The ANOVA between groups analysis indicated statistically significant group differences $F(3, 281) = 14.724$, $p < .001$ with a partial η^2 of .136 and an observed power of 1.00. A follow-up Scheffe's Post Hoc test was conducted to determine which groups were significantly different from one another. A Scheffe's Post Hoc test was selected because there were unequal groups, and a Scheffe's test provides the greatest protection against Type I error. Post Hoc comparisons indicated a

statistically significant difference in the perceived multicultural disability competency mean scores for the following group conditions: group 1 conditions (M = 209.00, SD = 22.458) (neither disability-related life experience nor multicultural counseling course completion) and group 3 conditions (M = 232.67, SD = 30.938) (disability-related life experience only), group 1 conditions (M = 209.00, SD = 22.458) (neither disability-related life experience nor multicultural counseling course completion) and group 4 conditions (M = 241.60, SD = 27.296) (both disability-related life experience and multicultural counseling course completion), group 2 conditions (M = 213.20, SD = 20.897) (only multicultural counseling course completion) and group 3 conditions (M = 232.67, SD = 30.938) (only disability-related life experience), and group 2 conditions (M = 213.20, SD = 20.897) (only multicultural counseling course completion) and group 4 conditions (M = 241.60, SD = 27 (both disability-related life experience and multicultural counseling course completion).296) (see Tables 7 and 8).

Table 7

One-Way, Between Groups ANOVA for Perceived Multicultural Disability Competence (PMDC) with Group Means and Standard Deviations

Variable	Group 1		Group 2		Group 3		Group 4		F	η^2
	M	SD	M	SD	M	SD	M	SD		
PMDC	209.0	22.45	213.2	20.89	232.6	30.93	241.6	27.29	14.724*	.136
	0	8	0	7	7	8	0	6		

* p<.001

Table 8

Scheffe Post Hoc Tests for Group Comparisons

Group Number		Mean Difference	<i>p</i>
	Group 2	-4.20	.969
Group 1	Group 3	-23.67**	.021
	Group 4	-32.60**	.000
	Group 1	4.20	.969
Group 2	Group 3	-19.47**	.040
	Group 4	-28.40**	.000
	Group 1	23.67**	.021
Group 3	Group 2	19.47**	.040
	Group 4	-8.93	.248
	Group 1	32.60**	.000
Group 4	Group 2	28.40**	.000
	Group 3	8.93	.248

Note: ** denotes a significant difference between two groups.

Taken together, these results partially support hypothesis 3a and fully support hypothesis 3b. Hypothesis 3a stated that students reporting both disability-related life experience(s) and multicultural counseling course completion (group 4) would have statistically significant different perceived multicultural disability competency scores than students reporting only disability-related life experience(s) (group 3), students reporting only multicultural counseling course completion (group 2), and students who reported neither disability-related life

experience(s) nor multicultural counseling course completion (group 1). However, results indicated statistically significant group mean differences on perceived multicultural disability competency scores only between students reporting both disability-related life experience and multicultural counseling course completion (group 4) and students reporting only multicultural counseling course completion (group 2) and students reporting neither disability-related life experience nor multicultural counseling course completion (group 1). Hypothesis 3b stated that students reporting only disability-related life experience(s) (group 3) would have statistically significant different mean scores on perceived multicultural disability competence than students reporting only multicultural counseling course completion (group 2) and neither disability-related life experience(s) nor multicultural counseling course completion (group 1). Results confirmed hypothesis 3b, suggesting that disability-related life experience has a greater effect on perceived multicultural disability competency scores than just taking a multicultural counseling course or the combination of not having disability-related life experience(s) and not completing a multicultural counseling course.

Research question 4. Research question 4 assessed the amount of variance that the two independent variables, disability-related life experience, as measured by level of helpfulness (item 4 of the biographical questionnaire), and completion of a multicultural counseling course (item 5 of the biographical questionnaire), contributed to the outcome of the three different domains of multicultural disability competence as measured by the three subscales of the CCDS (self-awareness, perceived knowledge, and perceived skills). A G*Power3 analysis with an effect size of .3, an alpha level of .05, and a power of .95 indicated that a sample size of 107 participants was needed (Faul et al., 2007). Hypothesis 4 stated that the independent variables

would contribute significantly to the outcome domains of self-awareness, perceived knowledge, and perceived skills.

To analyze the research question and its associated hypotheses, three multiple regression models were employed using the enter method. For each model, the independent variables, disability-related life experience(s) (item 4 of the biographical questionnaire) and multicultural counseling course completion (item 5 of the biographical questionnaire), were simultaneously entered into all models. Because the CCDS utilizes three subscales (self-awareness, perceived knowledge, and perceived skills), a regression model was analyzed for each subscale. The assumptions of linearity, normality, collinearity, homogeneity of variance, and homoscedasticity were checked prior to conducting the analyses using plots and collinearity statistics.

For self-awareness and model 1, all assumptions for conducting a multiple regression were met. The regression equation was significant $F(2, 274) = 10.837, p < .001$ with a coefficient of determination ($R^2 = .073$). Of the two predictors, disability-related life experience(s) was the only significant predictor in Model 1; however, it explained only 7.3% of the variance (see Table 9).

Table 9

Multiple Linear Regression Model for Self-Awareness Using the Enter Model (n = 277)

Variables Included in Model	β	<i>b</i>	<i>p</i>
Constant	72.990		
Disability-Related Life Experience	4.067	.239	.000
Completion of Multicultural Counseling Course	2.252	.106	.071

$R^2 = .073$

For perceived knowledge and model 2, all assumptions of multiple regressions were met. The regression equation for Model 2 was significant $F(2, 274) = 17.843, p < .001$ with a coefficient of determination ($R^2 = .115$). In Model 2, both disability-related life experience(s) and multicultural counseling course completion were significant; however, they accounted for only 11.5% of the variance in the model (see Table 10).

Table 10

Multiple Linear Regression Model for Perceived Knowledge Using the Enter Model (n = 277)

Variables Included in Model	β	<i>b</i>	<i>p</i>
Constant	56.145		
Disability-Related Life Experience	6.264	.296	.000
Completion of Multicultural Counseling Course	3.740	.141	.014

$R^2 = .115$

For perceived skills and model 3, a box plot indicated two outliers. The two cases with outliers on the skills subscale were removed from the data set before conducting the analysis. Model 3 indicated a significant regression equation $F(2, 272) = 24.271, p < .001$ with a coefficient of determination ($R^2 = 0.151$). Disability-related life experience(s) was the only significant predictor in Model 3, and it explained approximately 15.1% of the variance (see Table 11).

Table 11

Multiple Linear Regression Model for Perceived Skills Using the Enter Model Following Removal of Extreme Cases (n = 275)

Variables Included in Model	β	<i>b</i>	<i>p</i>
Constant	39.456		
Disability-Related Life Experience	8.956	.362	.000
Completion of Multicultural Counseling Course	3.445	.111	.050
$R^2 = .151$			

Research question 5. Descriptive statistics were computed to measure the extent to which the topic of ability/disability is covered in multicultural counseling courses in CACREP-accredited programs relative to other topics covered in the course. Item 6 of the biographical questionnaire assessed the level of attention given to ability/disability on a 3-point Likert-type scale where 1 = no attention, 2 = less attention, and 3 = similar attention. Results indicated that 76.5% ($n = 218$) of the sample responded to item 6 of the biographical questionnaire, denoting their completion of a multicultural counseling course. Of these 218 participants, 12.8% ($n = 28$) reported that the topic of ability/disability was given no attention, 54.6% ($n = 119$) reported less attention and 32.6% ($n = 71$) reported similar attention relative to other topics covered in a multicultural counseling course (See Table 11). These results provide support to the hypothesis that the topic of ability/disability is given less attention than other topics covered in a multicultural counseling course.

The researcher was interested in learning more about the instructional strategies counselor educators use to address the topic of ability/disability and/or persons with disabilities in multicultural counseling coursework. For item 7 of the biographical questionnaire, participants selected all instructional strategies used to cover the topic of ability/disability in their multicultural counseling courses. Readings/lectures and class or small group discussions were the two most commonly reported instructional strategies used, followed by the use of multimedia, disability simulations or other experiential activities, and other, respectively (see Table 12). Participants identified guest speakers and student presentations as other instructional strategies used in their multicultural counseling coursework.

Table 12

Participants' Reported Instructional Methods of How the Subject of Disability Was Covered in Their Multicultural Course by Frequency (n = 285)

Type of Instructional Method	N	Percentage (%)
Readings or Lecture	153	53.7
Class or Small Group Discussion	133	46.7
Disability Simulation or Other Experiential Activities	24	8.4
Use of Multi-Media (e.g. video clips, movies, etc.)	65	22.8
Other	39	13.7

Responses to the Qualitative Item

Item 8 on the biographical questionnaire provided participants with the opportunity to comment on any experiences they believed have contributed to their multicultural disability competence. This open-ended question was optional and generated 62 responses, representing a

21.75% response rate. After reading participant comments, the researcher found that participants referenced both disability-related life experience(s) and academic training.

Approximately 73% of participants who responded to item 8 of the biographical questionnaire referred to different types of experience(s) they have had regarding the topic of ability/disability and/or interactions they have had with persons with disabilities. These types of experiences can be categorized into the following areas: (1) personal experience(s), (2) interpersonal experience(s), (3) work-related experience(s), (4) volunteer experience(s), and (5) academic and/or professional training experience(s). A small number of participants identified themselves as individuals with disabilities or described being temporarily disabled. For the category of interpersonal experience(s), participants described interpersonal interactions with both family members and friends who experienced a range of disabilities (e.g., physical, sensory, and mental disabilities). Participants with work-related experience(s) often described these experiences occurring within an educational setting, whereas a few others reported being case managers for individuals with disabilities. A limited number of participants reported volunteering with specific organizations (e.g., Special Olympics and Wounded Warriors) or being involved with other disability-related organizations. Participants referred to academic and professional training experience(s) in terms of undergraduate coursework, professional workshops/presentations, and specific graduate coursework (apart from multicultural counseling). For some participants, the topic of ability/disability was addressed in courses, such as school counseling, assessment and testing, human sexuality, and exceptional learners).

When participants addressed their multicultural disability competence, they referred to their disability-related life experience(s) as valuable and informational. These participants indicated that their experiences helped to increase their self-awareness, knowledge, and skills. A

few of these participants remarked that their disability-related life experience(s) has also helped them to identify gaps in their multicultural disability competence.

Participants expressed concerns about the general lack of education regarding persons with disabilities, as well as the limited to non-existent coverage of ability/disability in the counseling curriculum.

Summary of Findings

Participant responses to the CCDS and the researcher-developed biographical questionnaire were analyzed using descriptive and inferential statistics to answer the five research questions in this study. Two Spearman's rho correlations were calculated: a statistically significant positive relationship was found between perceived multicultural disability competence, measured by the CCDS, and both level of helpfulness associated with disability-related life experience and multicultural counseling course completion. These findings supported the research hypotheses. As the level of helpfulness associated with disability-related life experience(s) increased the level of perceived multicultural disability competence also increased.

Similarly, completion of a multicultural counseling course was associated with higher levels of perceived multicultural disability competence, and non-completion of a multicultural counseling course was associated with lower levels of perceived multicultural disability competence. Of these two correlational analyses, a stronger relationship was found between level of helpfulness associated with disability-related life experience(s) and perceived multicultural disability competence than the relationship between multicultural counseling course completion and perceived multicultural disability competence.

For research questions 3 and 4, multivariate analyses were conducted to examine group differences in perceived multicultural disability competency scores and to assess the influence of predictor variables on the three domains of multicultural disability competence (i.e., self-awareness, perceived knowledge, and perceived skills), respectively. A one-way ANOVA revealed statistically significant group differences in perceived multicultural disability competence based on participants' reported disability-related life experience(s) and multicultural counseling course completion. Follow-up tests indicated that participants reporting only disability-related life experience(s) and participants reporting both disability-related life experience(s) and multicultural counseling course completion scored statistically significantly higher on perceived multicultural disability competency than did participants reporting only multicultural counseling course completion and participants reporting neither disability-related life experience(s) nor multicultural counseling course completion, thereby confirming the research hypotheses.

For research question 4, three multiple regression models were computed to assess how well level of helpfulness associated with disability-related life experience(s) and multicultural counseling course completion predicted participants' self-awareness, perceived knowledge, and perceived skills subscale scores on the CCDS. All three models were significant but only partially supported the research hypothesis. Disability-related life experience(s) was the only significant predictor for self-awareness and perceived skills. Alternatively, both disability-related life experience(s) and multicultural counseling course completion were significant predictors for perceived knowledge. Although these results reveal differences among the predictor and outcome variables, both disability-related life experience(s) and multicultural counseling course completion accounted for a small amount of variance in all models. More

specifically, the coefficient of determination was highest for the perceived skills model, followed by the perceived knowledge model and self-awareness model, respectively.

For research question 5, descriptive statistics were computed to determine the extent to which the topic of ability/disability was covered for participants who completed a multicultural counseling course in their CACREP-accredited counseling programs. Results supported the research hypothesis, indicating that for the majority of participants in this study the topic of ability/disability was given less attention than other topics covered in a multicultural counseling course.

Chapter 5 Discussion

Chapter five includes an overview of the study and a discussion of findings. Results are discussed in relation to the current literature on multicultural counselor training, preparation, and competence generally and to persons with disabilities specifically. Limitations are also identified. The chapter concludes with implications for counselor educators and counselor training programs, followed by recommendations for future research on multicultural training and preparation specific to counseling clients with disabilities.

Overview of the Study

The purpose of this study was to better understand the perceived multicultural disability competence of master's-level counselor trainees enrolled in CACREP-accredited programs as related to their multicultural counseling course completion and their disability-related life experience(s). A secondary purpose was to determine the extent to which the topic of ability/disability was covered in multicultural counseling coursework relative to other topics covered. The study addressed the relationship between counselor trainee perceived multicultural disability competence and the variables of multicultural course completion and disability-related life experience(s). Multivariate methods were employed to examine group differences in perceived multicultural disability competence and to determine how well multicultural course completion and disability-related life experience(s) predicted the multicultural counselor competency domains of self-awareness, knowledge, and skills.

The present study was built on research conducted by Diaz-Lazaro and Cohen (2001), Hollimon (2007), McDougall (2008), McLennon (2012), and Strike et al. (2004). Results from these studies indicated that multicultural training and exposure/contact with persons with disabilities are important factors to consider when examining multicultural disability

competence. These variables were defined and measured using different methods, were examined independently and collectively to better understand multicultural disability competence, and were fundamental to the design of the current study.

This study has three unique elements that distinguish it from previous studies. First, it is the only known study to survey a national sample of master's-level counselor trainees in CACREP-accredited programs regarding their multicultural disability competence. Second, training was assessed solely on multicultural counseling coursework. Third, disability-related life experience(s) was conceptualized in terms of exposure/contact but was measured differently than in previous studies.

The competency scale of the CCDS was used to measure the construct of perceived multicultural disability competence, and a biographical questionnaire was used to obtain descriptive data and to measure multicultural counseling coursework completion, coverage of the topic of ability/disability, and the level of helpfulness of disability-related life experience(s). An open ended question asking participants to describe any experience(s) they believed have contributed to their multicultural disability competence was also included.

Master's-level counselor trainees in CACREP-accredited programs were the population of interest, and this population was accessed using the e-mail addresses of CACREP liaisons and counseling listservs. All data were collected using Qualtrics™ and were examined using IBM SPSS 24. A total of 349 surveys were started and 285 surveys were completed, indicating an 85% completion rate. Descriptive and inferential statistics were computed to answer the research questions, and the findings are discussed below.

Discussion of Findings

CCDS and its subscales. Based on results of the CCDS, internal reliability statistics were calculated, resulting in the following Cronbach's alpha levels for the entire scale and for the self-awareness, perceived knowledge, and perceived skills subscales, respectively: $\alpha = .907$, $\alpha = .696$, $\alpha = .81$, and $\alpha = .851$. These reliability statistics achieved satisfactory internal consistencies and are comparable to those calculated in previous studies with the most reliable subscale being perceived skills, followed by perceived knowledge, and then self-awareness (McDougall, 2008; McLennon, 2012; Strike et al., 2004).

Participant responses to the 60 items on the CCDS resulted in an overall average multicultural disability competency score of $M = 235.54$, which was similar to descriptive data reported in previous studies: Hollimon (2007) ($M = 235.45$), McLennon (2012) ($M = 223.02$), and Strike et al. (2004) ($M = 242.60$). Additionally, participants in this study reported, on average, the highest level of competency in self-awareness ($M = 87.52$) followed by perceived knowledge ($M = 79.01$) and perceived skills ($M = 69.01$). These results followed a similar pattern to previous studies (Hollimon, 2007; Strike et al., 2004) and are consistent with the assertion that the self-awareness and knowledge domains of multicultural competence tend to be emphasized more than the skills domain within multicultural training (Malott et al., 2009; Priester et al., 2008). McDougall (2008), on the other hand, found a slightly different pattern for the mean subscale scores on the CCDS, resulting in the highest mean score on the perceived knowledge subscale ($M = 82.37$, followed by the perceived skills subscale ($M = 81.01$) and the self-awareness subscale ($M = 75.27$). Differences across studies may be due to the characteristics of the sample, amount of experience, and/or level of training. However, caution should be used

when making comparisons across studies or making inferences about the psychometric properties of the CCDS as limited data are available on this instrument.

Perceived multicultural disability competence. This research study examined whether a relationship existed between master's-level counseling students' perceived multicultural disability competence and the perceived level of helpfulness associated with their disability-related life experience(s). A statistically significant, moderate positive relationship was found between participants' perceived multicultural disability competence and the perceived level of helpfulness associated with their disability-related life experience(s) ($r_s = .378, p < .001$). These results indicated that higher levels of perceived multicultural disability competence were associated with the belief that interactions with persons with disabilities help to enhance one's ability to effectively counsel clients with disabilities. Although disability-related life experience(s) was measured differently in the present study than in previous studies, the findings add to the existing literature demonstrating that exposure/contact has some level of impact on multicultural disability competence (Hollimon, 2007; McLennon, 2012; Strike et al., 2004). However, caution must be used when making comparisons or interpretations between the current study and previous studies because exposure/contact are defined and measured from multiple vantage points.

This research study also examined whether a relationship existed between master's-level counseling students' perceived multicultural disability competence and multicultural counseling course completion. A statistically significant positive but weak relationship was found between participants' perceived multicultural disability competence and multicultural counseling course completion ($r_s = .184, p = .001$). The positive relationship between multicultural counseling course completion and multicultural disability competence was expected as multiple studies have

provided evidence for the efficacy of multicultural counseling coursework (D'Andrea et al., 1991; Diaz-Lazaro & Cohen, 2001; Heppner & O'Brien, 1994; Malott, 2010; McLennon, 2012). However, the weak relationship found between these variables is unsettling. The weak, positive relationship found may suggest that, for master's-level counseling students in this study, completing a multicultural counseling course did little to enhance their perceived multicultural disability competence. These findings may reflect, at least in part, the limited attention given to the topic of ability/disability in multicultural counseling coursework found in this study and by Priester et al., 2008, or the lack of consideration given to other important aspects of multicultural training in the current study, including the learning environment (Dickson & Jepsen, 2007), clinical and supervision training experiences (Allison et al., 1994; Allison et al., 1996), and program ambiance (Dickson et al., 2008).

Group differences in counselor trainee perceived multicultural disability competence were examined based on participants' affirmation or denial of disability-related life experience(s) and multicultural counseling course completion. Significant group differences in perceived multicultural disability competence were found ($F(3, 281) = 14.724, p < .001$). Results partially supported the research hypotheses. As expected, follow-up tests revealed that counselor trainees reporting both disability-related life experience(s) and multicultural counseling course completion ($M = 241.60$) and those reporting only disability-related life experience(s) ($M = 232.67$) had statistically significantly higher group means on perceived multicultural disability competence than participants reporting only multicultural counseling course completion ($M = 213.20$) and participants reporting neither disability-related life experience(s) nor completion of a multicultural counseling course ($M = 209.00$). However, participants reporting both disability-related life experience(s) and completion of a multicultural counseling course did not indicate, as

predicted, statistically significant differences on perceived multicultural disability competence from those reporting only disability-related life experience.

These findings seem to substantiate the relevance of both disability-related life experience(s) and multicultural counseling course completion to perceived multicultural disability competence. However, differences may exist in how these variables, together and individually, impact overall perceived multicultural disability competence. For instance, analyses failed to find statistically significant differences in perceived multicultural disability competence between participants reporting both disability-related life experience(s) and completion of a multicultural counseling course and those reporting only disability-related life experience(s). These findings may be indicative of the limited attention given to the topic of ability/disability in multicultural counseling coursework. Additionally, the statistically significant differences found between participants reporting only disability-related life experience(s) and those reporting only completion of a multicultural counseling course suggest that disability-related life experience(s) may have a greater impact on overall perceived multicultural disability competence than multicultural counseling course completion. It is also plausible that multicultural counseling course completion may not be sufficient to enhance counselor trainees' multicultural disability competence.

Previous studies have produced results comparable to the findings of the present study. In particular, researchers have found that the combination of accumulated contact with persons with disabilities and training result in higher levels of perceived multicultural disability competence than less exposure/contact and training (Diaz-Lazaro & Cohen, 2001; McLennon, 2012; Strike et al., 2004). Similarly, Hollimon (2007) found that participants with personal/interpersonal contact with persons with disabilities reported higher levels of perceived

multicultural disability competence than those with no contact or only academic training. Collectively, these results seem to indicate that disability-related life experience(s) is an important factor in the development of multicultural disability competence. However, the manner in which exposure/contact and training are measured needs to be considered within the context of these findings.

Self-awareness, knowledge, and skills. Level of helpfulness associated with disability-related life experience(s) and multicultural counseling course completion were used to predict the outcomes of self-awareness, perceived knowledge, and perceived skills, resulting in three multiple regression models. All models produced significant regression equations, but there were differences among the predictors within the models. Level of helpfulness associated with disability-related life experience(s) and multicultural counseling course completion significantly predicted the outcome variable of perceived knowledge. However, level of helpfulness associated with disability-related life experience(s) was the only significant predictor for both self-awareness and perceived skills. These results suggest that disability-related life experience(s) is relevant to the prediction of all three domains of multicultural disability competence, while completion of a multicultural counseling course seems to significantly predict only perceived knowledge.

All three models yielded significant predictors, yet these predictors, level of helpfulness associated with disability-related life experience and multicultural counseling course completion, accounted for only a small amount of the variance. Of the three models, the perceived skills model revealed the largest coefficient of determination ($R^2 = 0.151$), followed by the perceived knowledge model ($R^2 = .115$) and the self-awareness model ($R^2 = .073$). The small amount of variance contributed by the predictors may be a reflection of how disability-related life

experience(s) and/or multicultural counseling course completion was measured. The results also may suggest there are other important variables to consider when determining relevant predictors for self-awareness, perceived knowledge, and perceived skills. For example, McDougall (2008) found that self-awareness was a significant predictor for both perceived knowledge and perceived skills.

Current literature provides limited information about predicting multicultural disability competence and the domains of self-awareness, knowledge, and skills specific to persons with disabilities. McLennon (2012), however, found that both contact and training significantly predicted overall perceived multicultural disability competence. Results from the McDougall (2008) study revealed that contact is a significant predictor for perceived knowledge and perceived skills. Although results from the present study partially support findings from McDougall's (2008) work, scholars should be extremely cautious about making any conclusions.

Disability content in multicultural coursework. Counselor trainees reporting completion of a multicultural counseling course ($n = 218$, 76.5% of the sample) were asked to indicate to what extent the topic of ability/disability or persons with disabilities was covered in their multicultural coursework relative to other topics. A total of 67.4% of the 218 counselor trainees reporting completion of a multicultural counseling course indicated that the topic of ability/disability was given no attention ($n = 28$, 12.8%) or less attention ($n = 119$, 54.6%) than other topics covered in their multicultural counseling coursework. By comparison, 32.6% ($n = 71$) indicated that the topic of ability/disability was covered as a distinct topic of multiculturalism/diversity and given similar attention relative to other topics covered in their multicultural counseling courses.

These findings indicate that the topic of ability/disability or persons with disabilities often continues to be given limited to no attention in multicultural counseling coursework. However, the majority of participants (87.2%) indicated that the topic of ability/disability was, to some extent, addressed in their multicultural counseling courses. In general, results may suggest that some level of progress has been made since the Priester et al. (2008) study, the results of which indicated that only 25% of introduction to multicultural counseling syllabi generally mentioned the topic of disability.

Qualitative responses. Participants were given the option to comment on any experiences they believed have contributed to their multicultural disability competence. This open-ended question generated 62 responses, representing a 21.75% response rate. The researcher found that responses referred mostly to disability-related life experience(s) and academic training. These themes are consistent with prior research addressing specific factors (e.g., exposure/contact and training) pertinent to multicultural disability competence (Diaz-Lazaro & Cohen, 2001; McLennon, 2012; Strike et al., 2004) and concerns about the underrepresentation of persons with disabilities in counselor training (Olkin, 2002; Priester et al., 2008; Rawlings & Longhurst, 2011).

A significant percentage of participants responding to the open ended question (approximately 73%) referred to different types of disability-related life experience(s) they have had regarding the topic of ability/disability and/or interactions they have had with persons with disabilities. The identified categories are congruent with the different types of disability-related life experience(s) identified in item 2 of the biographical questionnaire in this study and that were used in studies conducted by Hollimon (2007), McLennon (2012), and Strike (2001). Categories included (1) personal experience(s), (2) interpersonal experience(s), (3)

work-related experience(s), (4) volunteer experience(s), and (5) academic and/or professional training experience(s).

Disability-related life experience(s)' and 'academic training' seemed to coincide with one another. When participants commented on experiences that impacted their multicultural disability competence, they often cited personal, interpersonal, and/or work-related experiences rather than academic training. In turn, they expressed concern about the lack of attention given to the topic of ability/disability in counseling curriculum. In general, these two areas mirror findings from the quantitative results in this study. Additionally, previous research suggests that accumulated disability-related life experience(s) (including training) helps to increase multicultural disability competence (Diaz-Lazaro & Cohen, 2001; McLennon, 2012; Strike et al., 2004), yet training programs do little to provide adequate training for counselors to work with clients with disabilities (Allison et al., 1994; Allison et al., 1996; Green et al., 2009; Milsom & Akos, 2003).

Summary of Findings. The overall findings of the present study add to the existing literature on multicultural disability competence and lend support to findings from previous research studies. In this study, both disability-related life experience(s) and completion of a multicultural counseling course had a positive impact on perceived multicultural disability competence. However, disability-related life experience(s) had a stronger positive relationship to perceived multicultural disability competence than did completion of a multicultural counseling course. Participants reporting disability-related life experience(s) had statistically significantly higher scores on perceived multicultural disability competence than did participants reporting only completion of a multicultural counseling course. Additionally, results suggested that disability-related life experience(s) was a significant predictor for self-awareness, perceived

knowledge, and perceived skills; whereas multicultural counseling course completion significantly predicted only perceived knowledge.

Participant responses to the qualitative items were consistent with findings in the present study, including the focus on disability-related life experience and its impact on multicultural disability competence. Moreover, participants' qualitative responses indicated concern about the inadequate education and training they received regarding working with clients with disabilities, which was also reflected in the quantitative measure assessing the extent to which ability/disability was covered in multicultural counseling coursework.

This study has some unique attributes that add to the existing research literature on multicultural disability competence. First, study results indicate that ability/disability is often given less attention than other topics addressed in multicultural counseling courses within CACREP-accredited programs. Second, results indicated that disability-related life experience(s) has a greater impact on overall multicultural disability competence than multicultural counseling course completion. Finally, disability-related life experience(s) significantly predicted self-awareness, perceived knowledge, and perceived skills, while multicultural counseling course completion was only a significant predictor for perceived knowledge.

Limitations

Limitations of this study are related to sampling, data collection, instrumentation, and definitions. The sample was drawn from master's-level students enrolled in CACREP-accredited counseling programs. Therefore, not all master's-level counseling students are represented in this study, and results are generalizable only to master's-level students in CACREP-accredited counseling programs. Given the high percentage of participants reporting disability-related life experience(s) (97.2%), it is possible that more students with a particular interest in or experience

with persons with disabilities responded to the survey than did students with less interest or experience, thereby potentially influencing the results. Additionally, the relatively large percentage of participants (76.8%) reporting completion of a multicultural counseling course may reflect a greater sense of comfort when responding to a survey focused on multiculturalism and diversity issues.

The use of e-mail, listservs, and social media to access the desired population, combined with the web-based nature of the study, may have introduced some limitations. Because a request for participants was e-mailed to CACREP liaisons, there is no guarantee that the liaisons forwarded the survey link and information about the study to master's-level students. It is possible that some e-mail requests were delivered to intended recipients' SPAM folders. Similarly, requests posted to CESNET-L may not have directly reached the desired population as it is likely that most master's-level students do not subscribe to CESNET-L. Participation was also limited to those who subscribed to the COUNSGRAD listserv, the AMCD community, the AMCD graduate student Facebook page, and those attending the 2016 ACA Conference.

Another potential limitation relates to the psychometric properties of the CCDS and the biographical questionnaire. The CCDS is a relatively new measure with no normative data. Therefore, participant's scores on the CCDS cannot be compared to a normative sample. Additionally, the CCDS and biographical questionnaire relied on self-report, and it is possible that not all participants responded to the survey items honestly.

The definitions of disability and disability-related life experience(s) used in this study may have presented some limitations. The term disability was defined using the ADA's definition of disability. This definition includes both physical and mental (i.e. psychiatric) disabilities. However, as was discussed in chapter two, disability can be defined from a range of

perspectives which can also reflect a stigma hierarchy associated with persons with different types of disabilities. Findings from this study may have been influenced by the use of the definition used and may have resulted in different findings if disability had been defined only in terms of a physical disability or only in terms of a mental disability.

Implications and Recommendations

Findings from the present study provide information about the perceived multicultural disability competence of master's-level counseling students enrolled in CACREP-accredited programs. Study results contribute to and enhance the current knowledge base on the impact of exposure/contact and training on perceived multicultural disability competence. The present study also produced the only known data capturing master's-level counseling students' perceptions of the extent to which the topic of ability/disability is covered in multicultural counseling courses in CACREP-accredited programs. Collectively, these findings have implications for counselor trainees, counselor educators, and counselor training programs. Results of the present study suggest that master's-level counseling students in CACREP-accredited programs may not be receiving adequate training regarding multicultural issues for persons with disabilities in their multicultural counseling courses, and there is some preliminary evidence that the needs and concerns of persons with disabilities are not addressed in other areas of training (Allison et al. 1994; Milsom, 2002; Reed-Cunningham & Fleming, 2009). Findings from this study indicated that disability-related life experience(s) not only had a greater impact on perceived multicultural disability competence than multicultural counseling course completion, but it also significantly predicted self-awareness, perceived knowledge, and perceived skills. However, there is no guarantee that counselor trainees have acquired prior disability-related life experience(s) that may enhance their multicultural disability competence.

Master's-level counseling students reported feeling least competent in their level of skills to work with clients with disabilities, as compared to their level of knowledge and self-awareness. Additionally, they indicated feeling less competent in their level of knowledge, as compared to their self-awareness. Consequently, it is recommended that counselor trainees be presented with multiple training opportunities that can enhance all domains of multicultural disability competence. Without adequate training, future counselors may practice outside their boundaries of competency and place their clients with disabilities at risk.

Counselor educators. Results of this study suggest that counselor educators teaching multicultural counseling courses in CACREP-accredited programs may not be addressing the topic of ability/disability or may be giving it less attention than other topics. This finding suggests that the following questions may need to be explored. Do counselor educators view the topic of ability/disability or persons with disabilities as relevant to multicultural counseling? What training, preparation, and practice experiences do counselor educators have regarding persons with disabilities? Are counselor educators equipped to provide competent instruction?

Counselor educators may utilize the results of this study, along with the questions raised above, to reflect on their own multicultural disability competence. Those who deliver multicultural instruction might consider the efficacy of disability-related life experience(s) and develop instructional strategies to increase exposure/contact. Counselor educators who have training, practice, and instructional experiences regarding persons with disabilities can utilize their knowledge and skills to increase the multicultural disability competence of fellow counselor educators with little or no experience by mentoring these colleagues, presenting at professional conferences, and publishing manuscripts germane to this subject.

Counselor training programs. Findings from this study provide evidence that counselor training programs are not consistently addressing the topic of ability/disability as an important area of diversity. Rehabilitation professionals, educators, and training programs may be integral in enhancing counselor training programs' coverage of this pertinent area of diversity. The recent merger between CACREP and CORE can serve as a catalyst for developing training standards for CACREP-accreditation that addresses the needs and concerns of persons with disabilities. This merger can create an accreditation organization representing a unifying body of counseling that subsequently acknowledges the field of rehabilitation as part of the counseling profession. As a consequence, training standards developed for the rehabilitation counseling specialization can be considered when updating the training standards for other counseling specializations. Training standards specific to the topic of ability/disability and persons with disabilities can help ensure that counselor educators integrate this area of counseling into their course curricula.

Recommendations for Future Research

Very limited research has been conducted on multicultural disability competence and the training and preparation experiences of counselor trainees regarding clients with disabilities. This research study used descriptive statistics and correlational and multivariate analyses to examine master's-level counseling students' perceived multicultural disability competence, given their reported multicultural counseling course completion, and disability-related life experience(s). Future researchers could consider how different aspects of exposure/contact within counselor training experiences (e.g., coursework, practicum/internship, supervision) impact multicultural disability competence and the individual domains of self-awareness, knowledge, and skills. Since a general, all-encompassing definition of disability was chosen for

this study, there is no way of determining whether master's-level counseling students' multicultural disability competence would differ by type of disability. Future researchers could investigate multicultural disability competence associated with persons with physical, psychiatric, and/or cognitive disabilities.

Although results from this study seemed to indicate that counselor educators are giving some level of attention to the topic of ability/disability in multicultural counseling coursework, more studies need to be conducted in order to further evaluate the extent to which the topic of ability/disability is integrated into multicultural counseling courses in CACREP -accredited programs. Similarly, little is known about the instructional strategies counselor educators use when they do incorporate the topic of ability/disability into multicultural counseling coursework. Future researchers could examine the instructional strategies used in coursework and how these strategies may individually and collectively impact domains of multicultural disability competence. Additionally, the CCDS could be used to measure pre- and post-test scores on perceived multicultural disability competence at the beginning and end of a course. Longitudinal studies could assess perceived multicultural disability competence at different points in counselor training, such as at the beginning of training, prior to clinical practicum/internship, and at the end of training. The use of a longitudinal approach to assess perceived multicultural disability competence has the advantage of identifying how well a training program is preparing their students to work with clients with disabilities. For example, such studies can help determine to what extent students are being exposed to course content relevant to ability/disability and the degree to which their practicum/internship experiences include working with clients with different abilities.

Self-report measures, such as the CCDS, are subjective in nature and may not accurately depict multicultural disability competence. To address these limitations, additional methods for assessing multicultural disability competence should be considered. For example, case study scenarios involving a client with a disability could be introduced, and respondents could identify relevant treatment themes as a way to evaluate skills competencies. This approach could help assess the accuracy of the respondent's identified treatment themes or their inclusion of stereotypes and/or assumptions related to persons with disabilities. Also, the ADA Knowledge Survey (Hernandez, Keys, & Balcazar, 2003) or an instructor-developed objective test could serve as other methods for evaluating knowledge competencies.

Finally, qualitative research designs provide a discovery-oriented approach to research and help to generate new ideas for future research. Qualitative research studies could produce some valuable information that has not yet been revealed through quantitative research studies. The qualitative component of this study was limited to the single open-formatted item that asked participants to comment on any additional experiences they believed enhanced their multicultural disability competence. Participant responses may have been influenced by the design of survey items, particularly those inquiring about multicultural counseling course completion and disability-related life experience(s). Therefore, a qualitative study focusing on the ways in which both personal and training-related experiences have impacted multicultural disability competence could provide some insight.

Conclusions

The results of this study suggest that master's-level counseling students in CACREP-accredited programs perceive their competency to be highest in the domain of self-awareness, followed by knowledge, and then skills. Also, findings seem to indicate that master's-level

counseling students in CACREP-accredited programs generally are not receiving the same level of exposure to the topic of ability/disability as they are to other topics covered in their multicultural counseling courses. However, results from this study suggest that counselor educators are giving some level of attention to the topic of ability/disability in multicultural counseling coursework.

Whereas both multicultural counseling course completion and disability-related life experience(s) had a positive relationship with perceived multicultural disability competence, there were differences in their level of impact on perceived multicultural disability competence and their contribution to the prediction of self-awareness, perceived knowledge, and perceived skills. In particular, master's-level counseling students reporting both completion of a multicultural counseling course and disability-related life experience(s) and those reporting only disability-related life experience had significantly higher overall scores on multicultural disability competence than participants reporting only completion of a multicultural counseling course and those reporting neither completion of a multicultural counseling course nor disability-related life experience(s). Additionally, disability-related life experience(s) seemed to predict all domains of multicultural disability competence (i.e., self-awareness, knowledge, and skills), while completion of a multicultural counseling course contributed only to the prediction of perceived knowledge.

The results of the present study contribute to the limited research on multicultural disability competence and present an initial assessment of the extent to which the topic of ability/disability is addressed in multicultural counseling courses in CACREP-accredited programs relative to other topics covered in multicultural counseling coursework. This study is also the only known study to directly examine the multicultural disability competence of

master's-level counseling students in CACREP-accredited programs. Findings both support and add to the existing literature on the efficacy of exposure/contact on multicultural disability competence. Findings from this study support previous research, demonstrating disability-related life experience(s) had a stronger relationship with and a greater impact on perceived multicultural disability competence than did multicultural course completion. Results from this study also add to the existing literature in two primary ways. First, disability-related life experience(s) was measured differently than in previous research. For two analyses disability-related life experience(s) was analyzed in terms of level of helpfulness associated with contact with persons with disabilities. Second, findings indicated that disability-related life experience(s) can have some level of impact on the prediction of self-awareness, perceived knowledge, and perceived skills.

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Appendices

Appendix A: Agreement for the Procedural Use of the Counseling Clients with Disabilities Survey

In using the Counseling Clients with Disabilities Survey (CCDS) I agree to the following terms:

1. I understand that the CCDS is copyrighted (2001) by Diane L. Strike, Ph.D. The CCDS will not be appended to written materials (e.g., dissertations, theses, teaching/workshop materials, manuscripts, etc.) that are circulated for general reading.
2. The entire scale will be used when administering the CCDS, and individual items and/or scales will not be administered separately. Individual items and/or scales will not be used or adapted for the development of other instruments.
3. I am a trained professional in counseling, psychology, rehabilitation, or a related field, having completed coursework or training in psychometrics and research ethics. Alternatively, I am working under the supervision of such an individual.
4. In using the CCDS, I will adhere to all ethical standards of the American Psychological Association and/or related professional organizations. Furthermore, I will follow the guidelines for Research with Human Subjects put forth by my university, institution, or professional setting. Ethical considerations include, but are not limited to, subject informed consent and confidentiality of records.

5. There is no charge for the CCDS. I will receive an original of the CCDS (in print format to use as a guide for making copies from the electronic format), and I will make the number of copies needed for one study. A separate Utilization Request Form should be completed for each separate study using the CCDS.

6. The CCDS will be kept under secure conditions and will only be used for my own research purposes. The CCDS will not be given to other interested parties who should be referred to the author if they wish to preview or use the instrument.

7. I will send a copy or summary of my research results for any study incorporating the CCDS in manuscript form to Dr. Strike, regardless of whether the study is published, presented, or fully completed. If requested, I will make the raw data available to Dr. Strike who is researching the construct of disability competence and is ethically responsible to monitor developments on the scale in terms of reliability, validity, and utility.

I understand and agree to the terms stated on pages 3 and 4.

Signature _____ Date _____

Name _____

Address _____

Phone _____ Email _____

Research Topic Title _____

Planned Use of the CCDS (e.g., Dissertation, Survey, Pretest/Posttest, etc.) _____

Students provide research supervisor's/mentor's signature, name, affiliation, phone number, and

email address.

Signature _____ Date _____

Name _____

Affiliation _____

Phone _____ Email _____

Appendix B: Biographical Questionnaire

Please respond to the following questions based on your own experience(s).

1. Counseling area of emphasis
 - A. Community, Clinical Mental Health counseling
 - B. School counseling
 - C. Marriage, Couple, and Family therapy/counseling
 - D. College, Student Affairs counseling
 - E. Substance Abuse, Addictions counseling
 - F. Rehabilitation counseling
 - G. Other, please specify
2. Do you have a disability? Yes or No
3. Have you had direct interpersonal interactions and communication with persons with disabilities (e.g., personal, work, or volunteer-related settings)? Yes or No
4. If you answered “Yes” to question 3, how would you rate the quality of these interactions relative to your ability to effectively counsel persons with disabilities?
 - A. Very helpful
 - B. Somewhat helpful
 - C. Not at all helpful
5. I have completed a multicultural counseling course as part of my required graduate coursework? Yes or No

6. If you completed the required multicultural counseling course, to what extent was the topic of disability and/or persons with disabilities covered in your multicultural counseling coursework experience?
 - A. Disability was not at all covered in my multicultural counseling course.
 - B. Disability was covered in my multicultural counseling course but given much less attention compared to other topics covered in the course.
 - C. Disability was covered as a distinct aspect of multiculturalism/diversity and given a similar amount of attention as other topics covered in my multicultural counseling course.
7. If the topic of disability or persons with disabilities was covered in your multicultural counseling course, indicate how the topic was addressed (all that apply).
 - A. Readings/lecture
 - B. Class or small group discussion
 - C. Disability simulation or other experiential activities
 - D. Use of multi-media (video clips, movies, etc.)
 - E. Other (Please specify)

Please include any additional comments that you think have contributed to your multicultural disability competence.

Appendix C: Approval Letter from IRB

University Committee for the Protection

C:\Users\jmgrande\Desktop\signature.jpg

of Human Subjects in Research

University of New Orleans

Campus Correspondence

Principal Investigator: Barbara Herlihy

Co-Investigator: Melissa D. Deroche

Date: January, 11 2016

Protocol Title: “The relationship between perceived multicultural disability competence, multicultural counseling coursework, and disability-related life experience”

IRB#: 01Jan16

The IRB has deemed that the research and procedures described in this protocol application are exempt from federal regulations under 45 CFR 46.101 category 2, due to the fact that data will be collected anonymously.

Exempt protocols do not have an expiration date; however, if there are any changes made to this protocol that may cause it to be no longer exempt from

CFR 46, the IRB requires another standard application from the investigator(s) which should provide the same information that is in this application with changes that may have changed the exempt status.

If an adverse, unforeseen event occurs (e.g., physical, social, or emotional harm), you are required to inform the IRB as soon as possible after the event.

Best wishes on your project.

Sincerely,

Robert D. Laird, Ph.D., Chair

UNO Committee for the Protection of Human Subjects in Research

Appendix D: Request Letter to CACREP Liaisons

Dear CACREP Liaison:

I am a graduate student pursuing my doctoral degree in counselor education and supervision and am conducting my dissertation research under the direction of Dr. Barbara Herlihy and Dr. Matthew Lyons (Co-Chairs) in the College of Education and Human Development at the University of New Orleans. I am writing to request your assistance in accessing potential participants for my dissertation study entitled: “The Relationship between Perceived Multicultural Disability Competence, Multicultural Counseling Coursework, and Disability-related Life Experience.”

To date, the topic of ability/disability has been given limited attention in the multicultural counseling literature. Moreover, my research is timely given the recent merger between CACREP and the Council on Rehabilitation Education (CORE) and the expected recommendations for including the topic of disability in all counseling course curriculum. The purpose of this study, therefore, is to examine Master’s-level counseling students’ perceived level of competence to counsel clients with disabilities and to investigate the extent to which ability/disability is covered in multicultural counseling courses in CACREP-accredited programs.

I am asking you to share this invitational letter with your master’s-level counseling students enrolled in your institution’s CACREP-accredited counseling program(s). Eligibility for participation in this study requires being eighteen years or older and being enrolled as a master’s-level counseling student in a CACREP-accredited counseling program. The surveys are likely to take 10-15 minutes to complete. Surveys are available online using the anonymous survey link below

http://neworleans.col.qualtrics.com/SE/?SID=SV_24h4L4IzTtompf

If you are not connected automatically, please copy-and-paste the link into the address box in your Internet browser and click enter.

Participating in this study is thought to have minimal risks. However, respondents may experience uncomfortable thoughts and/or emotions related to their perceived ability to competently counsel clients with disabilities. Possible benefits of this study include participants becoming more aware of their attitudes and beliefs, knowledge, and skills regarding persons with disabilities. Study results may also provide important information about, how and in what ways, counseling programs prepare counselors to work with clients with disabilities.

Participation in this study is entirely voluntary. Respondents may decline to participate or choose to withdraw from this study at any time without penalty. Participants who complete the surveys will be provided with the option to submit their email addresses and be entered in a drawing for one of five \$20 Amazon gift cards. I appreciate your assistance with this research study.

Please direct any questions or concerns about this study to the co-investigator, Melissa Deroche (mddps@uno.edu); the principal investigator and faculty advisor, Dr. Barbara Herlihy (bherlihy@uno.edu); or the Office of Human Subjects Research at the University of New Orleans (unoirb.edu).

Sincerely,

Melissa D. Deroche, M.Ed., LPC-S, LMFT

Doctoral Candidate University of New Orleans

348 Bicentennial Education Building

University of New Orleans, Lakefront Campus

2000 Lakeshore Drive

New Orleans, La 70148

Appendix E: Request for Participation to AMCD Graduate Student Facebook Group and AMCD
Community List

AMCD Community:

Please consider participating in my quantitative dissertation study described below.

Participants must be 18 years or older and a current master's-level counseling student enrolled in a CACREP-accredited counseling program.

I am a graduate student pursuing my doctoral degree in Counselor Education and am conducting my dissertation research under the direction of Dr. Barbra Herlihy and Dr. Matthew Lyons (Co-Chairs) in the College of Education and Human Development at the University of New Orleans. The purpose of this study is to explore Master's-level counseling students' perceived level of competence to counsel clients with disabilities and the relationship between multicultural disability competence, multicultural counseling coursework, and interpersonal contact with persons with disabilities. No prior experience working with clients with disabilities is required to participate in this study.

The surveys are likely to take 10-15 minutes to complete. The informed consent document and surveys are available online using the anonymous survey link below
http://neworleans.co1.qualtrics.com/SE/?SID=SV_24h4L4IizTtompf

You may need to copy and paste the link into your browser.

Sincerely,

Melissa Deroche, LPC-S, LMFT, NCC

Doctoral Candidate

University of New Orleans

Appendix F: Request for Participation to CESNET-L Listserv

Dear CESNET Community:

You are invited to participate in a dissertation research study that seeks to explore counselor multicultural disability competence. The purpose of this study is to examine counselor trainee perceived level of competence to counsel clients with disabilities and to investigate the extent to which the topic of ability/disability is covered in multicultural counseling coursework in CACREP-accredited programs. This study is conducted under the direction of Dr. Barbara Herlihy and Dr. Matthew Lyons (Co-Chairs) and has been approved by the Institutional Review Board (IRB) at the University of New Orleans. It is likely that participants are not members of this listserv, so I am requesting your assistance in identifying eligible participants and asking you to forward this request to them.

To qualify for this study, participants must meet the following criteria.

1. Be 18 years of age or older
2. Enrolled as a master's-level counseling student in a CACREP-accredited program

No prior experience or training to work with clients with disabilities is required to participate in this study. Surveys are likely to take 10-15 minutes to complete. Surveys are available online using the anonymous survey link below

http://neworleans.c01.qualtrics.com/SE/?SID=SV_24h4L4IIZTtompf

If you are not connected automatically, please copy-and-paste the link into the address box in your Internet browser and click enter. You will first be presented with an informed consent that provides an explanation of the purpose of the study, the voluntary nature of the study, measures taken to ensure anonymity, and any potential known risks and benefits of participation.

Participation in this study is entirely voluntary. Respondents may decline to participate or choose to withdraw from this study at any time without penalty. Participants who complete the surveys will be provided with the option to submit their email addresses and be entered in a drawing for one of five \$20 Amazon gift cards.

Please direct any questions or concerns about this study to the co-investigator, Melissa Deroche (mddps@uno.edu); the principal investigator(s) Dr. Barbara Herlihy (bherlihy@uno.edu) or Dr. Matthew Lyons at mllyons@uno.edu; or the Office of Human Subjects Research at the University of New Orleans (unoirb.edu).

Thanks for your assistance.

Warm Regards

Melissa

Melissa D. Deroche, LPC-S, LMFT, NCC

Doctoral Candidate in Counselor Education and Supervision

University of New Orleans

Department of Educational Leadership, Counseling, and Foundations

2000 Lakeshore Drive

New Orleans, LA 70148

E-mail mddps@uno.edu

Appendix G: Request for Participation to COUNSGRAD Listserv

Dear COUNSGRAD Community:

I am a graduate student pursuing my doctoral degree in counselor education and supervision at the University of New Orleans and have not yet reached a sufficient sample size. Please consider participating in my dissertation research study. The purpose of this study is to examine Master's-level counseling students' perceived level of competence to counsel clients with disabilities and to investigate the extent to which ability/disability is covered in multicultural counseling courses in CACREP-accredited programs.

To qualify for this study, participants must meet the following criteria.

1. Be 18 years of age or older
2. Currently enrolled as a master's-level counseling student in a CACREP-accredited program

No prior experience or training to work with clients with disabilities is required to participate in this study.

Surveys are likely to take 10-15 minutes to complete. Participants who complete the surveys will be provided with the option to submit their email addresses and be entered in a drawing for one of five \$20 Amazon gift cards.

The informed consent and surveys are available online using the anonymous link below.
http://neworleans.co1.qualtrics.com/SE/?SID=SV_24h4L4IizTtompf

Please direct any questions or concerns about this study to Melissa Deroche, doctoral candidate at the University of New Orleans (mddps@uno.edu); the Co-Chairs of my dissertation committee, Dr. Barbara Herlihy (bherlihy@uno.edu) or Dr. Matthew Lyons (mlyons@uno.edu); or the Office of Human Subjects Research at the University of New Orleans (unoirb.edu).

Warm Regards,

Melissa

Melissa D. Deroche, M.Ed., LPC-S, LMFT

Doctoral Candidate in Counselor Education and Supervision

University of New Orleans

Dept. of Educational Leadership, Counseling, and Foundations

2000 Lakeshore Dr.

New Orleans, La 70148

Email: mddps@uno.edu

Appendix H: Request for Participation ACA Flyer

Multicultural Disability Competence Study

Melissa Deroche, M.Ed., LPC-S, LMFT

University of New Orleans Doctoral Candidate

Are you a current master's-level counseling student in a CACREP-accredited program? The following anonymous survey will take between 10-15 minutes of your time AND you have the chance to win one of five Amazon gift cards!

The survey examines counselor trainee's perceived level of competence to counsel clients with disabilities and investigates the extent to which the topic of ability/disability is covered in multicultural counseling coursework in CACREP-accredited programs.

Informed consent and surveys can be found at the anonymous link below:

http://neworleans.co1.qualtrics.com/SE/?SID=SV_24h4L4IizTtompf

If you have any questions, please contact me at mddps@uno.edu. Thank you for taking the time!



Appendix I: Informed Consent

In accordance with the Office of Human Subjects Research at the University of New Orleans and professional codes of ethics, the following information provides you, the potential participant, with an explanation of the purpose of the study, the voluntary nature of the study, measures taken to ensure anonymity, and any potential known risks and benefits of participation.

Introduction/Purpose

I am a graduate student conducting my dissertation research under the direction of Dr. Herlihy and Dr. Matthew Lyons in the College of Education and Human Development at the University of New Orleans. I am conducting a research study that will provide important information about Master's-level counseling students' perceived level of competence to counsel clients with disabilities given their regarding multicultural counseling course completion and/or their interpersonal experience(s) with persons with disabilities. No prior experience or training to work with clients with disabilities is required to participate in this study.

Procedures

If you choose to participate in this study, you will be asked to complete the Counseling Clients with Disabilities Survey (CCDS; Strike, 2001) and a researcher developed biographical questionnaire. These surveys are online, anonymous, and are estimated to take 10-15 minutes to complete. Upon completion of the surveys, you will be given the option to submit your email address to be entered into a drawing for one of five Amazon gift cards. Your email address will be kept separate from your survey responses. The results of the research study may be published; however, your name will not be used because there will be no way to identify you after you submit your responses.

Voluntary Participation and Withdrawal

Your participation in this study is entirely voluntary. If you choose not to participate or to withdraw from this study at any time, there will be no penalty.

Risks/Discomfort and Benefits

Participation in this study is thought to have minimal risks. However, respondents may experience uncomfortable thoughts and/or emotions related to their perceived ability to competently counsel clients with disabilities. Possible benefits of this study include participants' becoming more aware of their attitudes and beliefs, knowledge, and skills regarding persons with disabilities. Study results may also provide important information about, how and in what ways, counseling programs prepare counselors to work with clients with disabilities

Consent

Your completion and electronic submission of the surveys will indicate your consent for participation in this study. It is possible for there to be a record of this submission somewhere on your computer in a cache (as in most Internet communication), therefore, you may want to clean out your temporary Internet files and close your browser after completing the surveys.

Contacts

Please direct any questions or concerns about this study to the co-investigator, Melissa Deroche (mddps@uno.edu); principle investigator and faculty advisor, Dr. Barbara Herlihy (bherlihy@uno.edu); or the Office of Human Subjects Research at the University of New Orleans (unoirb@uno.edu). Thank you for your participation.

Sincerely,

Melissa D. Deroche, M.Ed., LPC-S, LMFT

Doctoral Candidate University of New Orleans

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2000 Lakeshore Drive

New Orleans, La 70148

Vita

Melissa D. Deroche earned a Bachelor's of Arts in Psychology in 1996, a Master's of Education degree in Counseling in 1999, and a Doctor of Philosophy degree in Counselor Education in December 2016, all from the University of New Orleans. She is a Licensed Professional Counselor-Supervisor (LPC-S) and a Licensed Marriage and Family Therapist (LMFT) in Louisiana. Melissa also holds certification as a National Certified Counselor (NCC).

Melissa has fifteen years of experience working as a professional counselor in community-based agencies, a state psychiatric hospital, rehabilitation agencies, and as a private practitioner. She has served as an individual and group supervisor for several master's-level counselor trainees placed in school and clinical settings and currently supervises a Louisiana Provisional LPC.

Since the late 1990's, Melissa has consistently presented at state, regional, national, and international professional counseling conferences. . She has presented on Topics, including counselor training specific to ability/disability, the use of technology in clinical supervision, attachment theory, counseling ethics, and counseling survivors of sexual violence. Melissa currently serves on the Executive Board of the Louisiana Association for Counselor Education and Supervision, has served as a conference proposal reviewer for the American Counseling Association, and was invited to serve as a guest reviewer for the *Journal of Counselor Preparation and Supervision*.

Melissa has co-authored a book chapter in *Using technology to enhance counselor supervision: A practical handbook* (Rousmanier & Renfro-Michel, 2015) and has published as a contributing author in the *ACA ethical standards casebook* (Herlihy & Corey, 2014). Her

research interests include multicultural counselor training specific to ability/disability, ablest microaggressions, and counselor educator pedagogy.