PERCEIVED COMPETENCE AND ATTITUDES OF COUNSELING PSYCHOLOGY GRADUATE STUDENTS REGARDING PEOPLE WITH DISABILITIES

Except where reference is made to the work of others, the work described in this dissertation is my own or was done in collaboration with my advisory committee. This dissertation does not include proprietary or classified information.

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PERCEIVED COMPETENCE AND ATTITUDES OF COUNSELING PSYCHOLOGY GRADUATE STUDENTS REGARDING PEOPLE WITH DISABILITIES

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DISSERTATION ABSTRACT

PERCEIVED COMPETENCE AND ATTITUDES OF COUNSELING PSYCHOLOGY GRADUATE STUDENTS REGARDING PEOPLE WITH DISABILITIES

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Historically, people with disabilities (PWD) have been stigmatized and discriminated against by society as a whole. People with disabilities constitute the largest minority group within the United States. Hence, counseling psychologists will likely work with PWD no matter the counseling setting. Therefore, the purpose of the current study was to identify the attitudes counseling psychology graduate students hold towards PWD and discover any relationship between those attitudes and their perceived competence regarding PWD. Also, this study aimed to find if prior close, equal status contact with PWD was related to greater perceived competence regarding PWD and more positive attitudes regarding PWD.

One hundred thirty-two counseling psychology graduate students in doctoral level programs participated in this study. Participants were located across the United States and all were student affiliates of the American Psychological Association (APA). Perceived competence regarding PWD was assessed through the use of the Counseling Clients with Disabilities Survey (CCDS) and attitudes towards PWD was assessed through the Attitudes Towards Disabled Persons Scale, Form A (ATDP-A).

The findings indicated that counseling psychology graduate students tend to have positive attitudes and perceived competence regarding PWD and disability related issues. Specifically, the participants demonstrated greatest perceived competence in the area of self-awareness, followed by perceived knowledge and lastly, perceived skills. The sample was divided into two groups based on their reported level of contact with PWD. Those who reported close contact with PWD had a higher perceived competence regarding PWD. No connection was found between their reported level of contact with PWD and attitudes towards PWD. Lastly, a weak positive correlation was found between attitudes regarding PWD and perceived competence regarding PWD. These findings displayed a wealth of understanding regarding counseling psychology graduate students' perceived competence and attitudes regarding PWD.

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CHAPTER I

INTRODUCTION

Within the United States approximately 51 million people identify as having a disability (U.S. Census Bureau, June 21, 2006). In the past three decades disability status and how society relates to people with disabilities (PWD) has grown increasingly more important (Americans With Disabilities Act [ADA], 1990). Specifically, the ADA (1990) outlines that no person can be discriminated against based on the basis of a disability. Further, the act indicates that services available to people without disabilities must also be available to PWD (ADA, 1990). The ADA specifically defines disability as "a person who has 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" (U.S. Department of Justice, 2005, ¶ 2).

Society as a whole has been forced not only to face the legal issues of accessibility and discrimination towards PWD, but also how PWD are viewed in general. The changing perspective of how PWD are viewed and treated has made it imperative for those in the mental health field to reexamine how services can be tailored to best fit the needs of PWD. With relation to the current study, counseling psychologists are legally bound by specific laws that protect PWD with regards to their services offered to PWD. This legal mandate is mirrored by the development of the American Psychological

Association's Office on Disability Issues in Psychology and the Committee on Disability Issues in Psychology (CDIP). In order to best tailor services for PWD, psychologists need to examine current views and treatments.

Counseling psychologists are faced with the challenge of examining how to best serve PWD as the number of people with disabilities increases. A specific challenge to the field of counseling psychology with regard to PWD is to remain competent with legal, societal, and psychotherapeutic issues. The CDIP (1996) of the APA specifically indicated that the ADA affects psychologists in private clinical practice, academic settings, health facility settings, and employment settings. This appears to leave no practicing psychologist without being affected by the ADA in some manner. Further, counseling psychologists must also examine how their personal attitudes may affect their ability to provide therapeutically healthy services to the client with a disability (Sue, Arredondo, & McDavis, 1992).

The American Psychological Association mandates that all psychologists provide services only for which they are compete

nt to provide (APA, 2002). The necessity for counselors to become competent regarding working with PWD is clearly put forth by the Multicultural Counseling Competencies and Standards set forth by Sue et al. (1992). Sue (2001) pointed out, "multicultural counseling competence must be about – providing equal access and opportunity, being inclusive, and removing individual and systemic barriers to fair mental health services." Interestingly, Pelletier, Rogers, and Dellario (1985) found that consumer advocates, rehabilitation administrators, rehabilitation counselors, and consumers rated

the knowledge and skills of mental health professionals regarding the provision of services to PWD as a moderate barrier. Specific barriers to the provision of care included:

> (a) inadequate professional training of those working with individuals with severe physical disability; (b) lack of professionals with specialized knowledge and skills regarding physical disability, (c) general lack of contact and experience with individuals with physical disability, (d) attitudinal problems, and (e) problems stemming from a medical/diagnostic model that may preclude a more comprehensive perspective (Pelletier et al., 1985).

Leigh, Powers, Vash, and Nettles (2004) followed up with a more recent analysis of the barriers to providing mental health services to PWD as perceived by clinical psychologists, neuropsychologists, and rehabilitation psychologists. Specific barriers to the provision of psychological services to PWD included "funding, accessibility, lack of provider knowledge, limited training in disability issues and services, and lack of sensitivity" (Leigh et al., 2004). The consistent barriers related to experience, knowledge, skills, and attitudes of psychologists regarding PWD highlight the need for improved competence (Pelletier et al., 1985; Leigh et al., 2004).

One area of increasing growth of the number of PWD is within colleges and universities. The increasingly larger numbers of students with disabilities is believed to be approximately 12% of the total student population (U.S. Department of Education, 2001). This means that approximately 1 to 2 of every 10 individuals encountered by counseling psychologists could potentially have at least one disability. Hence, the likelihood that counseling psychologists will work with these students in the college or university setting is very great. The development of the ADA (1990) and the increased

number of PWD in colleges and universities have been reflected by economic allocation of federal funds specifically for the counseling needs of PWD in colleges and universities. In 2006, the U.S. Department of Education allocated approximately $280,581,410 just to the development of counseling related services for PWD in postsecondary education. Some of the services included vocational counseling, psychological counseling, assistive technologies, and advanced training for those who directly provide such services for PWD (U.S. Department of Education, 2006).

The high likelihood that counseling psychologists will work with PWD is not limited to universities and colleges. Parker and Chan's (1990) study found that 21% of directors of psychological services in accredited hospitals and specialized settings were counseling psychologists. Within their sample, counseling psychologists were second only to clinical psychologists.

There are specific concerns that many counseling psychologists will not be trained or ready to address the unique needs of these students. When discussing counseling PWD it is important to consider the very real occurrence of fundamental negative bias (Wright, 1988). Rather, as counseling psychologists who will likely at some point work with clients with disabilities, contextual variables may work to bias diagnosis and treatment. The bias may be negative or positive. Wright (1988) indicated a positive bias with PWD can be thought of as a "sympathy effect." Whether the counseling psychologist is swayed by a negative or positive bias, the fact remains that the counselor's ability to competently work with the client is hindered (Wright, 1988). Hence, subtle barriers that prevent the acceptance of PWD must be explored (Antonak & Livneh, 2000). Overall, the need to adequately train and help foster counseling

psychologists who are competent to provide services to PWD is evident. However, a review of the literature indicates only a paucity of research has examined the perceived competence of psychology students regarding working with PWD (Pledger, 2003; Strike, 2001).

Leung (2003) indicates that psychologists must be more than knowledgeable and skillful regarding counseling PWD. Psychologists must also "undergo a fundamental attitudinal change of ideas and notions that have been inherent in U.S. culture" (Leung, 2003). PWD have historically been faced with stigmatization based on their abilities. Specifically, PWD have been viewed as being less stable, weaker, less competent, less motivated, less sociable, more passive, less likable, less happy, less sensitive, and less free than nondisabled persons (Anderson & Antonak, 1992).

The origin of such stigmatization is believed to lie within attitudes held towards PWD (Livneh, 1982; Wright, 1983). The processes that create and sustain attitudes have received much speculation and attention from sociological and psychological researchers. Some consider attitudes to be psychosocial processes that lie inactive within the person unless evoked by specific circumstances (Oskamp, 1991). Attribution theory suggests the "general evaluative tendency" of people is a culmination of the beliefs held regarding whether an object, such as PWD, has desirable or undesirable attributes (Marsh & Wallace, 2005, p. 369). This "general evaluative tendency" is the attitudes held toward such objects (Marsh & Wallace, 2005, p. 369). With regards to the origin of negative attitudes towards PWD, Livneh (1982) identified 12 potential sources commonly found in the literature. These sources ranged from social/cultural influences to affective responses

when faced with the reminder of one's own mortality after seeing a person with a visible disability (Novak & Lerner, 1968).

The amount of contact an individual has with PWD has often been implicated as a means to understand and possibly modify negative attitudes. Yuker (1965) indicated a person with negative attitudes towards PWD will try to minimize the interaction and avoid the person with a disability. Likewise, a person with positive attitudes may seek to interact with PWD. Further, people with positive attitudes towards PWD may see the "individual as a person rather than a disabled person" (Yuker, 1965). Historically, people who have less frequent and less intimate contact with PWD often express stereotypical negative reactions (Gaier, Linkowski, & Jacques, 1968; Taylor, 1981; Weinberg, 1976; Yuker, 1988). Postsecondary students with disabilities tend to report as being more knowledgeable and have more contact with PWD than peers without disabilities. The findings indicated that persons who share group membership may interact more easily with similar group members than those outside of the group. In this case, persons without disabilities may feel less comfortable when around PWD (Upton, Harper, & Wadsworth, 2005). Other studies of the correlation between contact and attitudes towards PWD have resulted in similar findings (Anthony 1972; Biordi & Oermann, 1993; Lyons, 1991). Cooper, Rose, and Mason (2003) found among a sample of psychiatrists, nurses, psychologists, and occupational therapists that knowledge of deafness did not correlate with the attitudes towards people who are deaf. However, they did find that the amount of contact with people who are deaf and of equal or higher status positively correlated with attitudes. The study indicated that improving attitudes towards people with hearing loss may be better affected through exposure rather than a learning experience in the

classroom (Cooper et al., 2003). Biordi and Oermann (1993) also indicated nursing students who had prior work experience in a rehabilitation setting had more positive attitudes towards PWD than nurses without prior experience. These findings give a strong implication for the potential need of interpersonal contact with PWD as a means of training and developing health professionals with positive attitudes regarding PWD. Unfortunately, these findings have not yet been confirmed in a sample of counseling psychology graduate students.

The knowledge of attitudes toward PWD offers great insight regarding interactions with people who do not have a disability. Specifically, understanding attitudes towards PWD would assist in the development and training of all mental health professionals including counseling psychologists (Yuker, 1988). A great barrier to a therapeutically helpful counseling relationship can be found in the attitudes of the counselor regarding the client with a disability. Those who hold negative attitudes towards PWD have been found across the counseling professions from rehabilitation counselors to school counselors (Beattie, Anderson, & Antonak, 1997; Furnham & Thompson, 1994; Holaday & Wolfson, 1997; McCarthy, 1988; Siperstein, Bak & O'Keefe, 1988). Within counseling settings, the more negative attitudes are often held by the person without a disability regarding the PWD (Fichten, Amsel, Bourdon, & Creti, 1988). However, it should be noted that the literature regarding the attitudes of counselors-in-training is still not conclusive. Some studies have supported the contrary conclusion that counselors tend to hold generally positive attitudes towards PWD (Carney & Cobia, 1994; Elson & Snow, 1986; Garske, 2002; Huitt & Elston, 1991; Martin, Scalia, Gay, & Wolfe, 1982). In most cases, these studies have focused on

rehabilitation counselors and/or master's level counselors. None have specifically focused on doctoral level counseling psychology students.

Overall, continued studies of attitudes may give clarity to the socialization process and prejudice formation. Further, understanding attitudes towards PWD may help researchers to actually predict the respondent's behavior towards PWD. The importance of being able to predict behavior towards PWD would assist in the training and development of future counseling psychologists who will work with PWD. Knowledge of the underlying formation and composition of attitudes towards PWD is "necessary for changing them and thereby increasing the integration of persons with disabilities into the larger society" (Antonak & Livneh, 2000).

This review has provided a context for considering attitudes towards PWD and the variables that mediate or influence such attitudes. Furthermore, there has been long term awareness that these factors, along with competence, may effect the rehabilitation and psychological counseling services that these individuals receive from professionals. Recognition of this may be best reflected in a mandate for counseling psychologists to be adequately trained and prepared to address the unique counseling needs of PWD (Sue et al., 1992; Sue, 2001). Hence, the necessity of studying the interaction of attitudes and perceived competence that counseling psychology graduate students hold towards clients with disabilities is imperative to understanding the potential impact on the therapeutic relationship. Even more so, the knowledge of attitudes held by counseling psychology graduate students can lend assistance to the training and development of competent counseling psychologists who very likely will work with PWD.

Purpose of Study

Previous studies have shown that counselors and psychologists in different specialty programs hold varying attitudes and levels of competence regarding PWD. Hence, the purpose of this study was to identify the attitudes counseling psychology graduate students hold towards PWD and discover any relationship between those attitudes and their perceived competence to work with clients with disabilities. Lastly, this study determined if the amount of prior contact a student in a counseling psychology graduate program has with PWD correlates with their attitudes and perceived competence of working with such clients.

Significance

The results of this study offer greater understanding as to the attitudes of students in counseling psychology graduate programs regarding PWD. Further, this study gives better clarity to knowing how those attitudes interact with the competence of students in counseling psychology graduate programs to work with clients with disabilities. Lastly, this study indicates if the amount of prior contact students in counseling psychology graduate programs have with PWD is a significant variable that may interact with their attitudes and perceived competence to work with such clients. Hence, the results of this study offer insight for training programs as they revise and refine their curriculum in the training and development of future counseling psychologists to be competent regarding working with clients with disabilities.

Research Questions

This study sought to answer five questions:

1. What is the perceived level of competence (e.g., self-awareness, perceived knowledge, and perceived skills) among counseling psychology graduate students regarding counseling PWD?
2. What are the attitudes of counseling psychology graduate students regarding PWD?
3. Do counseling psychology graduate students with different levels of prior exposure/contact to PWD report different levels of competence regarding working with clients with disabilities?
4. Do counseling psychology graduate students with different levels of prior exposure/contact to people with disabilities report different attitudes toward persons with disabilities?
5. What is the relationship between perceived level of competence regarding counseling PWD and attitudes toward PWD?

Operational Definitions

Competence

For the purposes of this study, competence was defined and measured through the use of the Counseling Clients with Disabilities Survey (CCDS; Strike, 2001). Strike (2001) combined both the Multicultural Counseling Competencies and Standards (Sue et al., 1992; Arredondo, Toporek, & Brown, 1996) with the minority model of disability (Hahn, 1985) to measure the competencies needed for counselors to work with PWD. The specific subscales that measure overall *competence* as defined by both the

Multicultural Competencies and Standards and the CCDS include *self-awareness, perceived knowledge,* and *perceived skills* (Sue, et al., 1992; Strike, 2001). A higher score on the CCDS is indicative of a greater level of perceived competence regarding working with clients with disabilities (Strike, 2001).

Disability

Disability in research has historically been defined by government policy (Hahn, 1985). This definition is specifically derived through the ADA. Further, the development of the CCDS included the ADA definition to derive the level of competence. Hence, for the purposes of this study *disability* was specifically defined as a "physical or mental impairment that substantially limits one or more major life activities (e.g., hearing, seeing, speaking, breathing, walking, thinking/learning, feeling/behaving, keeping house, living independently, or working)" (U.S. Department of Justice, 2005; Strike, 2001). This definition is included on the CCDS to guide respondents.

Attitude

Antonak and Livneh (1988) clarify that the most widely adopted definition of attitudes in research is the "multidimensional view of attitudes". According to this view "an attitude is an idea charged with emotion which predisposes a class of action to a particular class of social situations" (Antonak & Livneh, 1988). In essence, an attitude is a predisposition toward a particular behavior. Hence, understanding attitudes gives a greater predicative ability of behavior (Yuker, 1965).

Yuker (1965) identified two dimensions of attitudes toward PWD: (1) acceptance or rejection, and (2) prejudice or lack of prejudice. Acceptance of PWD includes the willingness to relate to the person with the disability. Prejudice includes the tendency to

perceive people based on a group or category (e.g. disabled) rather than as individuals. A person can be accepting yet still display prejudice by grouping a person into the category of "disabled" (Yuker, 1965). For the purposes of this study *attitude* was defined by The Attitudes Toward Disabled Persons Scale Form A (ATDP-A; Yuker, Block & Campbell, 1960; Yuker & Block, 1986; Yuker, Block & Younng, 1966, 1970). A higher score on the ATDP-A indicates a generally more positive attitude towards PWD (Yuker & Block, 1986).

Contact

Contact in this study was measured through the use of demographic items found on the CCDS. The items assessed the type of contact with PWD and the amount of prior experience with and/or exposure to PWD. This definition is consistent with Contact Theory as first proposed by Allport (1954) and further applied to research with PWD. Specifically, effective contact for attitude change is related to the type of contact. For the purpose of this study, effective contact for attitude change was "characterized by cooperation, intimacy, and equal status" (Yuker, 1994). Such personal and interpersonal contact in prior studies has been related to such relationships as between family, coworkers, friends, dating, or sexual relationships. The demographic items used in this study from the CCDS are similar to the type of contact with PWD that was studied by Strike (2001) and other researchers (Geskie & Salasek, 1988; Strohmer, Grand, & Purcell, 1984; Yuker, 1992).

CHAPTER II

LITERATURE REVIEW

The United States is made up of approximately 51 million people who have at least one or more identified disability (U.S. Census Bureau, June 21, 2006). Hence, PWD constitute the largest minority group in the United States (Olkin, 2002). Further, demographic forecasts indicate that the number of persons with a disability is expected to rise as a result of advances in healthcare, a growing general population, and increasing number of older adults (Steinmetz, 2006). One might say that disability is a natural part of life. Only within the past three decades have PWD been brought to the forefront of necessary societal and governmental reform (Americans With Disabilities Act [ADA], 1990). Such necessary reform has included facing the issues of how people with PWD are perceived by society and the accessibility for equal opportunities. The change in perspective of PWD has stimulated the need for professionals within the mental health field to determine the best methods for providing services for PWD. That is, mental health providers must examine how PWD are viewed and treated within the profession.

Disability and Culture

Throughout history the majority cultural view of disability has evolved. Indicative of the changing views of disability are the many models related to disability. Of all models, three seem to be the most prominent. The three models include the biomedical, environmental, and minority or sociopolitical models of disability (Olkin, 1999; Smart &

Smart, 2006). One of the oldest and most well known models is the biomedical model. As medical advances progressed, disability became viewed as more of a medical or physical problem. Hence, the view of PWD tended to focus on their limitations or deficits. Thus, treatments and interventions with PWD were oriented toward finding a cure for the problem. Essentially, the problem was within the individual person with the disability. PWD are viewed as the passive recipients of services which place medical and mental health specialists in a dominant or paternalistic role (Smart, 2001). The biomedical models include basic assumptions about disability which are detailed by Asch (1998, p. 78):

1. Disability is biology, and disability is accepted uncritically as an independent variable.
2. Problems faced by persons with disabilities result from "impairment" rather than the larger environmental social context.
3. Persons with disabilities are victims, so treatment is aimed at changing the person.
4. Disability is central to an individual's identity, self-concept, and self-definition.
5. Disability is synonymous with needing help and social support.

As one can see by the above assumptions, the biomedical model stigmatizes and categorizes PWD rather than emphasizing the unique abilities of each person. Essentially, PWD are devalued or inferior to the non-disabled majority (Smart & Smart, 2006).

The environmental model of disability places less emphasis on biology and more on the functional abilities or skills of the individual. However, biology is also recognized

as a factor of disability. Further, the model attributes disability as being caused or exacerbated by the environment. Those who adhere to this model of disability recognize that some limitations incurred by disability are environmentally or socially based. Hence, treatment is both focused on the individual's aversive biological processes and adapting the environment to assist in better meeting the functional demands (Smart & Smart, 2006). The dual emphasis of both biological causes and environmental causes of disability is reflective of the changing views of disability within the healthcare profession worldwide (Reed et al., 2005).

The minority model, also referred to as the sociopolitical model, has developed the most recently (Hahn, 1985). Within recent years the minority model has been readily adopted by many prominent authors and researchers (Fine & Asch, 1988; Fowler & Wadsworth, 1991; Hershenson, 1992; Olkin, 1999; Shapiro, 1993). Unlike the other models described above, the minority model focuses primarily on the prejudice, discrimination, and stigmatization in society as opposed to the medical or functional limitations of the individual. Further, the model identifies difficulties experienced by a person with a disability as the result of the attitudes of society. In a sense, the model accentuates that the disabling conditions are the attitudes that place PWD in an inferior position than the majority of society (Hahn, 1985). Unlike, a permanent medical condition (e.g. spinal cord injury) that currently cannot be cured, the societal construct of disability can be changed. In essence, treatment is not focused on the individual with a disability making changes or accepting their limitations but rather the focus is on societal changes. Hence, disability "is not viewed as a personal tragedy but as a public concern" (Smart & Smart, 2006).

One example of how the minority model has been implemented to alter societal stigma regarding PWD is social marketing. Social marketing employs persuasive communication strategies to encourage attitude change. The hypothesis put forth by Kirkwood and Stamm (2006) is that an appropriate message will change attitudes. Change still remains a voluntary process and results from the organized persuasive efforts of one group to influence change or discard certain attitudes, practices, or behaviors. Kirkwood and Stamm's findings indicated that social marketing does tend to encourage the change of negative attitudes towards people with disabilities.

Within the counseling setting strict adherence to one of the three above noted models of disability may not be possible (Smart & Smart, 2006). For example, the emphasis of biology, diagnosis, and categorization is a part of the profession of counseling psychology (American Psychiatric Association [*DSM-IV-TR*], 2000) and therefore may not be avoidable. However, it is important to note that counseling psychologists should remain cognizant of the multifaceted factors that contribute to disability. Further, the role of a clients' disability status may or may not be relevant to the particular presenting concern of the client. In counseling, the disability should be recognized as being a part of the individual's identity and not the defining feature of the person with a disability. Lastly, the counseling psychologist should remain aware of their role in the disablement of a client so as not to contribute to the prejudicial and stigmatizing experience (Smart & Smart, 2006). Hence, the counseling psychologist should be aware of how their beliefs, attitudes, and knowledge may be used or changed to best serve the client with a disability.

Competence, Ethical, and Diversity Issues Regarding PWD

Counseling psychologists are not excluded from the ranks of mental health professionals who are faced with the challenge of discovering how to best serve the growing population of PWD. As indicated above, an estimated 12% of the total student population is believed to have a disability (U.S. Department of Education, 2001). Further, college students with disabilities report using counseling services more often than students without disabilities (National Center for Education Statistics, 1999). The growing number of students with disabilities increases the likelihood that counseling psychologists and other mental health providers in college and university counseling centers and vocational centers will work with PWD. Counseling psychologists are faced with the challenge to remain competent with psychotherapeutic issues and societal trends as they relate to PWD. The American Psychological Association addressed the ethical necessity for psychologists to only provide services for which they are competent to provide (APA, 2002). Code 2.01 of the Ethical Principles of Psychologists and Code of Conduct specifically indicates that the competence of psychologists working with PWD is "based on their education, training, supervised experience, consultation, study, or professional experience" (APA, 2002). The mandate for counselors to be competent providers of mental health services to PWD is further echoed by the Multicultural Counseling Competencies and Standards (Sue et al., 1992). Likewise, the APA requires that for graduate training programs in psychology to be accredited, they must implement a "thoughtful and coherent plan to provide students with relevant knowledge and experiences about the role of cultural and individual diversity in psychological phenomena" (Committee on Accreditation, 2008). Hence, the necessity for future

counseling psychologists to be adequately trained is paramount to their provision of ethical and beneficial services to PWD (Yuker, 1988).

The significance of continued bigotry, prejudice, and discrimination is so important to the field of psychology as a whole that many landmark events such as the 1973 Vail Conference, 1975 Austin Conference, 1978 Dulles Conference, and the 1978 President's Commission on Mental Health have influenced the direction of multicultural competence in mental health services (Sue & Sue, 1999). The sensitization of the field of psychology regarding multicultural needs is even more evident by the topics covered at the second biennial National Multicultural Conference and Summit (NMCS; Bingham, Porché-Burke, James, Sue, & Vasquez, 2002). The purpose of the conference was to facilitate organizational changes specifically related to diversity and multiculturalism within the field of psychology. During the conference, many presenters emphasized the value and necessity of "understanding, recognizing, and facilitating difficult dialogues in classrooms" as well as other social and service settings regarding diversity issues, such as disability (Bingham et al., 2002).

As highlighted through Olkin's (2002) work, PWD are made up of not only the majority population but every other minority group as well. Further, PWD remain one of the most economically and educationally deprived groups due to cultural norms and stigma. These sad truths are evident in that only 29% of people with disabilities are employed, as compared with 79% of the non-disabled population. Mostly, those PWD who remain unemployed have a desire to be employed. The annual income of 33% of PWD is less than $15,000. As evidenced by current laws and physical infrastructure, PWD literally remain physically segregated. The reality is that even with the increased

emphasis on political reform, multiculturalism and breaking biases held towards other people groups, PWD still remain a physically, socially, and emotionally segregated group. Olkin (2002) points out that no other people group must use a separate door or water fountain often found in an unsightly or undesirable location away from those used by non-disabled individuals.

Linton and Rousso (1988) point out that the societal view of PWD is of an asexual group that has no desire for sex or capability for sexual pleasure. Understandably these societal views of asexuality can be psychologically harmful to PWD, leading to low-self esteem, a negative body image, and limited social and sexual expectations for themselves. They point out that masters level counselors, psychologists, and health professionals often have limited or inadequate training for understanding and working with PWD who seek out sexuality counseling (Linton & Rousso, 1988). Olkin (2002) advocates that within research, training, and practice, psychologists must take into account these very real prejudices faced by all PWD.

In light of the increasing need and ethical requirement for clinical and counseling psychologists to be competent regarding working with PWD, it is especially troubling that few actually have the necessary level of expertise that is ethically required (Allison, Crawford, Echemendia, Robinson, & Knepp, 1994; Allison, Echemendia, Crawford, & Robinson, 1996; Kemp & Mallinckrodt, 1996). Olkin (2002) indicates that current research regarding PWD exemplifies the failure of psychology to adequately address disability issues. The conclusions of her article stress the importance for psychology programs to amplify the amount of curricular content and experiences dedicated to disability related issues and how those may affect the counseling setting. Further,

psychology programs need to make advanced psychological training more readily available to future counselors with disabilities (Olkin, 2002). These prejudices are indicated in recent reflections of a psychology faculty member who has a disability. The faculty member outlined how she felt her retention and achievement in a psychology department was more arduous than her non-disabled colleagues. Further, she indicated that even within a department that prides itself on multiculturalism and diversity, she felt a "painful invisibility" while working amongst her colleagues. Also, the exclusion of her identity as a woman with disabilities was experienced and caused her "profoundly negative consequences on...psychological and physical well-being" (Vasquez et al., 2006). This personal account supports the overall conclusion of the NMCS that cultural competence regarding PWD "must become more than an aspiration; it must become a reality" within the field of psychology and mental health (Bingham et al., 2002).

This reality of the need for greater cultural competence regarding PWD is highlighted through the mental health research. Pelletier et al. (1985) found that consumer advocates, rehabilitation administrators, rehabilitation counselors, and consumers felt "inadequate professional training" and a lack of "specialized knowledge and skills" regarding PWD was a moderate barrier to the provision of adequate mental health care for PWD. Also, Leigh et al. (2004) found that clinical psychologists, neuropsychologists, and rehabilitation psychologists report barriers to providing adequate services to PWD include limited provider knowledge, training in disability issues, and sensitivity regarding PWD. Likewise, studies indicate that recently trained clinical and counseling psychologists rate their own level of competence and confidence to work with people with disabilities low (Allison et al., 1996; Bluestone, Stokes, & Kuba, 1996). The