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

issue of the necessary amount and quality of training regarding PWD has been studied to determine what tends to promote self-perceived competence. The number of training cases during the clinical training of clinical and counseling psychologists has been found to be a significant predictor of self-perceived competence regarding PWD. Further, the quality of supervision that focused on PWD was a significant predictor of self-perceived competence. Unexpectedly, the amount of exposure to diverse faculty, course coverage of diversity issues, and the amount of clinical supervision that addressed diversity issues did not predict self-perceived competence regarding PWD (Allison et al., 1996).

Training regarding PWD has traditionally included emphasis on special education needs, vocational training, and counseling specifically related to acute adjustment to life with a disability (Linton, 1998). Hence, the focus remains on the disability as being the only problem or concern of the client with a disability. Reeve (2000), a counselor with a disability stated, "The assumption that becoming disabled is psychologically devastating also implies that all disabled people will therefore need counseling to come to terms with their losses" (p. 670). The client with a disability may seek counseling for issues related to the disability but often it is for issues more pressing than the disability (Olkin, 1999). One conceptualization error frequently found among clinical and counseling psychology graduate students as well as clinical and counseling psychologists is the failure to address critical aspects of the client's life rather than focusing purely on the disability when the disability is not the crucial concern (Kemp & Mallinckrodt, 1996). Quite possibly this error is the result of narrow training focus that leaves future clinical and counseling psychologists without exposure to training regarding working with PWD (Linton, 1998). Possibly more disturbing than the apparent lack of training given to mental health

professionals about PWD is the paucity of research that has examined the perceived competence of psychologists regarding working with PWD (Pledger, 2003; Strike, 2001). However, one study by Allison, et al. (1996) examined the training variables that tended to predict a higher perceived competence regarding PWD. The number of therapy cases during clinical training was a significant predictor of higher perceived competence regarding PWD among a sample of clinical and counseling psychologists. Surprisingly, they also found that exposure to diverse faculty and staff, course content relevant to specific diversity groups, and general courses in diversity did not predict perceived competence regarding PWD. The results of the study highlights why it may be prudent for more research to examine what works with regard to diversity training and competence to provide services to PWD.

Mental Health Providers' Competence

Strike (2001) measured the self-reported level of competence regarding PWD among a sample of mental health professionals. The sample included psychiatrists, psychologists, social workers, career counselors, disability specialists, and other mental health professionals. Perceived competence regarding working with PWD was conceptualized by looking at three specific areas: *Self-Awareness*, *Perceived Knowledge*, and *Perceived Skills*. These areas of competence were derived from the Multicultural Counseling Competencies and Standards (Arredondo et al., 1996; Sue, et al., 1992) and the minority model (Hahn, 1985). This unique study was the first time the Multicultural Counseling Competencies and Standards and the minority model of disability have been integrated to assess perceived competence (Strike, 2001). *Self-Awareness* included the participants' introspective understanding of the impact of having a disability versus not

having a disability. *Perceived Knowledge* included a general understanding of factual knowledge regarding disability. Lastly, *Perceived Skills* included items that measured skills and behaviors that "are desirable in mental health professionals who may see clients with disabilities" (Strike, Skovholt, & Hummel, 2004, p. 323). Participants with the greatest amount of experience with PWD self-rated their overall level of competence significantly higher than those with limited disability related experience. Regardless of the amount of previous experience with PWD, the participants consistently rated *Self-Awareness* significantly ($p < .0001$) higher than *Perceived Knowledge* or *Perceived Skills*. *Perceived Skills* to work with PWD was significantly ($p < .0001$) lower than *Perceived Knowledge* and *Self-Awareness*. *Perceived Knowledge* regarding PWD was the second lowest self-reported competence and was rated significantly ($p< .0001$) lower than *Self-Awareness*. Strike's (2001) findings indicate a surprising and disheartening indication of current psychologists' and other mental health providers' limited self-rated competencies when it comes to providing services to PWD. Especially troubling is that knowledge and skills were perceived as being the most limited competencies. One would assume that knowledge and skills regarding PWD would be the easiest to provide in training settings.

Allison et al. (1996) measured self-rated competence regarding diverse client groups among a sample of clinical and counseling psychologists who are members of the American Psychological Association (APA). The participants completed a survey that required them to rate their perceived general level of competence regarding thirteen diverse people groups. The diverse groups included people who are identified as African-American, Asian American, Black-Hispanic, Caucasian, Native American Indian,

Hispanic, gay, lesbian, bisexual, man, woman, physical/sensory challenged (PWD), and economically disadvantaged. Allison et al. (1996) also identified the specific training variables related to the participants' perceived competence. Lastly, the characteristics of those who provide therapeutic services to these diverse groups were identified. The number of therapy cases during training was found to be a significant ($p < .0001$) predictor of perceived competence with people with a physical or sensory impairment. Also, the number of therapy cases at the time of the study was also found to be a significant ($p < .0001$) predictor of perceived competence with people with a motor impairment. Unfortunately, PWD were rated among the groups that psychologists have the lowest overall level of perceived competence (Allison et al., 1996). Considering that PWD is the largest minority group in the United States makes this apparent lack of competence disheartening (Olkin, 2002). Even more disturbing is that several clinical and counseling psychologists indicated that they continue to see client groups regardless of their minimal level of competence regarding those groups (Allison et al., 1996).

A more recent study measured the self-perceived competence and barriers to providing services to PWD among a sample of non-disabled psychologists and a sample of disabled psychologists (Leigh et al., 2004). The sample of participants included members of APA who were disabled and non-disabled specialists in clinical psychology, neuropsychology, and rehabilitation psychology. They found that non-disabled psychologists felt their level of competence and training for working with PWD was adequate when compared to the sample of psychologists with disabilities. They speculate that this discrepancy is likely the result of the non-disabled psychologists' unawareness of their need for additional training and support. Psychologists with a disability indicated

they did need additional training and support when providing services to PWD. Leigh et al. (2004) points out that the sample of psychologists with a disability may have more insight into the general lack of training for providing services to PWD amongst all professionals.

Hunt, Matthews, Milsom, and Lammel (2006) took a different approach to measuring perceived counselor competence regarding PWD. They interviewed lesbians with a physical disability regarding their counseling experiences. Using a qualitative approach, they found five major themes expressed regarding the participants' perception of their counselors. Among the themes was a rating of counselor knowledge regarding disabilities. The participants rated counselor knowledge regarding disability related issues as limited. Overall, the participants rated their counselor as incompetent. The data suggested that participants desired counselors who use a more multidimensional perspective and do not focus on sexual orientation or disability status as the defining characteristic of the client. Unfortunately, whether the counselors discussed were psychologists or masters level counselors was never specified (Hunt et al., 2006).

The findings discussed above support the notion that psychologists tend to feel ill-equipped to work with PWD. The lack of knowledge regarding working with PWD is also expressed through client views of psychologists. The limited training in clinical psychology, counseling psychology, and school psychology programs is itself "a powerful statement about the marginalization of people with disabilities" (Olkin & Pledger, 2003, p. 297).These findings strongly support the need for more thorough and applicable forms of multicultural and diversity training of counseling psychologists in

order to foster more competent professionals for future work with PWD (Allison et al., 1996; Strike, 2001; Sue et al., 1992).

Understanding Attitudes Towards PWD

The application of multicultural competencies with clients with disabilities requires more than just the development of skills and knowledge. Essentially, the psychologist must "undergo a fundamental attitudinal change" (Leung, 2003). The importance of attitude evaluation and change is so imperative that it has been echoed throughout multicultural and diversity literature (Fouad & Arredondo, 2007; Pope-Davis, Coleman, Ming, & Toporek, 2003; Sue, 2001; Sue et al., 1992). The Multicultural Counseling Competencies specifically addresses beliefs and attitudes regarding other cultural groups as being one of the major dimensions of cultural competence. Further, the successful integration of PWD into society can be assisted through the attitudes of counselors regarding PWD (Wong, Chan, Cardoso, Lam, & Miller, 2004). Great importance is placed on the self-awareness of one's own beliefs and attitudes as they apply to other cultural groups and reflection of how those attitudes may affect their ability to provide psychological services (Sue et al., 1992).

Attribution Theory

The attributions or inferences of causes are used by people to interpret perceptions of behavior or objects. The interpretations individuals make regarding observed behavior "plays an important role in determining reactions to the behaviors" (Kelley & Michela, 1980, p. 458). In essence, attribution theory suggests the "general evaluative tendency" of people is a culmination of the beliefs held regarding whether an object 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). The attitudes held by a person regarding the given object are made up of the cognitions, beliefs, and behaviors or consequences of the particular attributions (Kelley & Michela, 1980). Beliefs regarding an object can influence the attitudes held regarding that object. Likewise, those attitudes can influence the perception of the object which then influences the beliefs regarding the object (Marsh & Wallace, 2005). As outlined by Ajzen (2001), an attitude is the evaluation of an object in attribution dimensions as "good-bad, harmful-beneficial, pleasant-unpleasant, and likable-dislikable" (p. 28).

For example, attribution research has examined the link between the economic status of racial minority groups and prejudiced attitudes. The common findings have been that individuals who attribute economic disadvantage of racial minorities to internal causes (e.g. limited motivation) rather than external causes (e.g. limited opportunities) tend to hold more negative or prejudiced attitudes. These attitudes then can influence the perception of racial minorities as lacking motivation for behaviors consistent with economic thriving (Kluegel, 1990; Kluegel & Smith, 1986; Schuman, Steeh, Bobo, & Krysan, 1997).

As indicated through the attribution theory, the cause of a disability has historically been linked to attitude formation regarding PWD (Arokiasamy, Rubin, & Roessler, 1995). Yuker (1994) states that the "beliefs that a nondisabled person has regarding persons with disabilities is probably the major variable that influences attitudes" (p.5). Negative attitudes, including within the counseling setting, are formulated out of thoughts that the person with the disability is completely or partially to blame for the disability (Livneh, 1988).

Weiner (1995) elaborates that when presented with an object, such as an individual with a disability, people try to attribute responsibility. People make attributions about the cause and controllability of the event. If the person has or had control of the cause of the event, then the individual is judged to be responsible. Likewise, when the cause of the event is attributed to forces outside the individual's control, then the individual will not be judged responsible. Hence, Weiner (1995) indicates "thoughts progress from causal attribution to an inference about the person" (p. 9). Such causal attributions tend to affect the beliefs about a person's responsibility for causing their condition. Those beliefs lead to affective responses which can result in rejecting behaviors such as "avoidance, coercion, segregation, and withholding help" (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003, p. 162). Weiner, Perry, and Magnusson (1988) found that the level of anger, pity, and desire to help was dependent on the observer's attribution of controllability of the resulting disability. Physical disabilities were perceived as not controllable and brought forth little anger, increased pity, and a stronger desire to help. Mental illness or behavioral related conditions were perceived as controllable and brought forth greater anger, decreased pity, and less desire to help (Weiner et al., 1988). However, in either case the resulting affective responses or attitudes can have dire consequences to the helping relationship. These consequences will be covered later in this review.

Karasawa (1991) further tested responses regarding the onset and offset information about the cause of a person's problems. Affective responses tended to be negative as well as critical when the cause was viewed as controllable. Otherwise, causes that were perceived as uncontrollable tended to result in positive affect and increased

intent to help. In an assessment of the discomfort with coworkers with disabilities, coworkers with no-disability indicated that they would feel most discomfort with PWD who are classically viewed as having a controllable disability (Jones & Stone, 1995). These results amplify Weiner's (1995) indication that attributions of cause impacts affect which then influences behavior or the actions of the perceiver. With relation to PWD, people make attributions of the cause of someone's disability which then reflect whether they express generally positive or negative attitudes (Arokiasamy, Rubin, & Roessler, 1995; Jones & Stone, 1995; Weiner, Perry, & Magnusson, 1988).

As suggested above, attributions guide if a person will offer help and how they offer help. However, attribution theory outlines that such cognitions or attributions tend to introduce a level of bias within the helping relationship. Batson (1975) elaborates that within the helping relationship the helper may attribute the resulting negative situation to either the person in the situation or environmental forces. Likewise, the client may attribute their negative situation to personal causes or environmental forces. When the attributions of the helper and the client differ then an attribution bias has occurred. The helping behaviors are dependent upon the different perceived attributions of the situation.

The type of attribution for such situations has been found to be a mediator of the type of help given (Batson, 1975). Specifically, the helper decides whether the helping behavior will include addressing the personal qualities of the individual being helped or the environmental factors that are causing the negative situation (Jones & Nisbett, 1971; Batson, 1975). The misunderstandings that result from such attribution biases about the type of care needed can cause confusion between the helper and client and possibly inadequate helping behaviors (Batson, 1975). Hershenson (1992) postulated that many of

the difficulties in rehabilitation counseling arise out of disagreement among counselor and client regarding their conceptions of disability and expectations of the rehabilitation process, which are rooted in differing attributions of the disability.

Likewise, within the counseling setting, the counselor makes observations, inferences, and judgments regarding the client. Pepinsky and Pepinsky (1954) outlined the processes employed by the counselor for making inferences and how those affect judgments regarding the client. The model includes two inferences that mediate between counselor observations and clinical prediction. The inferences include "(a) an inference about the current functioning or status of the client, and (b) an inference about the probable" cause or attribution of the present status of the client (Strohmer, Haase, Biggs, & Keller, 1982, p. 589).). Thus, Pepinsky and Pepinsky's (1954) work of how inferences or attributions regarding a client, such as PWD, supports the notion found in attribution theory that attitude formation is directly linked to attributions regarding the individual.

Strohmer et al. (1982) studied this phenomenon by testing four distinct models of counselor judgment among a sample of doctoral level counseling, clinical, and educational psychology students. The results indicate that the most significant model of clinical judgments consist of three steps. The first step of the model includes inferences of functioning determined by information (i.e. disability status, personality status, academic achievement) provided by the client. Secondly, attribution inferences are determined by client information and inferences of functioning. Lastly, the inferences of functioning and causal attribution inferences determine the clinical judgment about the client. Hence, the actual client information provided results in little direct impact on the clinical judgment. Inferences of causal attribution and functioning mediate the impact of

the client information and how that information may influence the attitudes of the counselor.

As suggested earlier, the attribution or cause of client difficulty has been linked to the psychologist's decision making within the counseling setting. Specifically, attribution has been linked with doctoral level counseling psychology students' choice of diagnosis, expectation of progress in psychotherapy, and choice of treatments (Schwartz, Friedlander, & Tedeschi, 1986). A sample of graduate students in counseling psychology, social work, and educational psychology significantly altered their impression of clients based on attribution explanations (self vs. others). Specifically, the participants rated those clients who reported personal attributions of their situation as more motivated and much more attractive (Schwartz et al., 1986). Thus indicating that attitudes are a reflection of causal attributions as outlined in attribution theory (Marsh & Wallace, 2005).

A review of the literature regarding perceptions of clients by professional helpers indicates that several forces tend to influence such inferences or perceptions which are reflected through the behavior of the helper (Wills, 1978). Helpers included in the review consisted of psychologists, counselors, social workers, and others that provide direct assistance in mental health clinics or psychiatric hospitals. Using a factor analytic approach, Wills (1978) found that experienced helpers use three dimensions in perceiving clients. Those factors included manageability, treatability, and likeability. He found that manageability accounted for the greatest amount of variance within the helper perception. Manageability consisted of the extent the helper viewed the client as a management problem. Further, treatability reflected the extent the helper perceived the client's

susceptibility to the prescribed treatment. Lastly, likeability was found to load on the manageability and treatability dimensions but in some cases emerged as a separate factor. Wills (1978) offered the alternative description of likeability as being synonymous with attractiveness or the perception of how likable the client is and pleasant to work with in the helping relationship.

When discussing attribution theory within the helper relationship, the most obvious contribution of Wills's (1978) review included the tendency of helpers to make personality attributions as the cause of client difficulties. Further, some of the studies reviewed indicated that participants or the clients tend to attribute difficulties to situational factors rather than personality factors. In most of the studies reviewed he noted that the personality related attributions were based on a very small amount of behavior observed (Wills, 1978).

Livneh (1988) outlined that attributions are a significant portion of the development of negative attitudes regarding PWD. Consistent with attribution theory discussed above, he summarized that the cognitive component of attitude development towards PWD is most closely linked to the attributions of disability causation. When an observer or counseling psychologist has cognitions and beliefs that the person with the disability is the causative factor for their disability, negative attitudes are formulated (Livneh, 1988). Livneh (1988) also indicated that these cognitions are conscious dimensions of negative attitude development, yet the observer may not initially recognize that they attribute the cause of the person's disability to the behaviors or personality variables of the person with a disability. Thus, as indicated by attribution theory, attitude

formation and development regarding PWD is directly linked to the attributions associated with the cause of the disability.

Attitude Origins

The societal perceptions and biases regarding PWD are a part of our cultural tradition and are in part dependent upon the normative views within our culture (Leung, 2003). As indicated above with the discussion of the differing models of disability, the perceptions of PWD tend to change with cultural belief changes (Smart & Smart, 2006). The origin of such stigmatization is believed to lie within attitudes held towards PWD (Wright, 1983; Livneh, 1982). An attitude, in the broadest sense, is the "summary evaluation of a psychological object captured in such attribute dimensions as good-bad, harmful-beneficial, pleasant-unpleasant, and likable-dislikable" (Ajzen, 2001). According to Antonak and Livneh (1988) "an attitude is an idea charged with emotion which predisposes a class of action to a particular class of social situations." An attitude is essentially a tendency to display a particular behavior. Therefore, understanding an individual's particular attitudes allows for greater predicative power of their behaviors (Yuker, 1965). However, an attitude is much more than just positive or negative. An attitude is the spontaneous assessment of many beliefs held in association to the object being evaluated. Each belief is assessed by importance and so the most important beliefs tend to determine the resulting attitude. The beliefs are formulated through the evaluations of attributes of a particular object. This is often referred to as the "Expectancy-Value Model" of attitudes, which is rooted in attribution theory (Ajzen, 2001, p. 30). Some believe there is also an affective component that, at times, supersedes

beliefs. Hence, the process involves both a cognitive and affective component (Ajzen, 2001).

Negative attitudes towards PWD tend to conjure cognitions that PWD are sick, pitiful, or even a social hindrance (Warren, 1985). Personal emotions of discomfort, tension, and unease have been discovered to frequently occur when in the presence of a person with a disability (Gething, 1991). Gordon, Lam, and Winter (1997) indicated the strain or anxiety experienced may be caused by curiosity, the desire to stare or not knowing how to act when in the presence of a person with a disability. Some have found that the personal anxiety felt during an encounter with a person who has a disability can actually bring a person to desire to avoid or escape the situation and gain greater control over how often the situation happens (Berry & Jones, 1991). That finding is consistent with Livneh's (1983) study in which fear of death was a significant predictor of the attitudes of graduate level counselor education students regarding PWD. Specifically, increased fear of death was correlated with negative attitudes towards PWD (Livneh, 1982). Likewise, Hirschberger, Florian, and Mikulincer (2005) researched whether death anxiety was related to emotional reactions towards PWD. They postulated that people tend to avoid PWD because disability is a reminder of their own vulnerable nature. The reminder of physical mortality then leads to decreased compassion and psychological distancing (Novak & Lerner, 1968). Hirschberger et al's. (2005) study concluded that the reminder of death or mortality is a significant factor in emotional reactions to PWD. More specifically, male participants emotionally withdrew and reported less compassion for PWD when a primer including thoughts of death was presented. Conversely, female

participants tended to express increased compassionate responses towards PWD when a primer including thoughts of death were presented (Hirschberger et al., 2005).

Park, Faulkner, and Schaller (2003) postulated that the humans evolved a disease avoidance tendency as means of species survival. In so, they review that disease has historically been associated with disability. In many instances, disabilities and visible deformities were the result of some genetic or contagious disease and so those individuals were avoided as a means of personal protection. Their model, termed the disease-avoidance model, is rooted in a cognitive-affective perspective that hypothesizes affective responses (anxiety) to PWD and cognitions (negative attitudes) result in avoidance behavior when in the presence of PWD. Their conclusions and review of the literature offers preliminary support for the evolved disease-avoidance process underlying avoidance of PWD and societal stigma (Park et al., 2003).

Yuker (1965) identifies 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). In general, social attitudes towards people with disabilities have been negative or ambiguous (Frank & Elliott, 2000; Gething, LaCour, & Wheeler, 1994; Hergenrather, Rhodes, & McDaniel, 2005; Holmes & McWilliams, 1981; Livneh & Antonak, 1997; Yuker, 1994). Some consider attitudes to be psychosocial processes that lie inactive within the person unless evoked by specific circumstances (Oskamp, 1991). Livneh's (1982) review of the literature specifically identified 12 potential origins

of negative attitudes towards PWD. However, they can be more easily thought of by using six dimensional categories. These dimensions prove to be helpful at understanding the origin of negative attitudes but do not remain mutually exclusive and do tend to overlap (Livneh, 1988).

The first dimension includes "sociocultural-psychological sources" of negative attitudes. These sources tap factors ranging from social/cultural norms to psychodynamic and personal developmental experiences. Likely, the most notable societal based source of attitude development is early childhood experiences. Harper (1999) detailed that children are rarely taught overtly about liking or disliking PWD. Though, parents, peers, and media are the sources of prejudice attitudes indicated by social learning theories (Byrd, 1989). According to the social learning theory, children learn through observation of others. Learning is demonstrated through imitation of others even when the model is not around (Papalia, Olds, & Feldman, 1998). Rohan and Zanna (1996) found that value profile of the parent and child was similar even after the child grew to adulthood. Also, the parent and adult child expressed similar attitudes regarding minority groups. Other examples of societal influences on attitudes include the emphasis on physical beauty, health, and personal achievements (Livneh, 1988). The psychological factors may include a feeling of guilt by people who are not disabled for being "able-bodied". Then dissociating from the guilt as a protective action serves to create an attitudinal ambivalence towards PWD (Siller, Chipman, Ferguson, & Vann, 1967). One example of a societal norm is the belief that PWD should take on a "sick role" or that life with a disability means the person is perpetually in a state of loss and grief (Hume, Szymanski, & Hohenshill, 1989; Katz, Hass, & Bailey, 1988). Further, the expectation is that the

person with a disability feels they are in an undesirable state and require others to take care of them (Miller, 1992). This perspective or attitude can obviously lead to PWD being placed in an inferior status and are then underestimated (Atkinson & Hackett, 1995).

The second dimension discussed is affective-cognitive sources. Affective causes are the emotional reactions people may experience when faced with aesthetically aversive encounters that include body deformities or psychological conditions (Siller et al., 1967). The affective component is often an anxiety based reaction to being faced with the reality that one's body can be hurt and a similar impairment could happen to the observer (Novak & Lerner, 1968). In terms of the cognitive component of attitude development, the most easily understood is the attribution of blame towards the person with a disability. Negative attitudes are formulated out of thoughts that the person with the disability is completely or partially to blame for the disability (Livneh, 1988).

The third dimension, the conscious-unconscious dimension, implies that the sources of negative attitudes range from those that are fully aware to the observer to those determinates that are unknown to the observer. As discussed previously, a conscious process of attitude development may include attributing responsibility of the etiology to the person with a disability. An unconscious process may include associations made to fear or anxiety of physical loss or death (Livneh, 1988).

The fourth dimension differentiates attitudinal origins stemming from past experience with present situation variables. Similar to earlier described dimensions, this polar explanation of attitude formation places emphasis on early childhood practices that instilled basic understanding of cultural, social and moral beliefs as related to disease and

illness. Some of these early teachings may work to produce anxiety by emphasizing that illness is a punitive action for earlier sins or ancestral wrongdoing. These early experiences are then contrasted with present situational events such as fear of disapproval by other nondisabled individuals for offering sympathy towards a person with a disability. In this instance, relief of the fear and guilt is only brought on by dissociating from the feelings and ultimately denigration of the person with the disability.

The fifth dimension describes attitudes towards PWD as developing from internal versus external sources. This dimension suggests that the internal sources or factors include demographic or personality variables. For example, female observers tend to hold more positive attitudes towards PWD than male observers. Conversely, the external sources are disability related variables that serve to influence those observing the person with the disability. The suggested variables include the "prejudice-provoking" behaviors such as behaviors expressed by the person with a disability that may be interpreted as unacceptable or negative (e.g. not seeking gainful employment or withdrawal from social contact). Other external factors include the very characteristics of the disability. In many instances persons with psychiatric disabilities are viewed more negatively than those with physical or sensory disabilities.

The sixth dimension suggested by Livneh (1988) includes those which are theoretically based versus those that are empirically studied. Unfortunately, many of the origins of negative attitudes towards PWD are based purely on theory. However, the body of research related to this topic is steadily growing as more complex measures of attitudes are developed (Antonak & Livneh, 2000). Some of these studies will be discussed more thoroughly later. The six dimensions discussed do help to give structure

and clarity to understanding just how the origins of attitudes towards PWD are conceptualized within the greater body of literature.

Regardless of the origin of the stigmatization, knowledge of the attitudes toward PWD will give us better insight regarding the interactions with PWD and the potential consequences of such attitudes on the lives of PWD. Further, knowledge of attitudes towards PWD will assist in knowing how to foster societal change for an overall healthier life for both those with and without disabilities (Yuker, 1988).

Effects of Negative Attitudes

Livneh (1988) eloquently stated, "people with disabilities are construed as objects of ambivalence, triggering momentary, fluctuating favorable and unfavorable feelings of compassion and sympathy but also of aversion and distaste" (p. 37). As indicated above, attitudes towards PWD are likely the result from many factors (Livneh, 1982, 1988; Oskamp, 1991). Attitudes can affect many components of an individual. Negative attitudes can serve to bias information processing, judgments, and memory (Ajzen, 2001). Further, negative attitudes towards PWD result in many different forms of negative or undesirable behaviors. Historically, negative attitudes regarding PWD have resulted in such horrifying actions as institutional incarceration and removal of civil liberties (Hastings, 1981). In many instances these negative attitudes result in limited occupational opportunities (Gouvier, Steiner, Jackson, Schlater, & Rain, 1991). In the broadest sense, negative attitudes prevent PWD from fully participating in society (Brodwin & Orange, 2002; Cook, 1997; Frank & Elliott, 2000; Hergenrather, Rhodes, & McDaniel, 2005; Livneh & Antonak, 1997; Siller, 1976; Smart, 2001).

Negative attitudes may increase feelings of hopelessness and pessimism in PWD. Further, negative attitudes can diminish self-esteem (Makas, Finnerty-Fried, Sigafoos, & Reiss, 1988; Royal & Roberts, 1987; Paris, 1993; Stovall & Sedlacek, 1983; Tervo, Palmer, & Redinius, 2004). The negative attitudes among counseling psychologists and other mental health professionals can actually be more harmful to PWD than those expressed by the general society (Yuker, 1994). Consumers of mental health services with a severe physical disability tended to rate the attitudes of mental health professionals as a substantial barrier to the provision of beneficial services (Pelletier et al., 1985). Yuker (1994) goes so far as to suggest that rehabilitation professionals should be screened for negative attitudes prior to entering such professions.

As would be expected with any minority group, holding negative attitudes towards PWD can be damaging to the therapeutic relationship and the client's ability to adjust to life with a disability or other presenting concerns. In the counseling setting, negative attitudes can hinder the working alliance and eliminate the equal status of the client, thus perpetuating the disempowerment of the client. Such negative or biased attitudes of counselors regarding PWD can actually mean the counselor becomes a part of the oppressive culture that the client with a disability must face outside therapy (Reeve, 2000). Such an example of how these negative attitudes can affect the counseling setting is through the financial availability to provide services for PWD. If a counselor, who has significant control over budgeting, services, and information, holds negative attitudes regarding PWD, the effect can be financially compromised services (Reeve, 2000). At the very least negative attitudes are associated with inappropriate and ineffective treatment (Sue & Sue, 1999). Olkin (2002) suggested that the way a client feels during therapy is

dependent upon the way a psychologist views PWD. Specifically, the client with a disability may experience shame or the need to conceal their disability, powerless, and at the mercy of the professional (Olkin, 2002).

Further, negative attitudes in psychotherapy and assessment can lead to inaccurate conceptualizations on the part of the counselor (Reeve, 2000). Doctoral students in clinical and counseling psychology have actually reported feelings of sadness and diminished expectations of potential clients with disabilities (Elliot, Byrne, Byrd, MacNair, & Werth, 1993), which may include their ability to have intimate relationships. Wright (1980, 1960) identified that rehabilitation professionals may view PWD from a framework focusing on inability. That is, emphasis is placed on what the person cannot do. Little to no attention is then put on the capabilities and potential for growth of the client with a disability. Wright (1960) also outlined that psychologists may define a client with a disability based on one characteristic. As one might imagine, this emphasis on the limitations of a person can lead to an overall limited positive experience in counseling (Wright, 1983).

Nathanson (1979) illustrated "seven syndromes" than can occur specifically in the counseling setting due to negative attitudes of the counselor. The counselors identified by Nathanson (1979) included vocational counselors, rehabilitation counselors, social workers and other counseling professionals, including psychologists. The first is the *All That Matters Is Your Label* syndrome. This results in the counselor using the disability related label as a means of defining the client's need rather than the individual defining their unique and specific need, which may or may not be related to their disability. The second syndrome is the *I Feel Sorry For You* syndrome, in which pity guides the

counselor's view of the client with a disability. The counselor may view the client's life as "filled with pain, suffering, difficulty, frustration, fear, and rejection". Nathanson (1979) goes on to suggest that even when a counselor is aware of these feelings of pity and tries not to express them, the feelings may still inadvertently be expressed through voice tone or facial expressions. Similarly, the third syndrome, the *Don't Worry, I'll Save You* syndrome results when the counselor views the client as in need of help. Thus, the counselor can easily slip into a paternal role with the need to overprotect and "make things easier" for the client. Nathanson (1979) suggests this need to protect the client comes from the counselor's discomfort with seeing the client struggle or feel any uneasiness in psychotherapy. Therefore, the counselor rescues the client to resolve his or her discomfort rather than the client's (Nathanson, 1979).

The fourth syndrome is the *I Know What's Best for You* syndrome. In essence, the power within the relationship rests more heavily with the counselor. Often the power is then used to discourage or react negatively to many of the client's aspirations out of limited expectations of the client's abilities. Possibly more disturbing is the *If I'm Lucky, You'll Miss Today's Appointment* syndrome. The counselor feels disgust or unpleasant in the presence of the client and desires to avoid the client. In therapy this may be expressed through the lack of empathy or impatience (Nathanson, 1979). With syndrome six, the *I'm Amazed by Your Courage* syndrome, the counselor over values the client's achievements. The counselor's negative attitudes result in believing the client's ability to achieve is limited. When the client does have an achievement the counselor may actually use derogatory statements such as "remarkable" or "all by yourself" or "overcome by so many obstacles" (Nathanson, 1979). The seventh and last syndrome outlined is the *Who's*

More Anxious, You or I? syndrome. This syndrome results in the counselor viewing the client as a "stimulus for anxiety" (Nathanson, 1979). These feelings of anxiety may be the result of feeling overwhelmed by the unique differences between counselor and client. The anxiety also may be evident through the counselor's tendency to speak loudly, quickly, or simply when unnecessary (Nathanson, 1979). Further, within a sample of graduate counseling students the increased feelings of anxiety when presented with a client with a disability in a counseling setting have been shown to be related to decreased empathy with the client.

Realistically, all negative feelings or attitudes regarding PWD may not be avoidable in the counseling setting. However, the goal should be to further identify what attitudes are prevalent among counselors. Also, the goal should include discovering how those attitudes may affect the mental health provider's ability to competently practice.

Counselor Attitudes and Factors that Affect Attitudes

One specific benefit to gaining additional insight regarding attitudes towards PWD is to aid in training and evaluation of mental health professionals, including counseling psychologists (Yuker, 1988). Many studies have looked at how attitudes may be influenced and variables that indicate natural differences in level of attitude towards PWD. One of the most notable factors found to correlate with more positive attitudes towards PWD is education level. As people progress through grade school and then on to higher education the tendency is that their attitudes towards PWD become more positive (Maclean & Gannon, 1997; Yuker, Block, & Younng, 1970; Yuker, 1994). However, studies involving people in higher education tend to indicate that once higher education is

reached, attitudes vary greatly based on training and profession of choice (Garske, 2002, Gething et al., 1994; Tervo et al., 2004; Yuker, 1992).

Those who hold negative or biased attitudes towards PWD can range from medical professionals to masters level counselors-in-training or even other PWD (Anderson, & Antonak, 1997; Beattie et al., 1997; Furnham & Thompson, 1994; Holaday & Wolfson, 1997; Mackelprang & Salsgiver, 1996; Olkin, 1999; McCarthy, 1988; Siperstein, Bak & O'Keefe, 1988). In a sample of nursing faculty, beginning nursing students, graduating nursing students, registered nurses, and PWD, Brillhart et al., (1990) found that faculty members and graduating nursing students had the lowest attitudes of all the other groups towards PWD. Further, PWD and beginning nursing students had the most positive attitudes towards PWD (Brillhart et al., 1990). Likewise, within a nursing home setting, administrative personnel were found to have more positive attitudes than the nurses who provided the services for PWD (Gething et al., 1994). More recently, Tervo et al., (2004) also found the nursing undergraduate students are at the greatest risk of having negative attitudes regarding PWD. Students enrolled in occupational and physical therapy, psychology, speech and language, and audiology tended to have the most positive attitudes regarding PWD (Tervo et al., 2004). These differences of attitudes based on occupation or profession may be more closely related to the training received in medical related settings that emphasize little interpersonal contact with PWD (Addison & Thorpe, 2004).

A sample of rehabilitation counselors was found to have generally positive attitudes towards PWD (Garske, 2002). Conversely, Yuker (1992) specifically found that PWD are often viewed negatively by persons in medical and rehabilitation occupations.

Graduate students in psychology tended to have more positive attitudes regarding PWD than graduate students in engineering and medicine (Durfee, 1971). Further, psychologists have usually been found to have more positive attitudes regarding PWD than psychiatrists (Yuker & Block, 1986).

Carney and Cobia (1994) explored the attitudes toward PWD among a sample of master's level graduate students majoring in community counseling, school counseling, and rehabilitation counseling. Specifically, the researchers examined the impact of age, sex, status in training, program, and years of counseling experience. The purpose of the study was to bring new light to conflicting views within the literature regarding the types of attitudes held by counselors toward PWD. Using the Attitudes Toward Disabled Persons-Form A scale, the researchers found that graduate students in counselor education programs do tend to have more positive attitudes towards PWD. Students enrolled in the rehabilitation counseling program held more positive attitudes than the other groups. However, the only significant differences found between groups were school counseling majors and community counseling majors. These findings ultimately support the conclusion that counselors tend to hold generally positive attitudes towards PWD (Elston & Snow, 1986; Garske, 2002; Huitt & Elston, 1991; Martin et al., 1982). However, as indicated above, converse conclusions have been established through other research studies.

Yuker (1994) cautions that the differences found between professional or occupational standing is likely the result of education and training as indicated above. Also, the differences based on occupation may reflect the use of different models of disability used in training programs. The notion that differing models of training may

influence attitudes makes sense (Smart & Smart, 2006). As indicated above, more negative or less positive attitudes are reflected more often in the medically based professions (Anderson, & Antonak, 1997; Beattie et al., 1997; Furnham & Thompson, 1994; Holaday & Wolfson, 1997; Mackelprang & Salsgiver, 1996; Olkin, 1999; McCarthy, 1988; Siperstein, Bak & O'Keefe, 1988). Medically based training programs are likely to follow the biomedical model of disability while those in counseling professions are likely to train more closely using the minority model of disability and including a multidimensional view of PWD (Smart & Smart, 2006).

Gender has also been found to correlate highly with more positive attitudes towards PWD. Hergenrather & Rhodes (2007) found that female undergraduate students had more positive attitudes than their male counterparts regarding PWD. More positive attitudes regarding PWD have been associated with the female gender across many studies (Antonak & Livneh, 1988, 2000; Chubon, 1982; Dunn, Umlauf, & Mermis, 1992; Mitchell, Hayes, Gordon, & Wallis, 1984; Paris, 1993; Yuker & Block, 1986). Cooper et al. (2003) found that female psychiatrists, psychologists, occupational therapists, and nurses rated significantly more positive attitudes regarding people who are deaf than their male counterparts. Likewise, Yuker et al.'s (1970) analysis of the literature dealing with attitudes towards PWD indicated that in many studies female attitude scores were significantly higher than the scores of males. However, in a more recent analysis of the literature he indicates that the difference in attitudes based on gender "seems to be diminishing" (Yuker, 1992). Yuker's (1992) statement is further supported by Carney and Cobia's (1994) finding of no significant difference between the attitudes of male and female graduate students in counselor education programs regarding PWD. Addison &

Thorpe (2004) also found no difference in attitude scores based on gender among a sample of postgraduate counseling students, undergraduate psychology students, and undergraduate law students.

Contact Theory and Counselor Attitudes

Addison and Thorpe (2004) found that differences of attitudes are likely the result of personal experiences or close contact with someone with a disability. Contact theory was initially being developed during the beginning of the civil rights movement in the 1950's and 1960's (Allport, 1954; Amir, 1969; Cook & Selltiz 1955; Makas, 1993). Specifically, Allport (1954) noted that "Whatever makes for...more intimate acquaintance is likely to make for increased tolerance...True acquaintance lessens prejudice" (pp. 489, 264). Allport also indicated that prejudice based on ethnicity, religious affiliation, socieoeconomic status, and gender is multifaceted. However, contact with people affiliated with different minorities will reduce prejudice and improve attitudes towards such groups. He outlined that contact is not intended to be all inclusive of any type of contact with another individual. Notably, the individuals must share equal status, be sanctioned or supported by the community, actively cooperative in meaningful activities, and deep or genuine with the perception of common interests.

As indicated above, Allport's (1954) initial theory of the improvement of tolerance through contact lacked specific mention of PWD. However, his lack of attention to PWD is likely a reflection of the time period when PWD were not at the forefront of social change. Since the initiation of his theory into social psychology many have begun to transfer the concepts to apply to attitudes regarding PWD (Makas, 1993). The amount of close contact with PWD has been found to be highly correlated with more

positive general attitudes regarding PWD (Yuker, 1988). A study predicted that close contact between a child with a disability and volunteer would positively alter the non-disabled volunteer's attitudes regarding PWD. The results indicated that the close contact between child and volunteer decreased social distancing and positively influenced attitudes, thoughts, and feelings regarding PWD (Fichten, Schipper, & Cutler, 2005).

Yuker and Hurley (1987) studied the correlation between contact and attitudes among a sample of nurses, graduate level psychology students, other graduate level students, university faculty, and health professionals attending conferences on substance abuse in PWD and other related health topics. They found a moderate correlation between the contact with PWD and attitudes towards PWD (Yuker & Hurley, 1987). As noted above, close contact is thought of as "equal-status" contact rather than physical proximity to a person with a disability or the amount of time spent with a person with a disability (Geskie & Salasek, 1988). Yuker (1992) indicates that close contact is generally thought of as being "characterized by cooperation, intimacy, and equal status" (p. 18). He also specifically noted that more positive attitudes are often related to contact within the context of friendships or other related close relationships (Yuker, 1992) Likewise, negative attitudes are often the result of relationships that focus on the disability or negative characteristics associated with the disability such as within treatment settings (Yuker, 1992; Geskie & Salasek, 1994). Other studies indicated that close contact was indicative of interpersonal contact such as with family, coworkers, friends, dating or sexual relationships with PWD (Strike, 2001; Strohmer, Grand & Purcell, 1984).

Similarly, Fichten et al. (1989) found that persons with no disability tended to be less comfortable with individuals who do have a disability. These conclusions were confirmed by a correlational study between negative attitudes and reported allowable intimacy between non-disabled participants and PWD. The results indicated that more positive attitudes were significantly correlated with higher reported allowable intimacy with PWD (Olkin & Howson, 1994). These findings support the notion that unequal status within the type of contact between two individuals is likely a variable that may affect attitudes (Fichten et al., 1989). Cooper et al. (2003) suggests that contact with PWD who are perceived to be of equal or higher status positively correlates with more positive attitudes. Cooper et al. (2003) goes on to suggest that more mental health professionals with disabilities who participate in counselor training would assist in the development of more positive attitudes amongst future mental health professionals. These findings support the notion of Allport's (1954) Contact Theory that contact with people in minority groups can reduce prejudice and improve attitudes towards such minority groups. Overall, the need to further study the influence of contact between doctoral level graduate students in counseling psychology is highly evident. Possible changes in the training, notably increased equal status contact, of future counseling psychologists to improve their attitudes and competence regarding working with PWD is imperative.

As one can see, many variables may influence the attitudes of a person regarding PWD. However, the most cited and consistent variables to be related to differences in attitudes are the amount of contact with PWD, level of education, and training or specific knowledge regarding PWD. Thankfully, these variables are also those that tend to be more easily influenced for the purposes of training future counseling psychologists.

Hence, the need to further study how perceived competence regarding PWD and attitudes regarding PWD are related is imperative to understanding possible changes that may be needed in counseling psychology training programs. Therefore, one purpose of this study is to identify such possible connections between attitudes and contact with PWD as a means of further suggesting possible training needs of doctoral level counseling psychology graduate students.

Within the current study, "disability" has been defined in broad terms but it is important to recognize that disability has many different forms. Each disability type has specific needs and difficulties related to that particular disability. Hence, special competencies may be required for the adequate counseling of client with different disabilities. Also, different disabilities have been found to illicit varying degrees of positive and negative attitudes within different population samples (Goodyear, 1983; Siller, 1976; Siller et al., 1967). These variances based on disability types are important to recognize and study for the purpose of improving counseling psychologists' competencies and attitudes. However, an individual analysis of competencies and attitudes regarding different disability types is beyond the scope of this study and will not be analyzed at this time.

Summary

This review of the relevant literature has offered a framework for understanding attitudes and competencies currently held regarding PWD. Further, this review has explored variables that may influence the attitudes and competence of mental health professionals regarding PWD. These variables can and do affect the therapeutic process. This notion is further reflected in the mandate set forth for counseling psychologists to be

adequately trained and prepared to address the unique counseling needs of different minority groups (Sue et al., 1992; Sue, 2001). Additionally, this review has also alluded to the apparent gaps found within the literature regarding the attitudes and perceived competence of counseling psychologists and counseling psychology graduate students towards 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 level of competence to work with clients with disabilities. Lastly, this study identified the association that the amount of contact with PWD has with the attitudes and perceived competence of counseling psychology graduate students regarding PWD.

CHAPTER III

METHOD

The intention of this study was to ascertain the perceived competence and attitudes of doctoral students in counseling psychology programs regarding people with disabilities (PWD). Also, the purpose was to discover any relationship between the type of contact experienced with PWD and the attitudes and perceived competence of counseling psychology graduate students regarding PWD. The following sections of this chapter detail the research questions which guided this study, participant characteristics, instruments used, procedures, and data analysis.

Research 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?

Participants

Age, Ethnicity, Gender

There were a total of 132 participants, including 109 females (82.6%) and 23 males (17.4%), who participated by returning the mailed questionnaires and identified themselves as currently being in a doctoral level counseling psychology program. The number of returned questionnaires resulted in a 13.2% return rate. The mean age of participants was 32 years ($\underline{M}$ = 31.5, $\underline{SD}$ = 7.32), the median age was 29, and modal age 26. The participants ranged from 24 to 67 years of age.

Of the participants, 10 identified as African American/Black ($\underline{n}$ = 7.6%), 1 identified as American Indian/Native American ($\underline{n}$ = .8%), 10 identified as Asian/Pacific Islander ($\underline{n}$ = 7.6%), 102 identified as Caucasian/White ($\underline{n}$ = 77.3%) , and 8 identified as Hispanic/Latino/Chicano ($\underline{n}$ = 6.1%). One participant identified as other ($\underline{n}$ = .8%) and specifically self-identified as bi-racial. (See Table 1).

The participants' years of counseling experience resulted in an average of 6 years ($\underline{M}$ = 6.09%, $\underline{SD}$ = 4.8) and ranged from zero to 25 years. The reported highest degree

completed by the participants included 113 with master's level degrees (85.6%), and 17 with bachelor's level degrees (13.1%). All participants reported they were currently in a doctoral level degree program: one hundred eighteen (89.4%) reported being in a Ph.D. program, 12 (9.1%) reported being in a PsyD program and 2 (1.5%) reported being a Ed.D. program. As per the requirement of the current study, all participants reported being in a counseling psychology program (See Table 1).

Table 1

Demographic Characteristics

Variable	n (N=132)	%	Mean (SD)
Gender			
Male	23	17.4	
Female	109	82.6	
Age	132		32(7.3)
Ethnicity			
African American, Black	10	7.6	
American Indian, Native American	1	.8	
Asian, Pacific Islander	10	7.6	
Caucasian/White	102	77.3	
Hispanic, Latino, Chicano	8	6.1	
Other	1	.8	
Years of Experience			6.09(4.79)
Highest Degree Completed			
BA, BS	17	12.8	
MA, MS	113	85.6	
Current Degree Program			
Ph.D Program	118	89.4	
PsyD Program	12	9.1	
Ed.D. Program	2	1.5	

Note. All participants indicated their highest degree completed so the total does not equal 100%.

The participants were also asked to indicate if they had worked with clients with disabilities based on six options of specific types of disability categories indicated on the demographic sheet. Ninety-eight percent (97.7%) of the participants indicated they had worked with at least one or more persons with a disability. Two percent (2.3%) of the participants reported they had never worked with a person with a disability.

Of those who reported working with at least one person with a disability, they indicated having worked with the people with the following types of disabilities: blind or low vision; chemical or alcohol dependency history; deaf or hard of hearing; learning disability, ADD, or ADHD; mental health or psychiatric; mobility or orthopedic; and other disabilities. Examples of other disabilities that participants wrote on the survey included acquired brain injury, developmental disorders, dementia, spinal cord injury, etc. See Table 2 for a more detailed analysis of the different types of disabilities the participants indicated on the demographic sheet.

Table 2

Client Disabilities

Type of Disability	n	%
Blind, low vision	51	38.6
Chemical/alcohol dependency history	111	84.1
Deaf, hard of hearing	57	43.2
Learning disability, ADD, ADHD	120	90.9
Mental health, psychiatric	124	93.9
Mobility, orthopedic	78	59.1
Other	15	11.4
None	3	2.3

Seventy-three percent (n = 96, 72.7%) of the participants reported at least some personal or interpersonal experience with disability which for the purpose of this study will be termed *Close Contact Group*. Twenty-seven percent (n = 36, 27.3%) of participants indicated they had limited experience with disability which included no experience, academic experience, seminars, or workshops. These participants with limited experience will be termed *Limited Contact Group* for the purposes of this study. See Table 3 for a complete breakdown of the specific types of experience reported by the participants and group assignment. Four percent (n = 5, 2.8%) of the participants wrote in other types of contact with disabilities. These participants were assigned to the *Close Contact Group* if they indicated some personal or interpersonal experience with disability. Likewise, those who wrote responses that indicated no personal or interpersonal experience with disability would have been assigned to the *Limited Contact*

Group but no such responses were written. Examples of those responses written that were indicative of personal or interpersonal contact included "Several colleagues of mine have disabilities". Another participant wrote "I had a supervisor who was paralyzed from the waist down". Also, another participant wrote "I was a teacher's assistant for a professor who was visually impaired".

Table 3

Experience with Disability

Type of Experience	n (N=132)	%
Close Contact Group	96	72.7
I have a disability	10	7.6
I have a medical condition (not a disability)	27	20.5
A member of my immediate family or close friend has a disability	47	35.6
A member of my extended family, co-worker, or acquaintance has a disability	73	55.3
Recent work experience involving disability (within the past 5 years)	89	67.4
Past work experience involving disability (5 or more years ago)	42	31.8
Limited Contact Group	36	27.3
I do not have a disability or medical condition	72	54.5
Disability was the focus of all or most of my academic training	7	5.3
Disability was addressed in classes, seminars, or workshops I attended	78	59.1
Other experience	5	3.8
None	1	.8

Note. Participants were directed to circle all that apply so totals do not equal 100%.

Instrumentation

Competence Survey

Strike (2001) developed the *Counseling Clients with Disabilities Survey* (CCDS) to measure mental health professionals' competence with clients with disabilities. The CCDS is a 60 item survey with an additional seven demographic questions plus a space for additional comments. The first 60 items make up three subscales that include the *Self-Awareness* scale, the *Perceived Knowledge* scale, and the *Perceived Skills* scale. Each scale is equally divided into 20 questions per scale. The items are made up of statements which the respondents express their agreement or disagreement on a six-point scale (1 = Strongly Disagree, 2 = Disagree, 3 = Slightly Disagree, 4 = Slightly Agree, 5 = Agree, 6 = Strongly Agree). Each scale has a possible score between 20 and 120. The higher scores on each scale are indicative of greater perceived competence by the respondent.

The Self-Awareness scale is designed to measure respondents' perception of the effect of being disabled. The scale includes questions that tap the individuals' "self-awareness, beliefs, and attitudes toward disability" (Strike et al., 2004). The Perceived Knowledge scale taps factual knowledge regarding disability issues. The Perceived Knowledge scale gives an indication of prior exposure and training regarding disability. Lastly, the Perceived Skills scale taps the individuals' skills and behaviors that are believed to be beneficial to mental health providers who work with PWD.

This instrument also includes several items pertaining to demographic variables. One of the seven demographic questions assesses the type of contact with PWD. This item was used to address research question number four. The remaining six demographic questions address sex, ethnicity, highest degree completed, years of counseling

experience, experience working with different types of disabilities, and the degree to which the participant is currently pursuing. Two additional demographic questions addressing age of the participant and the area of specialty within the current degree being sought were added to the list of demographic questions for a total of nine demographic questions. The area of specialty question was used to confirm that the participant is pursuing a degree in counseling psychology. The CCDS is a copyrighted survey, held by Diane Strike, Ph.D. (Strike, 2001). It is only through her explicit verbal permission that the additional demographic questions were added. Further, she concluded the additional demographic questions do not significantly compromise the reliability or validity of the CCDS (Strike, personal communication, March 20, 2007).

Due to the relatively recent development of the CCDS, little data regarding reliability and validity of the instrument has been obtained. However, Strike's (2001) initial study did establish positive findings with regard to the CCDS's utility as a true measure of counselor competence to work with PWD. Internal consistency of the total scale was established with a Cronbach's α of .94. The reliability of the separate scales also achieved satisfactory internal consistencies. The Self-Awareness scale was found to have a Cronbach's α of .67, the Perceived Knowledge scale had a Cronbach's α of .87, and the Perceived Skills scale had a Cronbach's α of .90 (Strike, 2001).

Construct validity of the CCDS was formulated through an extensive review by professionals who specialize in areas such as test construction and methodology, multicultural counseling competence, and disability issues. Reviewers were asked to review the survey items and determine if each adequately reflected the individual

construct to be measured. Strike (2001) indicates that the review process successfully established that the CCDS is a valid measure of the above stated constructs.

Attitudes Survey

The *Attitudes Toward Disabled Persons* (ATDP-A) Scale Form A measures attitudes toward PWD (Yuker & Block, 1986; Yuker, Block & Campbell, 1960; Yuker, Block & Younng, 1966, 1970). The ATDP-A is composed of 30 statements that express beliefs about PWD (e.g. "Disabled people are often unfriendly"; "Most disabled people feel that they are as good as other people."). Respondents express agreement or disagreement with each statement by using a six point Likert-type scale (+1 = I agree very much, +2 = I agree pretty much, +3 = I agree a little, -1 = I disagree a little, -2 = I disagree pretty much, -3 = I disagree very much). The total score ranges from 0 to 180, with higher scores indicating more positive attitudes regarding PWD. Yuker and Block (1986) report the test-retest reliabilities for the ATDP-A range from .74-.91 and the split half reliabilities range from .73-.89. Carney and Cobia's (1994) study confirmed the acceptable reliability of the ATDP-A with counselors-in-training (Cronbach's $\alpha = .81$). Further, the validity of the ATDP-A as a measure of attitudes towards PWD has been established through moderate correlations with over 50 other measures of attitudes towards PWD. Median correlations of the ATDP-A with other measures of attitudes towards PWD ranged from .19-.98 (Yuker & Block 1986).

Procedure

One thousand mailing labels containing the names and postal addresses of current American Psychological Association (APA) student affiliates who self-identified as being in a doctoral level graduate program and majoring in counseling psychology were

obtained through the permission and assistance of the APA Research Office. Each student affiliate meeting the qualifications indicated above was mailed an information letter (see Appendix) describing the study, a copy of the CCDS, a copy of the ATDP-A, and a self-addressed stamped envelope. This study proceeded only after being approved by the Auburn University Institutional Review Board for the Use of Human Subjects in Research. The Auburn University Institutional Review Board for the Use of Human Subjects in Research was to ensure the proper protection of the identity of potential participants.

The information letter included contact information for the primary researcher and detailed instructions for completing and returning the surveys through the use of the self-addressed stamped envelope. Also, the information letter included a detailed description of the purpose of this study. Implied consent to participate in this study was obtained by the completion and return of the surveys to the primary researcher. Each returned envelope had a unique code number affixed to it for the purpose of identifying those participants who did not return the survey materials. Coding was only used to match participants in the mailing and was not at any time linked to the returned instruments (except to be removed from the second mailing list). After the second mailing, all lists and coding was to be destroyed.

The follow-up mailing was intended to be conducted two weeks (14 days) following the initial mailing. All participants who had not returned the surveys was to be sent a second mailing of the detailed information above. The purpose of the second mailing was to maximize the overall return rate of surveys. The second mailing was not

conducted because after 14 days following the initial mailing a sufficient number of surveys had been received for adequate statistical analysis of this study.

Data Analysis

Research Question 1

What is the perceived level of competence (e.g., self-awareness, perceived knowledge, and perceived skills) among counseling psychology graduate students regarding counseling people with disabilities?

A repeated measures analysis of variance (ANOVA) was used to compare across the three sub-scales (i.e. Self-Awareness, Perceived Knowledge, Perceived Skill) measured by the CCDS. Also, a descriptive analysis was performed to determine the mean score for the CCDS total scale which was used to in the analysis of Research Question 3.

Research Question 2

What are the attitudes of counseling psychology graduate students regarding PWD?

The ATDP-A results in a single score of attitude toward PWD, so this question was addressed through a descriptive analysis to determine the total scale mean.

Research Questions 3 and 4

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?

Do counseling psychology graduate students with different levels of prior exposure/contact to people with disabilities report different attitudes toward persons with disabilities?

Questions 3 and 4 demanded that different levels of contact be defined. Levels of contact were obtained by placing participants in one of two groups based on responses to one of the demographic questions on the CCDS. Group 1 is referred to as the Close Contact Group and Group 2 is referred to as the Limited Contact Group. Responses required for placement in the Close Contact Group indicated personal or interpersonal contact with PWD. Specifically, participants must have identified as having personal experience with a disability or medical condition or interpersonal contact with family, friends, acquaintances, or co-workers with disabilities. If participants did not meet these requirements they were placed in the Limited Contact Group.

Once group membership is established, a multivariate analysis of variance (MANOVA) was completed to determine whether the independent variable, group membership, was related to the overall reported competence and attitudes of counseling psychology graduate students.

Research Question 5

What is the relationship between perceived level of competence regarding counseling PWD and attitudes toward PWD?

A correlational analysis was completed to determine the relationship between the reported level of competence regarding counseling PWD and attitudes towards PWD.

CHAPTER IV

RESULTS

The purpose of this study was to discover the perceived competence and attitudes of doctoral students in counseling psychology programs regarding people with disabilities (PWD). Also, the purpose was to identify any relationship between the type of contact with PWD and the attitudes and perceived competence of counseling psychology graduate students regarding PWD. The following sections of this chapter are descriptive information regarding the research questions and results of this study.

Research Question 1

What is the perceived level of competence (e.g. self-awareness, perceived knowledge, and perceived skills) among counseling psychology graduate students regarding counseling people with disabilities?

Overall perceived competence was measured through the use of the *Counseling Clients with Disabilities Survey* (CCDS) which includes three separate scales of specific counseling competencies (*Self-Awareness, Perceived Knowledge,* and *Perceived Skills*). The overall mean competence score for this sample was 235.45. A one-sample *t*-test was performed to compare the overall mean with that of Strike's (2001) original sample. The mean CCDS score was significantly [$t(130) = -2.75$, $p = .007$] lower than that of Strike's (2001) sample.

A repeated measures analysis of variance (ANOVA) was conducted to compare across the three competence scales (i.e. self-awareness, perceived knowledge, and perceived skills). Mauchly's Test of Spericity was violated ($p < .001$) so the null hypothesis was rejected. The Lower-bound results of the within-subjects effects indicated that there was a significant difference [$F(1,130) = 281.66, p < .001$] in reported level of perceived competence between all three competence scales. The difference between the three scales of perceived competence resulted in a moderate effect ($\eta^2 = .68$). Likewise, Wilks' Lambda of the multivariate test resulted in a significant statistic [$F(2, 129) = 211.42, p < .001$] with a moderate effect ($\eta^2 = .77$). Post-hoc analysis using Bonferroni comparisons revealed that all three means were significantly different from each other ($p < .001$). The mean of the *Self-Awareness* scale ($M = 88.86$) was significantly higher than the means of the *Perceived Knowledge* scale ($M = 78.53$) and the *Perceived Skills* scale ($M = 68.05$). Also, the mean of the *Perceived Knowledge* scale was significantly higher than the mean of the *Perceived Skills* scale. These results indicate that the participants rated their overall level of knowledge and skills regarding people with disabilities significantly lower than their self-awareness regarding people with disabilities. See Table 4 and 5 for additional information.

Table 4

N, Mean, and Standard Deviations for the CCDS scales

CCDS Scale	n	Mean	SD
Self-Awareness	131	88.86	8.08
Perceived Knowledge	131	78.53	11.71
Perceived Skills	131	68.05	13.96
Total CCDS scale	131	235.45	29.82

Note: CCDS = Counseling Clients with Disabilities Survey

Table 5

Pairwise Comparisons of the CCDS Scales

CCDS Scale	Mean Difference	Std. Error	Sig.
Self-Awareness--Perceived Knowledge	10.33	.85	.000
Self-Awareness--Perceived Skills	20.81	1.02	.000
Perceived Skills--Perceived Knowledge	10.48	.75	.000

As a follow-up analysis, the three CCDS scales were compared with the means reported by Strike (2001) in her initial study with the CCDS through the use of three separate one sample *t*-tests. The Self-Awareness scale was not significantly different between the current study and Strike's (2001) study. However, the scores on both the *Perceived Knowledge* scale and the *Perceived Skills* scale were significantly lower than the means from Strike's (2001) original study. These results should be interpreted with caution as Strike (2001) warned that her results should not be used as normative data. However, the results tend to indicate that the counseling psychology doctoral student

sample from the current study perceived they have less knowledge and skills regarding working with PWD than the sample included in Strike's (2001) study. See Table 6 for a list of the scores.

Table 6

One Sample T-tests Between Strike's (2001) Study and the Current Study CCDS scores

CCDS Scale	n	Mean	SD	t	Sig.
Self-Awareness	131	88.86	8.08	.33	.74
Strike (2001)	108	88.63	8.20		
Perceived Knowledge	131	78.53	11.71	-1.98	.05
Strike (2001)	108	80.56	13.14		
Perceived Skills	131	68.05	13.96	-4.39	.000
Strike (2001)	108	73.41	16.49		
Total CCDS score	131	235.45	29.82	-2.75	.007
Strike (2001)	108	242.60			

Research Question 2

What are the attitudes of counseling psychology graduate students regarding PWD?

Initial analysis of the ATDP-A results indicated the measure is reliable (Cronbach's $\alpha = .71$). The descriptive analysis of the total score of the ATDP-A resulted in a mean of 140.96 with a standard deviation of 13.10 and scores ranged from 112 to 172. The sample mean was found to be higher than the overall normative mean 110.76 found by Yuker et al. (1970). A one-sample *t*-test indicated that the participants' reported attitudes scores were significantly higher than the normative group [$t(129) = 26.29$, $p <$

.001]. These findings indicated that the current sample reported more positive attitudes regarding PWD than the normative sample used by Yuker et al. (1970).

Several supplemental analyses were conducted to determine other potential variables that may be of interest. As a follow-up analysis, an independent *t*-test was performed to identify any differences between ATDP-A scores of men (N = 23, M = 140.57, SD = 14.83) versus women (N = 107, M = 141.05, SD = 12.77) in the current study. The *t*-test results indicated there were no significant difference between the attitudes of men and women regarding PWD [$t(128) = 1.159$, $p = .874$].

Likewise, a two-tailed pearson correlation was conducted to compare the trend of age and attitudes (ATDP-A scores) towards PWD. The results indicated there was no significant trend between age and attitude scores. See Tables 7 and 8 for more detailed information.

Table 7

N, Mean, and Standard Deviations of Age and ATDP-A Scores

Measure	N	Mean	SD
Age	131	31.50	7.32
ATDP-A	130	140.96	13.10

Note. ATDP-A = Attitudes Towards Disabled Persons – A.

Table 8

N and Pearson Correlation of Age and ATDP-A Scores

Measure	ATDP-A *r*
Age	.034
Sig. (2-tailed)	.70
N	129
SS	418.21
Covariance	3.27

Notes: ATDP-A = Attitudes Towards Disabled Persons Scale – A.

Carney and Cobia (1994) used the ATDP-A to study the attitudes regarding PWD of graduate students in community counseling, school counseling and rehabilitation counseling programs. A one-sample *t*-test was conducted to compare the current sample with Carney and Cobia's (1994) sample. A significant difference was found between the two samples [$t(129) = 7.82, p < .001$]. This finding indicated the sample of counseling psychology graduate students held significantly more positive attitudes than Carney and Cobia's (1994) sample.

Research Question 3 and 4

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?

Do counseling psychology graduate students with different levels of prior exposure/contact to people with disabilities report different attitudes toward persons with disabilities?

A multivariate analysis (MANOVA) was completed to determine whether the independent variable, group membership, is related to the overall reported competence and attitudes of counseling psychology graduate students. Due to the analysis containing two dependent variables, the MANOVA was chosen over repeated univariate procedures as a means of limiting the possibility of Type 1 errors.

Box's test of the equality of covariance matrices indicated that the homogeneity of variances was met ($\alpha = .33$). Likewise, Levene's Test of Equality of Error Variances indicated that the homogeneity of variances assumption was met for the total scale scores for the CCDS ($\alpha = .93$) and the ATDP-A ($\alpha = .79$). Wilks' Lambda showed that there was no significant effect based on the level of contact ($\alpha = .512$) when the CCDS and ATDP-A scores were combined. However, the tests of between-subjects effects indicated that the CCDS total scale score was significantly higher in the *Close Contact* group as compared to the *Limited Contact* group. This indicated that personal and/or interpersonal contact with PWD may be related to a higher overall level of perceived competence regarding PWD. However, it should be noted that the CCDS total scale significance level was borderline ($\alpha = .045$) between significant and non-significant. Also, observed power

(power = .52) of the effect between contact and the CCDS score was below the minimum level generally used to determine adequate power (Cohen, 1988). Hence, the results must be interpreted with caution as they are likely adversely affected by sampling issues. Unexpectedly, there was no significant difference between groups with regards to their ATDP-A scores indicating that level of contact with PWD did not affect counseling psychology doctoral students' attitudes regarding PWD. See Table 8 for a more detailed breakdown of scores.

Table 8

N, Mean, Standard Deviations, and MANOVA for the CCDS and the ATDP-A Scores

Scale	n (N = 129)	Mean	SD	F	Sig.
CCDS total scale		234.91	29.74	4.08	.045
Close Contact	94	238.10	28.17		
Limited Contact	35	226.35	32.48		
ATDP-A total scale		141.07	13.09	2.24	.137
Close Contact	94	142.12	13.04		
Limited Contact	35	138.36	13.00		

Note. Computed using alpha = .05.

Research Question 5

What is the relationship between perceived level of competence regarding counseling PWD and attitudes toward PWD?

A bivariate correlation analysis of the relationship between reported perceived level of competence and attitudes regarding PWD was conducted. The results indicated there is a weak but significant positive correlation ($r = .296$, N = 129, $p = .001$) between

the participants' reported attitudes and perceived competence regarding PWD. This indicates that as counseling psychology graduate students' attitudes become more positive, their perceived level of competence also increases. Of course causation cannot be established through this analysis but the results do give a significant indication that the two variables (attitudes and perceived competence) are related.

CHAPTER V

DISCUSSION

As indicated above, previous studies have shown that people in different helping fields and training programs (nurses, masters level counselors in training, masters level counselors, clinical/counseling psychologists, rehabilitation specialists, etc.) hold varying attitudes and levels of perceived competence regarding people with disabilities (PWD; Anderson, & Antonak, 1997; Beattie et al., 1997; Carney & Cobia, 1994; Elston & Snow, 1986; Furnham & Thompson, 1994; Garske, 2002; Geskie & Salasek, 1994; Holaday & Wolfson, 1997; Huitt & Elston, 1991; Mackelprang & Salsgiver, 1996; Martin et al., 1982; McCarthy, 1988; Olkin, 1999; Siperstein, Bak & O'Keefe, 1988; Strike, 2001; Yuker, 1992; Yuker & Hurley, 1987). However, until the current study, no studies have specifically studied the attitudes or competence of counseling psychology doctoral students 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, the aim of this study was to determine if the amount of prior contact with PWD is related to the attitudes and perceived competence of doctoral level counseling psychology students regarding working with PWD

Research Question 1

What is the perceived level of competence (e.g., self-awareness, perceived knowledge, and perceived skills) among counseling psychology graduate students regarding counseling people with disabilities?

The overall perceived competence score was significantly lower than that of Strike's (2001) sample. However, Strike's (2001) original research with the CCDS was completed with a sample of psychiatrists, psychologists, social workers, career counselors, disability specialists, and other mental health professionals, whereas the current results were found among a sample exclusively consisting of doctoral level counseling psychology graduate students. The results suggest that counseling psychology graduate students perceived their level of competence regarding PWD as lower than that of peers and professionals in similar mental health fields.

The scores of the individual competency scales (i.e. *Self-Awareness, Perceived Knowledge,* and *Perceived Skills*) were also compared to Strike's (2001) sample. Of the three scales only *Perceived Knowledge* and *Perceived Skills* were significantly lower than those reported by the participants in Strike's (2001) sample. This comparison should be interpreted with caution because unlike the participants in the current study, Strike's (2001) sample obviously included persons who work in disability specific settings and have completed their graduate training. However, the majority (61%) of her participants were enrolled in some graduate training when they completed the CCDS (Strike, 2001).

Also of note is that the three competency scales of the CCDS were significantly different from each other and ranged from highest to lowest in the following order: *Self-Awareness*, *Perceived Knowledge*, and *Perceived Skills*. This finding is consistent with

Strike's (2001). However, as noted above, her original research was completed with a sample of psychiatrists, psychologists, social workers, career counselors, disability specialists, and other mental health professionals.

Strike (2001) identified that the *Self-Awareness* scale was derived from the Multicultural Counseling Competencies and Standards and the minority model that have been established as icons of diversity development needs within the field of psychology (Arredondo et al., 1996; Hahn, 1985; Sue, et al., 1992). Specifically, Strike (2001) indicated that *Self-Awareness* is a measure of the introspective understanding of one's own beliefs and cultural biases regarding PWD. The results from the current study indicate that counseling psychology graduate students perceive their level of self-awareness or understanding of their biases and beliefs regarding PWD as their greatest asset with regards to competence.

The *Perceived Knowledge* scale was also significantly lower than the *Self-Awareness* scale but higher than the *Perceived Skills* scale. The *Perceived Knowledge* regarding PWD was designed to convey the participants' "prior exposure or training about disability and encompass factual knowledge about disability and disability-related issues" (Strike, 2001, p. 98). This finding is not unexpected as it is consistent with Strike's (2001) finding.

Likewise, these findings are similar to those of studies with consumer advocates, rehabilitation administrators, rehabilitation counselors, consumers, clinical psychologists, neuropsychologists, and rehabilitation psychologists, which indicated that the knowledge of mental health professionals regarding PWD was a barrier to the provision of adequate

mental health services for PWD (Hunt, et al., 2006; Leigh et al., 2004; Pelletier et al., 1985).

Improving perceived competence regarding disability and disability related issues may need to be facilitated through enhanced training practices both in the classroom and through experiential activities as a means to increase perceived knowledge. Thankfully, studies have shown that from 1989 to 1995, counseling psychology doctoral programs requiring at least one course in multiculturalism has greatly increased from 59% to 89%. However, this does not indicate that those courses in multiculturalism include any material regarding PWD (Hills & Strozier, 1992; Ponterotto, 1997). As indicated in earlier chapters, adequate competence regarding specific issues of diverse populations, which include PWD, is both ethically and legally mandated for counseling psychologists (ADA, 1990; APA, 2002). Hence, improved training in these areas may need to be advanced in counseling psychology doctoral programs. Such improvement may include further emphasis on the importance of diversity among all clients including PWD.

Much like Strike's (2001) study with the CCDS, *Perceived Skills* of counseling psychology doctoral students was found to be the lowest rated competence. Unfortunately, the counseling psychology doctoral students in the current sample apparently perceived their skills for working with PWD as significantly lower than those participants in Strike's (2001) study. The *Perceived Skills* scale measures use of appropriate language in clinical and research practices as well as conceptualization abilities and characteristics of an ideal counselor (Strike, 2001). Regrettably, these findings have been further validated by another study that found clinical and counseling psychology graduate students frequently had errors in their conceptualization of potential

clients with disabilities (Kemp & Mallinckrodt, 1996). These findings are most unsettling as counseling psychologists will be in the position to work with PWD (Olkin, 2002; U.S. Census Bureau, June 21, 2006; U.S. Department of Education, 2001). Advanced skills for working with PWD may constitute the greatest need that counseling psychology doctoral training programs should address at the present time.

This study has shown that the perceived competence of counseling psychology doctoral students regarding PWD and disability related issues may need to be specifically addressed in the areas of counselor knowledge and skills. As noted in prior chapters, previous studies have found similar findings that both mental health providers in varying specialties and consumers with disabilities perceive the competence of mental health providers regarding PWD and disability related issues to be lacking in the areas of knowledge and skills (Hunt, et al., 2006; Leigh et al., 2004; Pelletier et al., 1985; Strike, 2001). Hence, the need to incorporate advanced training of counseling psychology graduate students regarding PWD is evident. Specific, areas of possible emphasis in training programs to improve perceived competence may include increased number of therapy cases with PWD and disability specific curriculum (Allison et al., 1996; Arredondo & Perez, 2003; Strike, 2001)

Research Question 2

What are the attitudes of counseling psychology graduate students regarding PWD?

The attitudes of counseling psychology graduate students regarding PWD were found to be significantly more positive than those of Yuker et al.'s (1970) normative sample. However, within the current sample, no significant difference was found between

the attitudes of women versus men. Further, no trend was found indicating more positive attitudes as a function of aging. This indicates that counseling psychology graduate students tend to hold more positive attitudes regarding PWD than the general population. This finding is expected and consistent with studies conducted with students enrolled in psychology, community counseling, school counseling and rehabilitation counseling programs (Carney & Cobia, 1994; Durfee, 1971; Tervo et al., 2004). Likewise, the finding that men and women hold similar attitudes is expected and consistent with Carney and Cobia's (1994) findings as well as Yuker's (1992) notion that gender is diminishing as a variable related to more positive attitudes regarding PWD.

Questions 3 and 4

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?

Do counseling psychology graduate students with different levels of prior exposure/contact to people with disabilities report different attitudes toward persons with disabilities?

The overall competence score of those participants in the close contact group was significantly higher than those in the limited contact group. However, this should be interpreted with caution because the significance level was marginal and the power level was less than adequate. This lack of power suggests that the design may not have been strong enough to detect significant differences. Hence, a larger sample of counseling psychology graduate students may have resulted in more significant findings.

The finding was expected since Strike's (2001) study found a significant difference on competence scores based on experience with PWD. Historically, multicultural competence research has implicated that cross-cultural contact is important to the development of multicultural counseling competence (Díaz-Lázaro & Carlos, 2001; Heppner & O'Brien, 1994; Merta, Stringham, & Ponterotto, 1988; Mio, 1989; Neville, Heppner, Louie, & Thompson, 1996). However, these studies did not seek to isolate the effect of close contact on competence regarding disabilities and disability related issues. The most obvious implication of this finding is that close contact is a significant predictor of greater perceived competence regarding PWD among counseling psychology graduate students. However, potentially a reason for the limited amount of significance suggests that counseling psychology graduate students who have had close contact with PWD may then have a greater understanding of the limits of their knowledge and skills. Based on the prior literature as noted above, a stronger effect was expected. One can speculate that a more sophisticated measure of close and limited contact with PWD may have resulted in a stronger effect. Likewise, more significant findings may have been produced with a larger sample of counseling psychology graduate students.

Unlike the connection of contact and perceived competence, attitudes and contact were not found to be significantly related. Specifically, attitudes towards PWD were no different among those participants who reported close contact with PWD as compared to those who reported limited contact with PWD. These results are most unexpected and the most puzzling of all findings from the current study.

A long history of research facilitated by contact theory has strongly supported the notion that close, equal-status contact with different culture groups is related to more

positive attitudes regarding those different culture groups (Allport, 1954; Amir, 1969; Cook & Selltiz, 1955; Makas, 1993).

One possible conclusion could be that the sample consisted of individuals who collectively had more positive attitudes regarding PWD. As noted in Question 2 above, this sample did have more positive attitudes than those of Carney and Cobia's (1994) sample and Yuker et al.'s (1970) normative sample. Hence, regardless of the type of contact with PWD, attitudes were positive. Further, some have speculated that the attitudes of counselors-in-training are generally solidified before they begin training. If so, then attitudes may be more related to persons selecting counseling psychology as a program of study rather than their amount of contact with PWD. These unexpected findings strengthen the notion that more complex and thorough studies of the effect contact may have on the attitudes of counseling psychology graduate students should be pursued. Also, other training advances to improve the attitudes of counseling psychology graduate students should be explored. It is comforting to know that counseling psychology graduate students tend to have much needed positive attitudes regarding PWD.

Research Question 5

What is the relationship between perceived level of competence regarding counseling PWD and attitudes toward PWD?

Perceived competence and attitudes regarding PWD resulted in a significant and positive relationship. However, the relationship was weak. A greater correlation coefficient may have resulted from a larger sample size. Nonetheless, a significant positive correlation was established. The positive correlation indicates that as attitudes

towards PWD become more positive, so does the self-perception of competence regarding PWD and disability related issues. One should take caution in not interpreting this finding as being causal.

Attitudes have often been considered a function of self-awareness and multicultural competence (Arredondo et al., 1996; Sue & Sue, 1999; Sue, 2001; Sue et al., 1992). However, to date, this researcher has been unable to discover any studies that directly linked the relationship between attitudes regarding PWD and competence regarding PWD. Hence, the findings at the very least implicate the need for further exploration of the specific relationship of attitudes towards PWD and the perceived competence regarding PWD.

Limitations

The current study does possess contain some unique limitations. The most obvious limitation is that even with a large and quickly growing establishment of multicultural counseling competence literature, very little has analyzed perceived competence regarding PWD and disability related issues. With this limitation, very little could be inferred about the perceived competence of counseling psychology graduate students regarding PWD. Hence, a larger, more intricate body of literature from which to draw conclusions from may have resulted in a better understanding of these results. Therefore, without cross validation, it is unclear if these results adequately reflect the attitudes and perceived competence of counseling psychology graduate students regarding PWD.

Likely limitations also existed in the collection of data from counseling psychology graduate students. One obvious limitation is that the current results are likely

biased in favor of persons who are willing to take the time to respond to questionnaires on disability related issues. Also, of the 1000 surveys mailed, only 132 (13.2%) were returned that met the qualification to be included in the current study. Response rate limitations may have resulted due to collecting data via traditional mailing without some monetary incentive. Internet or email based sampling procedures may have improved the response rate (Mehta & Sivadas, 1995).

Also, the current sample was limited to only those counseling psychology graduate students who are student affiliates of the American Psychological Association (APA). This may have resulted in a more homogeneous sample that does not represent the greater population of counseling psychology graduate students. Graduate students who make the initiative to join the APA may also be those who make the initiative to be more informed regarding diversity related issues.

Likewise, several demographic variables may be indicative of limitations in the study. Female participants made up an overwhelming majority (82.6%) of the sample. Also, 77% of the sample identified as Caucasian/White. As of recently female associates of APA account for 62.7% of the total number of associates and Caucasian/White associates only account for 53.3% of the total number of associates (Center for Psychology Workforce Analysis and Research, 2006). Lastly, the Limited Contact group only consisted of 27.3% of the sample. This group was adequate for statistical analysis in this study but a larger sample may have resulted in a stronger finding. A sample that was more representative of the membership of APA would have been preferable.

Another limitation may be found in the definition of disability used in this study. As indicated previously the term disability was defined through the use of the ADA's

definition of disability (ADA, 1990; U.S. Department of Justice, 2005). Specifically, this definition includes persons with both physical and psychiatric disabilities. As detailed earlier, different types of disabilities and causes of disabilities are often not thought of as being equally significant or deserving (Livneh, 1988). Hence, the findings of the current study may have been influenced by the use of a more specific definition of disability. For example, different findings may have results if a definition only included physical disabilities or just psychiatric disabilities. Likewise, different findings may have resulted if disability were defined in terms of visible versus not visible disabilities.

The use of a competence measure with no normative data was also a limitation of the current study (Strike, 2001). A more established measure of perceived competence regarding PWD would improve the ability to make thorough interpretations of data. This limitation was unavoidable as no other measure has been developed to study perceived competence regarding PWD and disability related issues (Strike, 2001).

Similarly, the use of an attitude measure that has not been normed in approximately 37 years created a challenge to comparing the current sample to Yuker's (1970) original sample. In the past several decades much has been done in the areas of multicultural awareness, diversity, and the push for equal rights of PWD (ADA, 1990). The cultural shift may mean that attitudes towards PWD may be more positive among the general population than indicated by Yuker's (1970) sample. Hence, a less significant difference may be found among counseling psychology graduate students and the general population with regards to attitudes toward PWD.

Also, the type of contact with PWD may have been inadequately measured through the use of the demographic items included in the CCDS. The demographic items

were used in Strike's (2001) study to determine the level of contact with PWD. However, a more sophisticated measure of contact that has been more greatly established within the professional literature may have resulted in different findings.

Recommendations for Training Programs

A purpose for studying the perceived competence and attitudes regarding PWD was to be able to offer any guidance or insight regarding the training needs of counseling psychology doctoral students regarding PWD. The results indicated that counseling psychology graduate students generally tend to have positive attitudes regarding PWD. However, based on the results discussed above, several recommendations can be made for counseling psychology training programs in the area of developing students' perceived competence regarding PWD.

This study found that counseling psychology graduate students perceive themselves as having significantly lower competence in the areas of knowledge and skills when compared to a sample of psychiatrists, psychologists, social workers, career counselors, disability specialists, and other mental health professionals (Strike, 2001). Likewise, the current study found that perceived knowledge and skills were the lowest scales of competence regarding PWD. These findings strongly support the need for altered training practices regarding disability issues in counseling psychology doctoral programs. Specifically, these findings support the suggestions made by previous authors that counseling psychology doctoral programs should increase the curricular content on disability related issues as a means of improving students' factual knowledge base regarding PWD (Olkin, 2002; Olkin & Pledger, 2003). This material also should be infused throughout the graduate training experience and not limited to a minor section of

a course on multicultural issues (Ponterotto, 1998). However, studies have shown that even those programs that do have at least one multicultural issues course usually include very little if any content on disability issues (Kemp & Mallinckrodt, 1996). Hence, any material covered on disability related issues and/or the importance of recognizing diversity among all people would be an improvement.

It is understandable that additional content in an already bulging curriculum may not be feasible. Therefore, enhanced experiential training activities in addition to increased content regarding disability issues may serve to increase students' perceived skills to work with PWD. Such enhanced activities may include experiences both in the classroom and in clinical training that emphasize the importance of recognizing the diversity issues that are individually specific to each client.

A specific skill echoed throughout the literature as necessary to being a competent psychologist is the ability to accurately develop a clinical conceptualization of the client who has a disability (Kemp & Mallinckrodt, 1996; Olkin, 1999). One example offered to counseling psychology training programs is to incorporate more opportunities in the classroom for students to actively practice conceptualization skills using case examples of clients with disabilities. In addition, counseling psychology training programs may integrate a mentor approach to diversity development in which the faculty member can offer themselves as a model for addressing disability related issues. The faculty member would be able to openly self-disclose about their own experiences in developing such multicultural skills and pursuit of awareness regarding specific diversity issues affecting each individual client. However, these approaches to training are useless unless the counseling psychology program actively recruits faculty members who are

multiculturally aware, knowledgeable, and possess necessary skills regarding PWD and disability related issues (Ponterotto, 1998).

One finding from the current study indicated that close, equal-status contact with PWD tends to increase perceived competence regarding PWD. A possible improvement to counseling psychology training programs may be to incorporate additional interpersonal experiences with PWD as a means of increasing perceived competence. One potential way that counseling psychology training programs may facilitate this is to actively seek faculty and students who identify as having a disability. When faculty or students with disabilities are not available, counseling psychology programs may wish to pursue volunteer programs in the community that offer interaction with PWD. This would allow students with little or no experience with PWD the opportunity to develop equal-status relationships with PWD. These types of experiences may act as a means of helping them to view PWD as persons first. Being able to view a potential client as a person rather than a diagnosis or as "disabled" has historically been considered a fundamental skill to the provision of helpful psychological services (Kemp & Mallinckrodt, 1996; Linton, 1998; Reeve, 2000; Yuker, 1965).

The purpose of this study was not to outline all potential training needs or to suggest all the necessary changes to counseling psychology training programs. However, this study has supported that improved training regarding disability related issues is necessary to the development of competent future counseling psychologists. Specifically, training programs should turn particular attention to improving curriculum as a mean of increasing factual knowledge regarding PWD and disability related issues. Likewise, programs should offer additional experiences to further develop conceptualization and

therapy skills for working with clients with disabilities. Lastly, counseling psychology programs may want to incorporate added opportunity for close, equal-status contact with PWD.

Future Directions

To date it is evident that much research has been done in the area of attitudes regarding people with disabilities (PWD). However, very limited research has been done in the area of competence regarding PWD. Likewise, this researcher has found no prior studies that analyzed the competence and attitudes regarding PWD with only counseling psychology doctoral graduate students. The area of multicultural competence, ethical obligation, and legal obligation to serving PWD is clearly evident. Therefore, it is strongly recommended that this area be further explored in future studies.

With regards to the findings of the current study, several recommendations can be made for future research. First, the finding that counseling psychology graduate students tended to be lacking in both perceived knowledge and skills regarding PWD indicates that additional research should be done to discover exactly what is being taught regarding diversity issues in counseling psychology programs. One would hypothesize that disability related issues may not be thoroughly discussed in the programs. Likewise, these studies may include investigations comparing the amount of content included in program curriculum versus the types of experiences offered to their students that may involve disability related issues.

Secondly, more thorough studies of the effect close contact with PWD have on perceived competence regarding PWD should be conducted. As noted above, close contact with diverse populations has long been established among the multicultural

counseling competence and social psychological literature as a means of decreasing prejudice and improving competence regarding diverse populations (Allport, 1954; Amir, 1969; Cook & Selltiz, 1955; Makas, 1993). Hence, additional studies may offer greater insight into the specific training needs of counseling psychology graduate students. Experimental studies looking at training programs that offer intensive training utilizing close contact with PWD and those that offer little training utilizing close contact with PWD may offer additional clarity to the experiential training needs of counseling psychology doctoral students. Likewise, additional studies into the effect close contact may have on the development of more positive attitudes regarding PWD may be beneficial to identify potential training modifications that should be made by counseling psychology doctoral programs. These studies into the effect of the type of contact with PWD may be benefited by the use of more thorough measures of contact.

Also, other measures of attitudes regarding PWD may need to be used to gain a more dynamic understanding of the attitudes held by counseling psychology graduate students. Such attitude measures would need to be normed more recently than Yuker's (1970) sample. Studies using other measures of attitudes regarding PWD would improve the ability to make conclusions regarding the attitudes held by counseling psychology graduate students.

Other future studies may need to isolate the attitudes and competence of counseling psychology doctoral graduate students regarding different types of disabilities (e.g. mobility vs. mental health). These findings could further be explored based on different demographic samples. Also of interest would be cross-sectional and/or longitudinal studies analyzing the development of attitudes and perceived competence

held by counseling psychology graduate student at the beginning of doctoral training, at the end of doctoral training, and post graduation. Such studies would indicate at what stage of training counseling psychology graduate students are the most vulnerable to diversity training efforts that are specific to working with PWD.

Summary

The purpose of this study was to discover the perceived competence and attitudes of doctoral students in counseling psychology programs regarding PWD. Also, the current study aimed to identify any relationship between the type of contact with PWD and the attitudes and perceived competence of counseling psychology graduate students regarding PWD. A sample of 132 counseling psychology graduate students that are student affiliates of the APA were used to collect the necessary data. The findings indicated that counseling psychology graduate students tend to have positive attitudes and perceived competence regarding PWD and disability related issues. A weak connection was found between close contact with PWD and counseling psychology graduate students' level of perceived competence regarding PWD. Yet, no connection was found between the kind 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 display a wealth of understanding regarding counseling psychology graduate students' perceived competence and attitudes regarding PWD. However, they also indicate the need for more thorough study of counseling psychology graduate students' perceived competence and attitudes regarding PWD.

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APPENDIX

AUBURN
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INFORMATION SHEET
For Research Study Entitled
Competency and Attitudes of Counseling Psychology Graduate Students Regarding People with Disabilities

You are invited to participate in a research study aimed at gaining a greater understanding of the perceived competency and attitudes of counseling psychology students regarding people with disabilities. This study is being conducted by Matthew Hollimon, BS, under the supervision of Jamie Carney, Ph.D., Professor, Department of Counselor Education, Counseling Psychology & School Psychology at Auburn University. We (I) hope to learn how counseling psychology graduate students rate their level of competency regarding people with disabilities and how that may relate to their attitudes regarding people with disabilities. You were selected as a possible participant because you are currently a doctoral graduate student and majoring in counseling psychology.

If you decide to participate, we (I) ask that you complete the two surveys included with this information sheet and return them in the stamped envelope that is addressed to Matthew Hollimon and included in this packet. Time to complete both surveys should take approximately 20-30 minutes.

There are no expected risks for those who participate in this study. You are allowed to withdraw from the study at anytime without penalty. Also, you may withdraw any data which has been collected about you from this study, as long as that data is identifiable.

Participation in this study will benefit the professional community who offer psychological, social, and rehabilitative support for those with disabilities by helping them to gain a greater understanding of competency and attitudes of current counseling psychology graduate students regarding working with people with disabilities. This study will also benefit those professionals who offer training to counseling psychology student as to what competencies and attitudes counseling psychology graduate students have regarding people with disabilities. Further, persons with disabilities may be benefited by the possible betterment of current services offered by counseling psychology graduate students and counseling psychologists to those who have a disability. We (I) cannot promise you that you will receive any or all of the benefits described.

Any information obtained in connection with this study will remain anonymous. Information collected through your participation may be used to fulfill the dissertation requirement of Matthew Hollimon, BS, and may be, published in a professional journal, and/or presented at a professional meeting. If so, none of

your identifiable information will be included.

Your decision whether or not to participate will not jeopardize your future relations with the Auburn University Department of Counseling, Counseling Psychology, and School Psychology.

If you have any questions we (I) invite you to ask Matthew Hollimon, at 501-821-1454, or by email at hollim1@auburn.edu. Also, you may contact Jamie Carney, Ph.D. at 334-844-5160 or by email at carnejs@auburn.edu.

For more information regarding your rights as a research participant you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone (334)-844-5966 or e-mail at hsubject@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE WHETHER TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP.

Matthew Hollimon 5/8/07
Matthew Hollimon Date
Primary Investigator

Jamie Carney 05/09/07
Jamie Carney, Ph.D. Date
Dissertation Chair