ABSTRACT

Title of Dissertation: REHABILITATION COUNSELORS'

PERCEIVED MULTICULTURAL

COMPETENCE: WORKING WITH AFRICAN

AMERICAN AND OTHER CULTURALLY

DIVERSE CLIENTS WITH SEVERE MENTAL

ILLNESS

Dorothy C. Whitehead, Doctor of Philosophy, 2003

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The purpose of this study is to examine rehabilitation counselors'

perceived multicultural competence in working with clients with severe

mental illness and specifically African Americans with severe mental illness.

The impact of the counselor's own cultural heritage and perception of their

counseling skills will be explored. Counselors' race, gender, training, and experience will be examined in terms of awareness, knowledge, terminology, and skills.

Research suggests that the primary disability group served by state and federal rehabilitation agencies is persons with psychiatric disability. The prevalence of serious mental disorders among African Americans is reflected by national as well as state statistics. Rehabilitation outcomes among minority individuals with serious mental disabilities are significantly lower (39.1%) compared to their white counterparts (44%). The large unemployment rate of minority persons with psychiatric disabilities is a reflection of the impact of cultural and diversity issues.

In this study 148 rehabilitation counselors from the National Rehabilitation Association, National Association of Multicultural Rehabilitation Concerns (NAMRC) Division, and the American Counseling Association, American Rehabilitation Counselors Association (ARCA) Division, completed the Multicultural Counseling Competence and Training Survey-Rehabilitation Version (MCCTS-R), the Mental Health Self Assessment For Counseling Competencies (MHSACC) and the Situational Attitude Scale (SAS) – Form B.

Results indicated that rehabilitation counselors perceive themselves to be competent in areas of multicultural knowledge, terminology, awareness and skills. Being female and a person of color other than African American was significantly related to multicultural knowledge. Counselors related years of experience to multicultural awareness, but did not perceive multicultural training as a significant predictor of any type of multicultural competence. There appeared to be no significant difference in the way African American and White rehabilitation counselors provided services across racial/ethnic groups; however, findings suggested a hierarchy of service provision consistent throughout the Mental Health Self Assessment for Counseling Competencies (MHSACC). Attitudes of African American and White rehabilitation counselors toward African Americans varied. Notably, there was a marked difference in attitudes relating to situations of a close social and/or personal nature. This study discusses implications of the results in relationship to prior research, future research, training and practice.

REHABILITATION COUNSELORS' PERCEIVED MULTICULTURAL

COMPETENCE: WORKING WITH AFRICAN AMERICAN AND

OTHER CULTURALLY DIVERSE CLIENTS WITH

SEVERE MENTAL ILLNESS

by

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Dissertation submitted to the Faculty of the Graduate School of the
University of Maryland, College Park in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
2003

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ACKNOWLEDGEMENTS

I could not have completed this endeavor without the support and encouragement of many.

I wish to extend my sincere appreciation to my committee members:

> Dr. Paul Power, my doctoral advisor and dissertation chair for your unwavering support and direction throughout the entire process. Your teaching style and your humor kept me motivated;

> Dr. Cheryl Holcomb-McCoy for your encouragement, your willingness to assist and for the use of your instrument;

> Dr. Robert Coursey for your sincerity and positive feedback which helped me to remain focused and realize that there was light at the end of the tunnel;

> Dr. William Sedlacek for the use of your instrument and your in-depth critique of the statistical analysis;

> and to Dr. Yolanda Edwards for agreeing to be on my committee and offering your expertise in the area of rehabilitation counseling.

I would like to extend my appreciation to Ethel Womble, my supervisor at the Department of Rehabilitation Services. Your support throughout this entire process meant a great deal to me.

To my husband, Robert, for your support and encouragement and for the times you helped with computer work. Thanks for your love.

Much love to my daughters, Toni and Valerie, for your continued encouragement and for never losing sight of the vision.

To my friend, Beverly Todd, for your unconditional support throughout this process, I will never forget this.

To my friend, Dr. Julia Bryan for your unfailing friendship, encouragement and for your help with statistics. I will always remember you.

And to my Sister girls, Barbara Smith, Dr. Cheryl McLee, Carolyn Martin, and Sherry Billings, I thank you for your prayers, your love, your support, and your unconditional friendship which motivated me from beginning to completion of my doctoral program.

Most of all, I thank my Lord and Savior, Jesus Christ for sustaining me. I give all praise, honor and glory to Him.

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CHAPTER 1

Introduction

This study will concentrate on counselors' perceived competence in

working with African Americans with a mental disability as well as other

ethnic minorities that will facilitate further research and inform rehabilitation

practitioners and educators concerning the usefulness of culturally

responsive service delivery to clients with mental illness, specifically

African Americans.

Interest in the special problem of African Americans with disabilities

who must confront discrimination on the basis of race as well as disability

has increased in recent years. Disability is markedly more common among

black adults than it is among whites or Hispanics (The President's

Committee on Employment of the Handicapped, 1985). The 1990 census

reported 54 million persons with disabilities in the United States. A

disproportionate number of these adults are African American. U.S. Census

Bureau data confirms, as reported by Walker (1988), that 14.1%

(approximately 2,280,000) of working age African Americans had one or

more disabilities. This translates to one in every seven African American

adults aged 16-64 having a work disability, but who are not institutionalized.

Most African American adults with disabilities are women (53.9%) and the average age is 42 years. Nearly 8 in 10 live in cities and have incomes below the official poverty line. Individuals who are African American and disabled cope with stigma specific to both statuses (Atkins, 1988; Wright, 1988). This poses a unique challenge for rehabilitation professionals (Alston & Mngadi, 1992).

African Americans as a group still suffer the most severe underemployment, undereducation and miseducation compared to any other group (Atkinson, Morten, & Sue, 1989). Although progress has been made over the past decades, unemployment, homelessness and drugs continue to be a major social issue for many African Americans. Research has overwhelmingly documented the linkage between race, ethnicity, multiple disabilities, social class, and education. Clearly, there is a direct connection between diagnosis, treatment, and outcome, which has a life long impact on minority persons. Most of these problems are directly or indirectly related to mental illness among this population (Milstrey, 1994). African Americans experience mental health problems at a significantly greater rate than majority group members.

An estimated 40 million people in the United States have psychiatric impairments; and of this number, one in every five families is affected in

their life time by a severe mental illness (National Alliance for the Mentally

Ill, 2000). Despite a strong desire to work, many of those who have severe

and persistent emotional problems have no long-term attachment to the labor

market (Garske, 1999). While there is a consensus among rehabilitation

professionals that employment is an important part of life for persons with

mental illness (VandenBoom & Lustig, 1997), estimates of unemployment

are at a rate of 85% for the working age member of this population (National

Institute on Disability and Rehabilitation Services, 1993).

In assessing the mental health status of African Americans, as with

other disabilities, African Americans are disproportionately represented in

terms of the total percentage in the U.S. population.   The following findings

are relevant, as reported by the 1994 Inventory of Mental Health

Organizations and General Hospital Mental Health Services. Although

African Americans comprise only 13% of the United States population, they

represent 25% of persons at year end in 24-hour hospital settings for mental

health disorders and 18% of persons in less than 24-hour settings. The Ohio

Department of Mental Health Report by the Minority Concerns Committee,

1992, revealed that 61% of African Americans receive an inpatient diagnosis

of a severe mental illness in contrast to 40% of White Americans and 42%

of Hispanic Americans. Based on paid claims, 71% of the population served

by the Public Mental Health System in Baltimore, Maryland is African American (Baltimore Mental Health Systems annual report, 2000). The population of Baltimore City is 63% African American. In addition, other statistics from the Maryland Division of Rehabilitation Services (1999 and 2000) reveal that the primary disability served was psychiatric disability and out of a total number of 3,011 and 3,094 persons successfully rehabilitated during that fiscal period, the number of African Americans (1,317 and 1,360) was lower than white counterparts (1,652 and 1,681).

National, as well as individual State statistics, appear to reflect the prevalence of serious mental disorders among African Americans. In examining differences in vocational outcomes, minority individuals with serious mental disabilities are rehabilitated at a rate of 39.1%, compared to 44% for white counterparts. The large unemployment rate of minority persons with severe mental disabilities reflects the compounding impact of diversity issues on a generally unacceptable client outcome. (ODHM Report by the Minority Concerns Committee, 1992).

Those African Americans who are poor and severely mentally ill experience unemployment as well as homelessness and other social ills intensely. Part of the difficulty lies in obtaining access to appropriate services. In analyzing the issue of appropriate services for African

Americans with severe mental disorders, three target areas have been identified for providing effective services: accurate assessment practices, culturally responsive treatment programming, and cultural competence training for staff (Plummer, 1996).

As noted by Schaller, Parker, and Garcia, 1998, service providers, including rehabilitation counselors, are increasingly called upon to provide culturally competent services (Arkansas Research Rehabilitation (ARTCVR), 1995; Dodd, Nelson, Oswald, & Fisher, 1991. Feist-Price & Ford-Harris, 1994; Walker, Belgrave, Nicholls, & Turner, 1991). The 1990's may become known as the decade of the cultural imperative in service provision (Isaacs & Benjamin, 1991). Cultural competence includes integrating both culture (patterns of human behavior that includes beliefs, values, and behaviors of a community, group, or society) and competence (the capacity to function within the context of culturally-integrated patterns of human behavior as defined by a community, group, or society) into service provision (Cross, Bazron, Dennis, & Isaacs, 1989). Rehabilitation counselors have available a large and growing body of literature on developing multi-cultural counseling knowledge and skills through a variety of cross-cultural counseling and communications models (Aponte, Rivers, & Wohl, 1995; D'Andrea, Daniels, & Heck, 1991; Parker & McDavis, 1979;

Pedersen & Ivey, 1993; Randall-Davis, 1989; Sue & Sue, 1990). Even

though there is a wealth of information, Rosenthal and Kosciulek (1996)

suggest that we seem to know more about inequities and discrimination in

counseling services than about setting up responsive services. However,

research confirms that the field of rehabilitation has historically

acknowledged the importance of issues of culture in service delivery and has

outlined specific criterion for the provision of culturally competent services

(Ayers, 1967; Kunce & Cope, 1996).

Many of the recommendations made previously are similar to those

that have appeared in mental health, special education, and rehabilitation

counseling literature in recent years (ARTCVR, 1997; Harry, 1992; Isaacs &

Benjamin, 1991). However, these recommendations generally "have not

been effectively incorporated into the rehabilitation service delivery system"

(ARTCVR, 1992, p. 28). In addition to literature from several fields,

rehabilitation/social services agencies currently identified as providing

culturally competent services may also suggest practices that can be used to

guide development of services with people from culturally diverse

backgrounds (Isaacs & Benjamin, 1991).

Baruth and Manning (1999) note that rehabilitation counselors, as

well as other service providers, will be called upon to provide professional

intervention with clients of differing cultural backgrounds, as the population of the United States grows more pluralistic and becomes more multilingual and multiracial (Heppner, & O'Brien, 1994). The already complex nature of the counseling process is further complicated when client and counselor come from different cultures. Problems that may arise could include but are not limited to generational, intracultural, racial and lifespan issues (Baruth & Manning, 1999).

A number of issues have been identified for rehabilitation counselors that can be used to guide development of services (ARTCVR, 1992; Ayers, 1967; Isaacs & Benjamin, 1991). Two issues, suggested by Isaacs and Benjamin (1991) as described by Schaller, Parker, and Garcia, 1998, can be applied by counselors for providing services with individuals and families from culturally diverse backgrounds, and include (a) how and by whom disability is defined, and (b) how services are offered and made accessible.

The concept of disability is the centerpiece of rehabilitation counseling services (Szymanski & Treuba, 1994). In spite of recognition of a more comprehensive, environmental conceptualization of disability, rehabilitation counseling continues to use definitions of disability based on pathological and statistical models (Jenkins, Patterson, Szymanski, 1992; Nosek, 1998). Middleton, Rollins, Sanderson, Leung, Harley, Ebener, and

Leal-Idrogo (2000) noted that the rehabilitation community's inadequate or even total lack of response to different racial, ethnic, and cultural persons has been noted at numerous conferences and meetings (Institute on Rehabilitation Issues, 1981, 1991, 1992; National Association of Multicultural Rehabilitation Concerns, 1994, 1995, 1997; National Council on Disability, 1993; Rehabilitation Services Administration, 1994; Walker, Belgraves, Nicholls, &Turner, 1991). Although the profession has made significant advances in bringing about an awareness of multicultural rehabilitation issues, there is a need to move forward by increasing knowledge and skills. Rehabilitation outcomes are affected by client characteristics, rehabilitation practitioners/personnel characteristics, and sociopolitical realities (Watson & Collins, 1993). It would be negligent not to recognize the fact that vocational rehabilitation as currently practiced reflects the values of the larger society (Katz, 1985; Sue & Sue, 1990). The white rehabilitation counselor is likely to inherit the racial and cultural biases of his or her forebears (Corvin & Wiggins, 1989; Dodd, Nelson, Ostwald, & Fischer, 1991; Wrenn, 1985). Therefore, historically underrepresented racially or ethnically diverse clients/consumers are likely to approach the rehabilitation service system with a great deal of healthy suspicions as to the rehabilitation counselors' conscious or unconscious

motives in a cross-cultural context. In all cases, the counselor, the

consumer/client, and the process are influenced by the state of race relations

within the larger society. Middleton et al., (2000), further suggest that this

idea is essential to understanding the historical and current experiences

involving the "isms": racism, "disabilityism", classism, sexism, ageism that

are encountered in the United States. The world views of the rehabilitation

counselor and the consumer/client ultimately are lined to these experiences.

With significant emphasis on multicultural competence in

rehabilitation counseling, taking a closer look at culturally competent

services for African Americans, the ethnic group with the most

disproportionate number of disabilities, is not untimely. Rehabilitation

practitioners and educators should seek to promote a greater awareness of

the importance of understanding the issues specific to providing services to

African Americans with disabilities, particularly those clients/consumers

who have severe psychiatric disabilities, who have the highest

unemployment rate of adult disability groups. A review of the literature

suggests that limited information exists regarding how cultural-specific

issues, such as being an African American client, influence the rehabilitation

counseling process. African Americans differ from other Americans in a

variety of ways such as continued minority status, oppression within the

United States, and the unique combination of psychological characteristics combined with socio-political factors (Sue & Sue, 1990). In order to provide effective counseling strategies, these factors must be considered and understood. In addition, because of the nation's changing demographics, and the importance of rehabilitation services, counseling issues specific to African Americans as well as other ethnic minorities, must be addressed (Feist-Price & Ford-Harris, 1994, p. 13).

Statement of the Problem

A consistent finding is the under utilization and premature termination of services by people from culturally diverse backgrounds and increased rates of utilization when services are perceived as culturally inappropriate (Boyd-Franklin, 1989; De La Cancela & Martinez, 1983; Keefe, 1979; Neighbors, 1990). One of the reasons African Americans have not been receptive to mental health and rehabilitation services could be due to the neglect of specific cultural needs and diverse family dynamics which exist in the Black community. Research confirms that cultural values relating to the environment, family structure, and belief systems (political and spiritual) impacts treatment and rehabilitation issues for this population. Historically, the services of psychopathology and theories of practice were based on experiences that were almost exclusively white in orientation (Bass &

Powell, 1982). It is suggested that one of the reasons for the disparity in successful outcomes for African Americans with severe mental illness is the lack of culturally sensitive service provision.

There is a consensus among rehabilitation professionals that employment is an important part of life for persons with mental illness. Yet, VandenBoom and Lustig (1997) estimate unemployment at a rate of 85% for working-aged persons who have mental illness (National Institute on Disability and Rehabilitation Services, 1993). African Americans represent 25% of the overall U.S. population who access mental health services in 24-hour hospital settings. In addition, a substantially disproportionate percentage of clients seeking vocational rehabilitation services are African American with serious mental illness. In light of the high unemployment rate of mentally ill working-aged adults, and the fact that African Americans represent a significantly higher percentage of those receiving mental health services than any other group, it is imperative for counselors to have specific culturally responsive competencies for this population. The provision of appropriate services to African American adults with mental illness is, therefore, dependent upon these counselors competencies.

Significance of the Study

A comprehensive review of the literature shows no evidence of any studies conducted on rehabilitation counselors' perceived multicultural competence in working with persons with mental illness, specifically African Americans with mental illness. The relationship between mental health and culture is long standing (Kluckhohn, 1961). Much of a patient's/client's behavior is structured around the individual's cultural or "ethnic" group affiliation, as is true of the practitioner. Both are influenced by beliefs that define world views and establish norms (Hughes, 1993).

Other studies and position papers have addressed cultural competency inequities, and biased service provision services to clients with mental illness in general, as well as service provision to particular racial/ethnic groups, including African Americans. None, however, have investigated multicultural competence relating to a specific disability across minority racial/ethnic groups, with emphasis on a particular group.

While there is a consensus among rehabilitation professionals that employment is an important part of life for persons with mental illness, literature on counselor's perceived multicultural competence in working with this particular population is scarce. Rehabilitation practitioners, mental health professionals and other service providers struggle with how to

provide this population with culturally responsive services. Effective service

provision can be accomplished by targeting three areas, accurate assessment

practices, culturally responsive treatment and rehabilitation planning, and

cultural competence training for staff.

This study will also add to the current base of knowledge and help to

increase awareness of issues which are potential barriers to the rehabilitation

success of this population.

Purpose of the Study

This study will examine Rehabilitation Counselors Perceived

Competence in working with African Americans who are severely mentally

ill. It will explore the impact of the counselor's own cultural heritage and

perception of their counseling skills in working with this population. The

counselor's race, gender, training, and experience will be examined in terms

of awareness, knowledge, terminology and skills.

Research Questions

The following questions guided this study:

1.   Is there a relationship between the following set of variables:

        rehabilitation counselors' age, gender, ethnic background,

        multicultural training, and years of experience, and their

        perception of :

a) their multicultural knowledge?

b) their understanding of multicultural terminology?

c) their multicultural awareness?

d) their multicultural skills?

e) their self-assessed competence in counseling racial and ethnic minorities with mental illness?

2. In their work with racially and ethnically diverse clients with mental illness, how do White and African American rehabilitation counselors compare in:

a) their verbal communication of acceptance of mental illness?

b) their non-verbal communication of acceptance of mental illness?

c) their success in producing desired outcomes?

d) their perceived levels of difficulty in working with these client groups?

e) their perception of the success of their rehabilitation training in preparing them to work with these client groups?

3. In their work with racially and ethnically diverse clients with mental illness, how do White and African American rehabilitation counselors compare in the extent to which they:

a) make referrals for education about community resources?

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b) provide encouragement of family involvement in the rehabilitation process?

c) make referrals for group therapy/counseling?

d) make referrals to assist with socialization needs?

4. How do White and African American rehabilitation counselors compare in their attitudes toward African Americans given a number of social and personal incidents and situations?

The research was evaluated based on the following hypotheses:

Ho 1. There will be no significant relationship between counselors' age, gender, ethnic background, multicultural training and experience, and their perception of:

a) their multicultural knowledge

b) their understanding of multicultural terminology

c) their multicultural awareness

d) their multicultural skills

e) their self assessed competence in counseling racial ethnic minorities with mental illness,

Ho 2. No significant difference in comparison between African American and White rehabilitation counselors will be explained by their:

a) verbal communication of acceptance of mental illness

b) non-verbal communication of acceptance of mental illness

c) success in producing desired outcomes

d) perceived levels of difficulty in working with these client groups

e) perception of the success of their rehabilitation training in preparing them to work with these clients

Ho 3. No significant difference will be reported in comparison between African American and White rehabilitation counselors in their work with racially and ethnically diverse clients by the extent to which they:

a) make referrals for education about community resources

b) provide encouragement of family involvement in the rehabilitation process

c) make referrals for group therapy/counseling

d) make referrals to assist with socialization needs

Ho 4. No significant difference will be reported by African American and White rehabilitation counselors in their attitudes towards African Americans given a number of social and personal incidents and situations.

Operational Definition of Terms

Assessment - Evaluation or appraisal; determination of the amount of something (Webster, 2001).

Attitudes - "a relatively enduring organization of interrelated beliefs that describes, evaluates, and advocates action with respect to an object or situation, with each belief having cognitive, affective, and behavioral components" (Rokeach, 1968, p. 132).

Attitude Toward African Americans - for the purpose of this study, will be measured by the Situational Attitude Scale (SAS-Form B) which "was developed to measure attitudes of whites towards blacks. To provide a racial content and make psychological withdrawal more difficult, 10 personal and social situations, with some relevance to a racial response were created". In this study the attitudes of African American and White rehabilitation counselors are examined. The SAS is discussed in more detail in Chapter 3.

Competence - Merriam-Webster Dictionary, 1994, p. 417, defines competence as the quality of being adequate, capable, and fit to meet specified requirements. For the purpose of this study, competence will be defined as attitudes, values, knowledge, and skills needed to deliver vocational rehabilitation services to clients with severe mental illness

(Coursey, R.; Curtis, L.; Marsh, D.; Campbell, J.; Harding, C.; Spanol, L.; Lucksted, A.; McKenna, J.; Kelley, M.; Paulson, R.; Zahniser, J., 2000).

<u>Cultural Awareness</u> - For purposes of this study cultural awareness shall be defined as an understanding of an appreciation for cultural differences and similarities within, among, and between groups (Woll, 1996). Also cultural awareness demonstrates an understanding of cultural differences in service provision, program design, and implementation (Center for Substance Abuse Prevention, 1994), as well as an understanding of the way members of different cultural groups define health, illness, and health care (Gordon, 1994).

<u>Cultural Responsiveness/Sensitivity</u> - Services that are culturally responsive are characterized by knowledge of the language of the client, sensitivity to the cultural nuances of the client, counselor representation of the client population, use of service models that reflect the cultural values and rehabilitation needs of the client and representation of the client population in decision making and policy implementation (United States Department of Health & Human Services ,1999).

<u>Culture</u> - The totality of socially transmitted behavior patterns, arts, beliefs, institutions and all other products of human work and thought typical of a

population or community at a given time, a style of social and artistic expression peculiar to a class or society (Webster's II, 2001).

Experience - Experience is defined in this study as the total number of years a counselor has worked professionally with persons with mental illness, multiplied by the average percentage of minority persons in their case load.

Mental illness/disorder - The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. Mental disorders have also been defined by a variety of concepts (e.g., distress, dyscontrol, disadvantage, disability, inflexibility, irrationality, syndronmal pattern, etiology, and statistical deviation). Each is a useful indicator for a mental disorder, but none is equivalent to the concept, and different situations call for different definitions (DSM IV, 1994). Mental disorder is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom (DSM-IV, 1994). Mental illnesses are physical brain disorders that profoundly disrupt a person's ability to think, feel, and relate to others and their environment. (National

Alliance for the Mentally Ill, 2000). For the purpose of this study, mental illness will be defined as the product of a complex interaction among biological, psychological, social, and cultural factors. The role of any of these major factors can be stronger or weaker depending on the specific disorder (U.S. Surgeon General, 2001).

<u>Minority</u> - The term minority has been conceptualized by Wirth (1945) as a group of people who, because of physical or cultural characteristics, are singled out from others in society for differential and unequal treatment. This definition does not revolve around numerical representation but on the lack of social, political, and economic power (Ponterotto & Pederson, 1993).

<u>Multicultural</u> - The term multicultural is defined in the <u>Accreditation Procedures Manual and Application</u> (CACREP, 1994) as "representing a diversity including different races, economic backgrounds, ages, ethnic backgrounds, genders, sexual orientations, and physical and mental abilities. Implies a pluralistic philosophy" (p. 108). The Professional Standards and Certification Committee of the Association for Multicultural Counseling and Development (AMCD), however, suggests that multiculturalism should be focused on ethnicity, race, and culture (Arrendondo & D'Andrea, 1995). For this study, the definition suggested by the Professional Standards and Certification Committee of AMCD will be used.

Multicultural Competence - Multicultural competence has been defined by Ponterotto and Casas (1987) as a counselor's "knowledge of clients' culture and status, actual experience with these clients, and the ability to devise innovative strategies vis-a-vis the unique client's needs" (p 433). Multicultural competence will be measured by the National Multicultural Counseling Competence and Training Survey.

Perception - To perceive, the act, process, or faculty of perceiving. Insight, intuition or knowledge gained by perceiving. For the purpose of this study, perception shall be identified as an impression in the mind of something perceived by the senses, viewed as the basic component in the formation of concepts (Webster, 1988).

Racial/Ethnic - For purposes of the study, racial/ethnic shall be identified as a group of people united or classified together on the basis of common history, nationality, or geographic distribution, of or relating to a religious, racial, national, or cultural group (Webster, 1984).

Rehabilitation Counseling Competencies - (The Profession and Standards of Practice, CRCC, 1997)

Rehabilitation counselors shall establish and maintain their professional competence at a level which ensures their clients will receive the benefit of the highest quality of service the profession is capable of offering.

1.	Rehabilitation counselors will function within the limits of their defined role, training and technical competency, accepting only those positions for which they are professionally qualified.

2.	Rehabilitation counselors will continuously strive, through reading, attending professional meetings, and taking courses of instruction, to remain aware of developments, concepts and practices that are essential in providing the highest quality of services to their clients.

3.	Rehabilitation counselors, recognizing that personal problems may interfere with their professional effectiveness, will refrain from undertaking any activity in which such problems could lead to inadequate performance. If they are already engaged in such a situation when they become aware of a problem, they will seek competent professional assistance to determine if they should limit, suspend or terminate their professional activities. Rehabilitation competencies will be measured by the National Multicultural Counseling Competence and Training Survey and the Mental Health Self-Assessment for Counseling Competencies.

Training - Training is defined in this study as the total number of contact hours a counselor has had in multicultural counseling. It includes courses taken at college, university, in-service training, workshops, and any other formal education specific to multicultural counseling.

Summary

This chapter has presented an introduction to the proposed research which is a study of the perceived competence of rehabilitation counselors offering multicultural rehabilitation counseling services to clients of differing cultures, specifically African Americans with severe mental illness.

The introduction documents the counseling profession's increased attention during the last two decades to the mental health status and needs of racial/ethnic minority groups (Casas, 1984) and includes the statement of the problem, purpose of the study, significance of the study, and research questions to guide the study.

Critics argue that the majority of traditionally trained counselors operate from a culturally biased and encapsulated framework (Parker, 1988; Pedersen, 1988; Wrenn, 1962, 1985) which results in the provision of culturally conflicting and even oppressive counseling treatments (Ponterotto & Benesch, 1988; Sue, 1981) These counselors, although well intentioned and well-meaning, often and unknowingly impose their White middle-class value system on to culturally different clients who may possess alternative and equally meaningful and justifiable value orientations (Katz, 1985; Ponterotto & Benesch, 1988; Sue, 1981).

The research strategy will involve an assessment of counselors' perception of their own competence and attitudes through an adaptation of the National Multicultural Counseling Competence and Training Survey, (Holcomb-McCoy, 1999) and the Mental Health Self Assessment For Counseling Competencies, a researcher generated tool which was developed after reviewing Multicultural Rehabilitation Competencies and Standards endorsed by Middleton et al. (2000), and the Situational Attitude Scale (Sedlacek & Brooks, 1970). The study points to a specific need for investigating counselor competencies in working with minority rehabilitation clients with severe mental illness, specifically African Americans who are the largest minority group in the U.S. at this time. The impact of counselor skill and cultural awareness is the focal point of this study.

CHAPTER 2

Review of the Related Literature

Multicultural counseling has been evolving as an area of

specialization for the past 30 years (D'Andrea & Daniels, 1996). The civil

rights movement of the sixties and the growing recognition of racism and

other forms of discrimination in the U.S. society resulted in ethnicity and

minority status becoming a focus of interest within the field of counseling

(Lee, 1996). As stated by Sue, Arredondo and McDavis (1992), research

documents a long history of recommendations regarding the need for a

multicultural perspective in counseling. During this period of evolution,

professional efforts including conferences held by the American Association

for Counseling and Development, the American Psychological Association,

and other government sponsored meetings, set forth directives and training

programs for the purpose of working effectively in an increasingly

multicultural environment. Some events that contributed to the multicultural

movement during the 1960's and 1970's include the American Psychological

Association's Ad Hoc Committee on Equal Opportunity in Psychology,

1963 and 1967, The Commission on Accelerating Black Participation in

Psychology, 1969, The Office of Black Student's Psychological

Association, 1970, Board of Social and Ethical Responsibility, 1971, the

ACES Commission on Non-White Concerns (McFadden, Quinn &

Sweeney, 1978); the Austin Conference, 1975; the Dulles Conference, 1978;

the National Conference on Graduate Education in Psychology, 1978; the

President's Commission on Mental Health, 1978; (Sue, 1990, 1991) and the

Vail Conference (Korman, 1973). Additionally, a number of studies during

the 1970's focused on the impact of race on counseling and psychotherapy.

The movement gained momentum as people began to realize that minority-

group clients receive unequal and poor mental health services. Failure to

return statistics (over 50% for African and Native Americans, compared to

42% for Chicano and European Americans, after the first session), made it

increasingly obvious that more culturally relevant counseling services were

needed. Sue included chapters on African, Native, and Asian Americans, as

well as various subcultures, racial groups, gender groups, and socio

economic levels, in his 1981 book, *Counseling the Culturally Different*

(Baruth & Manning, 1999). Other literature substantiates the need for a

multicultural counseling approach, concluding that traditional counseling

approaches and techniques have not been effective when applied to racial

ethnic minority populations (Casas, 1984; Casas, Ponterotto, & Gutierrey,

1982; Ibrahim & Arredondo, 1986; President's Commission on Mental

Health, 1978; Sue, 1990; Sue & Sue, 1990; Sue, et al., 1982; Sue, Arredondo, and McDavid, 1992).

Until the 1960's counseling and psychotherapy tended to overlook clients from differing cultural backgrounds who found themselves at a disadvantage in a predominantly majority culture and a middle-class world. Psychotherapy also limited its practice primarily to middle and upper middle class people and neglected lower classes and people from differing cultural backgrounds (Atkinson, Morten & Sue,1993). The diversification of the U.S. population has important implications for professional counselors and other mental health service providers. The need for counselors to increase their cultural sensitivity, and knowledge of cultures and culturally relevant counseling skills, in order to meet the demands of serving a culturally diverse population is paramount.

Concerns about the mental health needs of minority populations in the United States has heightened over recent years (Pope-Davis & Ottavi, 1994). Though there is agreement that counselors need to be multiculturally competent, effective strategies for improving competencies has not been easily available. In most training programs where multicultural competence has been prioritized, minority faculty members have been the primary persons to prompt the effort (Ponterotto & Casas, 1987).

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Although numerous articles have been written on multicultural competence, there is an overall lack of empirical studies that exist on the topic of rehabilitation counselors' multicultural competence in working with persons with severe mental disabilities, and specifically African American clients with severe mental disabilities. This chapter will consist of a review of relevant literature. The major themes that will be discussed in this study include:

1. Issues of culturally competent service provision

2. Issues specific to African Americans

3. Mental illness in America

4. Multicultural competencies for rehabilitation counselors working with clients with severe mental illness

Issues of Culturally Competent Service Provision

The diversification of the U.S. population has important implications for rehabilitation counselors and other services providers. We have one of the most diverse populations in the world, which is expected to continue during the millennium. Based on statistics, cultural competence is no longer an issue that we can just give lip service to, but it is an issue that must be addressed in a most profound way. Counselors must be equipped to meet the demands of serving a diverse society. In this section, issues of cultural

competency in service provision will be addressed under two headings: (1) Diversification of the U.S. Population and (2) Perceptions of Disability and Counselors Worldview.

Diversification of the U.S. Population

The U.S. Bureau of the Census (1996) predicted that by the year 2050 racial minority populations will out- number the now majority white American population (Wilson, Harley, McCormick, Jolinett, & Jackson II, 2001). In 1985 the total U.S. population was 238 million; 12 percent African American, 5.8 percent Hispanic, 1.6 percent Asian, .6 percent Native American and 80 percent Anglo American (U.S. Bureau of the Census, 1993). In 1990, the population totaled close to 249 million (U.S. Bureau of the Census, 1992). By the year 2020 it is predicted that the Anglo American population will be 70 percent, which, as previously stated, will be 60 percent by year 2050 (an actual decrease of 36 million from 1980). Helms (1989) cited that the African American population is expected to increase significantly while other racial minority groups will increase simultaneously. In keeping with the attempt to provide specific group services in such a diverse environment, practitioners and organizations across disciplines are instituting standards of practice for multicultural competence. Counselors are increasingly being called upon to acquire skills and develop multicultural

awareness for culturally sensitive service delivery. There is a perception among multicultural specialists that the majority of counselors are not adequately trained to provide appropriate culturally relevant services to clients who represent diverse groups (Grieger, & Ponterrotto, 1995; Sue & Sue, 1990). Traditional counseling interventions still utilized by culturally inexperienced counselors perpetuate cultural bias by imposing the dominant culture on minority clients (McGinn, Flowers, & Rubin, 1994; Cayleff, 1986; Pedersen, 1990).

Over the past two decades, increasing attention has been paid in rehabilitation counseling literature to multicultural awareness (Cooney, 1988; McGinn, et. al. 1994). Because minorities constitute an ever increasing proportion of the population, rehabilitation counselors can expect to encounter more minority consumers and must be prepared to practice in a multicultural environment (Wright, 1988). Smart and Smart (1992) argued that rehabilitation counselors must be even more prepared to assist minorities than other mental health professionals. Wilson, Harley, McCormick, Jolinette, and Jackson (2001), asserts further that "as part of this overall demographic shift, more racial minority customers will be in need of vocational rehabilitation services". Based on recent demographic statistics, the economy, and the ever increasing need for rehabilitation

services, counseling issues specific to African Americans and other ethnic and racial minorities must be addressed. In spite of the documented need for the development of culturally competent skills and awareness, the Rehabilitation Act Amendments of 1992 reported an inequitable provision of rehabilitation services to racial minorities at every level of the rehabilitation process (Granello & Wheaton, 1998; Shaller, Parker, & Garcia, 1998).

In light of this report, it would be expected that counselors would have some doubt regarding their multicultural counseling abilities. Yet, Granello and Wheaton (1998) examined the self-perceived multicultural competencies of 180 African American and European American vocational rehabilitation counselors in a Midwestern state rehabilitation agency. The participants were asked to identify competencies based on skills, awareness, knowledge and relationship, and were asked to assess their tendencies for responding to persons socially. The results indicated that both the African American and European American counselors perceived themselves to be multiculturally competent, especially in the area of multicultural skills. The European American counselors, as compared to African-American counselors, identified awareness and relationship as areas they were not strong in. No significant difference, however, was shown between races in the areas of skills and knowledge. Overall, rehabilitation counselors in this

study reported themselves to be most multiculturally competent in the area of multicultural skills followed by relationship knowledge and awareness. This is consistent with earlier research conducted by Pope-Davis and Ottavi, (1994) which surveyed graduate students and Sodowsky et al, (1996) who surveyed university affiliated counselors. The authors of this study, however, (Granello & Wheaton, 1998) recommended that training include two components that are often missed by traditional lecture - style programs:

(a) knowledge of one's own cultural background, including how one's heritage has influenced attitudes, values and biases,

(b) knowledge and understanding of the client's cultural background, including understanding how racism, discrimination, and stereotype might influence his or her lived experience.

Limitations of the study include the use of self report and the low number of African Americans included in the results (11%).

This study was important because it identified areas of needed training particularly in areas of relationships and awareness and the need for researchers to identify and encourage minority counselor participation in studies. Also, the finding regarding the self-perceived competency of rehabilitation counselors is interesting in light of the reported discrepancies

between services provided to majority and minority populations in the 1992

Amendments to the Rehabilitation Act.

Client Perceptions of Disability and Counselors' Worldview

The construct of disability is defined in terms of culture (Ayers, 1967;

Harry, 1992; Rubin, Pusch, Fogarty, & McGinn, 1995). Disability is

defined differently by different cultures/racial-ethnic groups. How disability

is defined is centered around what a given culture or society considers

normalcy (Mercer, 1973). Arnold (1987) noted that culture influences beliefs

about how disabilities are caused, what qualifies as a disability, behavioral

expectations of individuals with disabilities and the way in which others

respond to an individual with a disability. Reasonably, perceptions of

disability will vary, not only among members of the dominant culture, but

also among individuals from culturally diverse groups as well. Shaller,

Parker, and Garcia (2000), cites examples:

> Hispanic and African American parents' interpretations of and
>
> names for their children's difficulties in school often differs among
>
> parents and special education professionals (Harry, 1992; Harry,
>
> Allen, & McLaughlin, 1995). Parents may acknowledge that their
>
> child is having difficulties in school, but rejects the label and etiology
>
> used by the school for the problem. For example, if a child is labeled

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by a school as having mental retardation, parents may not distinguish between mental illness and intellectual impairment unless the impairment is at the extreme end of the spectrum (Harry, 1992). As a result, parents may feel that the school is labeling their child as having severe mental health problems. Harry, Allen and McLaughlin (1995) noted that African American parents may disagree with educational professionals' definition of disability as they may hold broader perceptions of normalcy and have a wider range of expectations for developmental milestones of children's behavior. Mardiros (1989) noted that Mexican American parents she talked with used both biomedical and socio-cultural (i.e. folk) explanations for the cause of their child's disability. Folk explanations for causation included divine intervention and holding negative attitudes toward people with disabilities in the past. Many traditional non-native American languages do not have words for constructs like mental retardation, disability, or handicap; instead, emphasis is on finding meaningful roles an individual with a disability can play in their community (Locust, 1988). For example, Trevino (1996) found that the term "disability" was foreign to Mexican and Mexican American migrants and seasonal farm workers participating in her study, yet all of the

participants had chronic and severe health problems (disabilities).

Finally, there is also evidence of different perceptions of disability

across societies from different countries. The above examples are only

a few illustrations of how the meaning of disability may be

constructed by members of different cultures or societies, or not

constructed at all. (p. 41).

Fundamental cultural values and beliefs form the basis for a group's

perception of disability. Marini's (2001) research on adjustment issues faced

by males from different cultures with severe disabilities, found that

Latino/Hispanic men who sustain a catastrophic disability are generally

devastated if their earning power as the head of the household is

compromised. Some view disability as a punishment from God. In addition,

role conflict may occur due to the patriarchal family structure, with the wife

submitting to the husband as the head of the household. The Asian-

American community, which encompasses 28 nationalities, the largest of

which include Chinese, Filipinos, Japanese, Koreans, Asian Indians and

Vietnamese as cited by the U.S. Bureau of the Census, (1993), traditionally

embraces harmony with nature and society. For the Chinese, harmony is a

balance between the Yin, the passive female cosmic principle, and the Yang,

the active masculine cosmic principle in Chinese dualistic philosophy

(Webster's II, 2001). Their belief is that becoming sick is brought on by an imbalance between the Yin and the Yang and is believed to be caused by God for punishment for having sinned (Lassiter, 1995). Disability and other family problems are viewed as having shamed or failed the family and the entire family has to bare the shame (Uba, 1994; Wong & Chan, 1994). Problems are kept secret as to not reveal the shame. Males are viewed as heads of household and wives are expected to take care of the family and the household. In keeping with the tradition of hierarchy in Asian culture the males expect indisputable loyalty from family members, which explains to some extent the sense of failure and devastation when one's ability to contribute to the family is impeded by disability (Marini, 2001). This belief often leads to the disability being kept secret and counseling is not actively sought (Sue & Sue, 1987).

Similar to Asian-Americans, Native Americans have large within group differences. Over 60% are of mixed heritage and experience different levels of acculturation (Trimble, Fleming, Beauvais, & Jumper-Thurman, 1996). Often times American Indians see themselves as extensions of their various tribes. For some who venture outside of the reservation, a sense of loss of self is experienced due to a loss of tribal identity (Anderson & Ellis, 1995). Women traditionally have a strong family role and extended family

members share in raising children. Elders are greatly respected. The male role as breadwinner and head of household is not as strong as it is in some other minority group cultures. Substance abuse and poverty statistics, as well as, unemployment rates, are high on reservations (Swinomish Tribal Mental Health Project, 1991). Unlike some other minority cultures, they do not view disability as punishment for having sinned. They tend to treat disabled family and/or community members as they would anyone else. The males continue to contribute what they are able to, and are regarded with respect and dignity (Joe & Miller, 1987).

Among African Americans, religion is a valued priority. The church is looked upon as an important member of the extended family (Levin & Taylor, 1993). The belief that all people are god's children may account for the idea that disabilities tend to be looked at more positively than with European-Americans (Pickett, Vraniak, Cook, & Cohler, 1993; Rogers-Dulan & Blacker, 1995). Contrary to the views of Latin/Hispanic views, most African-American men agree that wives should work according to their own preferences (Smith, 1981). This role flexibility and kinship bonds (access to extended family - blood and non-blood relatives) allow for more successful adjustments to the occurrence of disability. It is not uncommon in African American culture for a core family unit to be housed together with

extended family. As with other minority groups, African American families usually take care of family members with disabilities. Like Asian, Latin/Hispanic and Native Americans, the family comes first before the desires of the individual. Just as various racial/ethnic groups have their own perceptions of disability, society itself has formed attitudes toward persons with disabilities. Numerous studies exist on societal views about persons with disabilities (Belgrave, 1984; Belgrave & Mills, 1981; Marini, 1992; Yuker, 1988). However, the most prominent attitudes of non-disabled European-Americans concerning persons with disabilities are that persons with disabilities are generally thought of as objects of pity and/or admiration. The perception is that persons with disabilities are fundamentally different from non-disabled persons (Harris, 1991). Additionally, Lyons (1991) cites that European-Americans perceive persons with disabilities as helpless, incapable and inferior. African and Native Americans generally do not share this perception, but conversely Asian and Latino/Hispanic cultures do have similar perceptions and often become overprotective of the disabled member which can foster dependence (Uba, 1994; Pickett, et al., 1993).

Research confirms that the attitude and expectations of the society can impact quality of life and how people react toward a perceived minority

(Gething, 1991). According to Havranek (1991), the attitudes of others are often the most significant barriers encountered by persons with disabilities, and can have serious implications for delivery of services.

Hence, different cultures/racial ethnic groups perceive disability through their own cultural beliefs and experiences and make decisions regarding disability based on those beliefs. Herbert and Cheatham (1988), in a literature review addressing counselor and client characteristics, and prospective factors for failure in counseling Black clients with disabilities, suggests that the culturally competent counselor must understand, appreciate, and accept clients' perception of their relationship to nature, persons, and institutions. This perception was defined by Sue (1981) as the client's worldview, which is the driving force in one's thinking, behaving, decision making, and interpretation of life events. Sue further asserts that understanding these influences is important because counselors may impose different worldviews than those experienced by their clients. Understanding clients' worldview is critical to the counseling process.

Sarason (1984) defined worldview as being made up of the predispositions and assumptions people are socialized to hold about the make up of the world. Counselors' values are increasingly recognized as shaping the goals, tasks, and outcomes of counseling (Bergin, 1983;

Rosenbaum, 1982, Heppner & Claiborn; 1989). Because of the belief that the examination of therapists' values is especially important for research in multicultural counseling, Mahalik, Worthington and Crump (1999) conducted a study investigating whether therapists of differing racial/ethnic groups had different worldviews reflecting group membership and whether therapists' worldviews were similar to each other reflecting membership in a "therapist culture".

A random sample of 600 therapists was selected from the Directory of Ethnic Minority Professionals in Psychology and the American Psychological Association Membership Register. Each participant was asked to complete The Scale to Assess World Views (SAWV; Ibrahim & Kahn, 1987) a five scale 45 item inventory of value orientation statements. The factors on the five scales are: Human Nature, Social Relationships, Person to Nature, Time, and Human Activity. Three hundred and one responses were used to obtain results. T-tests were conducted to determine whether men and women and people born in and outside the United States could be combined. Men and women did not differ on any of the subscales. Respondents identified themselves as African American, White, Hispanic or Latin American, or Asian or Asian American as their race/ethnicity.

Results from the study showed that participants were similar in their worldviews and would endorse similar alternatives in value orientations, regardless of race/ethnicity. These findings support the idea that there may be a "therapist culture" in the U.S. with its own set of values (i.e., worldview) that may be different from the racial and ethnic groups in which they are members. Participants in this sample tended to endorse a worldview that was most like the White middle-class American worldview. There was some support for the hypothesis concerning differences between therapists based on racial/ethnic membership since significant differences were found on two of the five scales on the instrument, Person to Nature and Human Activity. The small pattern of differences and large within group consistency of values orientation is reflective of the fact that the participants were more similar than different in the views of the instrument's five major scales. The results of this study are supportive of previous studies concerning counselors' worldview and value orientation. The authors cite a similarity to Mahalik (1995) in an investigation of therapist core values and theoretical orientation, and identical results to those reported by Mau and Pope-Davis (1993) who reported worldview of counselors-in-training using the same instrument that was used in this study. According to the investigators these results have implications for training and seem to support the positions of

multicultural counseling scholars that counseling and psychotherapy are a reflection of Eurocentric values (Atkinson, Morton, & Sue, 1993; Sue & Sue, 1990 in Mahalik et al., 1999). In spite of the self report limitation, this research makes available crucial information about the value orientation of the participants and gives support to earlier findings in cross-cultural counseling and psychotherapy. Results "specifically, pointed to counselors' ignorance of client worldviews that differ from their own that is believed to lead to more negative attributions about clients (Sue & Sue, 1990) and frustration and anxiety for both client and counselor (Mau & Pope-Davis, 1993). The awareness of counselors' own worldviews and how they may differ from their clients is essential:" (Mahalik, Worthington, & Crump, 1999).

Issues Specific to African American Clients

A review of literature revealed that there is an overall lack of empirical studies, specifically on this topic. Fiest-Price and Ford-Harris (1994) confirmed that there is limited information on how cultural specific issues such as being an African American influences the rehabilitation counseling process. However, effective professional interaction with people of African ancestry, dispersed from other countries and cultures, has been researched and examined by social scientists and practitioners from other

disciplines, and who developed some theoretical considerations (Billingsley, 1968, 1990; Brisbane & Womble, 1992; Hill, 1972; Nobles, 1989; Pinderhughes, 1989; and Boyd-Franklin, 1989).

Pinderhughes (1989) asserted that "attention to the environment is required to understand the functioning of any family. The environment is all that is external to the family (i.e. neighborhood peer groups, church school, work places, but, also larger political, governmental, and economic institutions). Ideally, the environment should provide the protection, support, security and supplies that will enhance function. When these resources are inadequate, the results may be stress and conflict and failure in individual development of family members" (Germain, 1979). She also describes formulation of a victim system of racism and oppression which was mentioned earlier, a circular feedback process that exhibits properties such as stability, predictability and identity that are common to all systems. This particular system threatens self esteem and reinforces problematic responses in communities, families, and individuals.

Similarly, Hines and Boyd-Franklin (1989) described a multisystems approach whereby therapists must be willing to include the impact of social, political, socioeconomic, and other broader environmental conditions given that poor inner-city African Americans are likely to be involved with

numerous external systems, suggesting that environment and community be considered in diagnosis and treatment. African Americans contend with circumstances shaped by racism. For some, the stress of discerning and responding to subtle and overt racism may result in social and psychological isolation. Further these authors encourage research to permit greater understanding of the factors that contribute to resilience in the face of racism, classism, poverty, and sexism. They recommend inclusion of such factors as: family functioning, religiosity, availability and use of social support systems, history of low level but persistent stress, social policies, and style of coping in the counseling process.

Given these theoretical considerations and what has been written about inequities in service provision, in this section issues specific to African American clients will be presented from two perspectives: (1) Issues of Culture, Race, Racism, and Oppression and (2) Issues for Rehabilitation Counselors to Consider.

Issues of Culture, Race, Racism, and Oppression

Issues of culture, race, racism and oppression have and continue to impact access to and delivery of services to African Americans. Sue (1992) cited that counselors need to be cognizant of the fact that African American experiences are too often impacted by racism and discrimination (Feist-Price

& Harley, 1996). When counselor and client "come together in an institutional setting in a sociopolitical reality to address any number of life-impacting dilemmas or issues", Arredondo (1999), they bring with them a worldview that is influenced by the history and current experiences of racism and oppression in the United States (Sue, Arredondo & Mc Davis 1992).

In the field of vocational rehabilitation, race and acceptance has received much attention since the Atkins and Wright (1980), study on the experiences of African Americans and European Americans in the VR system. Their findings indicated that African Americans were accepted for services less often than European Americans and that African Americans were receiving unequal treatment based on race. Several other studies including Dziekan and Okocha (1993), found that African Americans were approximately 10% less likely to be accepted. Herbert and Martinez (1992) found that acceptance rates for African Americans, Hispanics, Asian Americans and Pacific Islanders were below the acceptance rates for European American clients.

Ten years after the Atkins and Wright study, (1980) and Wilson (2000) examined the effects of race, as well as education, work history and source of support at application on VR acceptance. The records of 62,178

clients who had received services in a large Midwestern state were extracted from the Rehabilitation Services Administration (RSA) 1996, (October 1, 1995 - September 30, 1996) database. After excluding cases with missing values on any of the variables, the final sample was 2,933 African Americans and 9,922 European Americans. The results indicated that there was a relationship between the category of primary source of support at application, level of client earnings at application, race and VR acceptance. As the primary support increased, evidence revealed that VR acceptance was increasingly likely. European Americans were more likely to get accepted than African Americans in this study. The author concluded that these results raise questions about the pattern of services given to certain groups of individuals and certain demographic variables not correlated with VR eligibility.

Capella (2002) determined that differences still exist for racial minorities and women in terms of acceptance rates, employment outcomes, and quality of successful case closures in the state-federal VR system. Two separate random nationwide samples of 10,000 people were drawn, from the RSA database, made up of persons with severe and nonsevere disabilities. The sample was further approximated for proportions of persons from each racial category to allow for adequate numbers of persons from minority

groups that made up small percentages of the sample (i.e., Native Americans and Asian Americans).

Findings indicated that differences based on race do still exist for some racial minority groups in terms of acceptance rates, employment outcome, and quality of successful closures in the state-federal VR system. This study provided the most current evaluation of inequity of VR services with a sample that involved data from all 50 states. It is the first since Atkins and Wright's 1980 study to compare African Americans and European Americans on a national level and to compare all racial groups to European Americans on a national level. This study is relevant, as it indicates that inequitable treatment still exists in terms of acceptance rates for African Americans and successful closure rates for African Americans and Native Americans.

Despite a wealth of information on multicultural counseling it has been noted that we seem to know more about inequities in counseling than about setting up responsive services (Rosenthal & Kosciulek, 1996). Practitioners and organizations across disciplines have been proposing and adopting competencies and standards to guide in providing multiculturally competent services.

In the field of substance abuse, practitioners have been exploring the problem of providing treatment and prevention services to culturally diverse populations. Despite the 1992 amendments to the Rehabilitation Act of 1973, which acknowledges that inequitable treatment of minorities had occurred in the state - federal vocational rehabilitation system, the field of rehabilitation has been slow in developing culturally responsive services for minority group clients. Just recently, The National Association of Multicultural Rehabilitation Concerns (NAMRC) endorsed the professional multicultural rehabilitation counseling competency standards developed by Middleton et al. (2002). The authors of this document noted that it should be viewed as the "minimal competencies for rehabilitation counselors to skillfully and competently serve historically under-represented racial and ethnic populations". These "traditionally underserved populations" which was referred to in Section 21 of the amendments included all racial minority groups (i.e., Native American, Hispanic American, Asian American, and African American). The amendments specifically mentioned that a larger percentage of African American applicants when compared to White applicants were denied acceptance into the VR system. To date, there has been no endorsement of multicultural competencies by the Commission on Rehabilitation Counselor Certification. The omission of the issue of culture,

race or ethnicity in the provision of clinical services to African Americans by many programs can be detrimental to the client as well as the treatment agency, as this impacts negatively on service provision and utilization (Dozier & White, 1998). Continued minority status, oppression, and other socio-political factors are examples of some of the ways that African Americans differ from other Americans (Sue & Sue, 1990).

Researchers have long noted that traditional western theories of counseling and psychotherapy are often effective in bringing about positive outcomes among people from the dominant cultural-racial group in the U.S.; but, numerous scholars of African American psychology including Akbar (1974, 1981), Brown (1999), Howard-Hamilton and Behar-Horenstein (1995), Helms (1984), Lee (1991), and Parham (1989) take issue with the appropriateness of using such traditional helping strategies with clients of African descent. All raise important questions regarding the use of these strategies when working with African American clients. The overuse of universally accepted views about mental health and psychological well being in the counseling profession can lead to an unethical imposition of values when working with people from culturally diverse client populations (Daniels, Arredondo, & McAndrea, 2001).

Ethnically competent practice with persons from racial/ethnic minority groups should consist of a multicultural perspective that adheres to the cultural values and sociocultural reality of the specific group (Chau, 1991). Health and human service professionals are challenged on an ongoing basis to provide increasingly effective services to ethnic groups including African Americans.

Practitioners across disciplines tend to agree on the significance of cultural factors in the socialization process. Consequently, each culture has its own unique values, beliefs, norms and dynamics which makes it impossible to treat all clients or groups from the same theoretical perspective.

Kunce and Vales (1984), suggested that the success of rehabilitation counseling services to ethnic minorities depends on the counselor's understanding of the life factors unique to clients whose sociocultural experiences are different. Challenges facing African Americans with disabilities are varied and complex and require counseling approaches sensitive to the characteristics of the African American community. Atkinson, Morten, and Sue (1989) reported that African Americans are the largest racial minority group in the nation and though progress has been made in past decades, discrepancies still exist in many areas. According to

research, this group still suffers the most severe underemployment,

unemployment, undereducation, and miseducation compared to any other

group and the impact of economic and educational disparities on the African

American community is particularly felt by those members with disabilities.

(Smart & Smart, 1994).

Issues for Rehabilitation Counselors to Consider

According to Ficke, (1992) the state-federal vocational rehabilitation

system is one of the largest service providers to persons with disabilities in

the nation. However, policy programs for delivery of services have

historically been designed for the general population and have not been

adequate for persons with disabilities from minority groups (Brown, 1993).

Acceptance into the program has often been a problem for minority group

members (Atkins & Wright, 1980; Dziekan & Okocha, 1993; Wheaton,

1995; Wilson, 1999). These issues of adversity for minorities in accessing

the system has surmountable implications when consideration is given to the

higher rates of disability for minority groups (Hayes-Bautista, 1992;

Marshall, 1987).

Atkins, (1988) outlined a research based asset-orientation approach to

providing services to African Americans with disabilities. The premise of

this approach is in the spirit of adherence to rehabilitation philosophy to

facilitate growth and development. "The counselor is caught between efforts to ameliorate the immediate problems of a particular client and an awareness that only deeper social reform can eliminate the general conditions creating the problems" (Raphael 1972, as cited in Atkins, 1988). Atkins declares that "it is incumbent upon rehabilitationists to adhere to their philosophy which espouses efforts to compensate for limitations, advocate for assets, and equalize opportunities for competing in mainstream American." A list of assumptions embraced by this approach are listed below:

(1) All persons deserve freedom to choose and the responsibility of their choices.

(2) Different does not equate with negative, bad, evil.

(3) All individuals can learn and Blacks are no exception.

(4) Risk taking is the norm rather than the exception for competent people.

(5) Racism is a part of the fabric of American life and all persons in this society are victims of racism.

(6) Success can only be defined in the context of specific situations by specific individuals and groups. Thus success varies and is dynamic as a process and goal. The diversity of types of success is not only acceptable but desirable. (P.45-49).

In summary, Atkins suggests that this asset oriented approach to cross cultural issues for Blacks with disabilities (BWD) advocates for the belief that African Americans can be successful despite seemingly overwhelming negative odds. Regardless of the consequence of the disability, race and personal qualities, African Americans need to know that rehabilitation personnel will see their abilities.

Walker et al. (1986) in a study involving both state and private rehabilitation agencies around the country found that although there was a larger number of African Americans with disabilities, Caucasian Americans received services twice or three times as often as African Americans. Brewington, Daren, Anella, & Randall (1990) outlined obstacles to successful rehabilitation which includes the client, the nature of the program and society. Client variables could include: interests, work experience, motivation, education and skills. Program and societal factors include quality of staff, resources, and attitudes prevalent in the society which could affect how services are provided.

Wilson and Stith (1991) cited five critical issues to be considered when working with African American families: (a) historical perspectives on the experience of Black American families, (b) the current and historical and social support system of the Black American family, (c) the unique

characteristics of the value systems of Black American families, (d)

communication barriers that may hinder the development of trust and (e)

strategies for providing effective systems-based services to Black clients.

Dating back to slavery, African Americans share a socio-cultural

history and experience based on negative associations to race and color.

Researchers agree that African Americans' ancestors in slavery evolved

systems and relationships to meet their needs and these systems had their

roots in African form and tradition (Blassingame, 1979) . African

Americans' strong reliance on the church and kinship network is consistent

with the African values of sharing affiliation and spirituality.

Thus, rehabilitation counselors need to have a workable awareness of the

African American extended kinship network, which involves close

coherence of biological and non-biological members. The issue of role

flexibility must be understood, and when necessary incorporated into

rehabilitation planning. It is fairly common for extended family members to

take over child rearing to benefit the child. Young people frequently depend

on the extended family network for assistance with college or other post

secondary education or training and to make the transition to independence.

Wives and older children sometimes take over as the heads of the family. In

single parent families, the elasticity of the kin network is especially evident.

Many times, responsibility is assumed by grandparents, aunts, uncles, cousins, neighbors, church members, and others considered to be family members. It is not unlikely for an African American client to enter the rehabilitation process with a primary goal of becoming employed to reunite parts of the core family unit who may be in the care of other relatives or kin. This concept of collective support and communalism is grounded in African tradition. The strength of the extended family is a valued component of family survival.

Role flexibility is mobilized in times of crisis, such as separation, illness hospitalization, or death of a family member. Poor or working class African American families who live in urban areas are disproportionately affected by unemployment and health crises that tax their networks emotionally and financially. Family members who can provide assistance sometimes face obstacles from schools and human services agencies regarding the involvement of extended family members in these crises (Staples, 1985).

Culturally competent rehabilitation counselors must be willing to address the impact of political, socioeconomic and other environmental conditions, described by Aponte (1976, 1994) as "ecostructural" and as mentioned earlier, by Boyd-Franklin (1989) as the multi-systems approach

to treatment of African American families. It is significant that both of these models suggest that consideration be given to environment and community.

Sanchez-Hucles (2002) suggests that another issue important for practitioners to be aware of is "naming". Traditionally African Americans have a history of being disrespected by the names they have been called. These names have evolved from Negro to Colored to Black during the civil rights era to Afro-American and, more recently, to African American. Not all Black Americans are comfortable with being referred to as Black or African American. Many older persons who had to deal with negative stereotyping are uncomfortable and ambivalent about the newer terms.

Clients begin their rehabilitation programs with their own set of beliefs, attitudes, values and goals. They meet rehabilitation counselors with their own beliefs, attitudes, values, and goals. Life experiences is another significant factor in service delivery, and being an African American exposes one to a unique set of life experiences which shape an individual's world- view. African Americans needing rehabilitation services are aware of negative stereotypes and attitudes held by the society in general. They know that slow economic progress is often attributed to laziness and lack of motivation to work hard (Atkins, 1988). This notion often stands in the way of African American clients seeking services. When services are sought

these sometimes preconceived notions on the part of the client, the counselors, and often times agencies, many times impacts client success.

Feist-Price and Harley (2000), affirm that career counseling for African Americans with disabilities should be based on a cross-cultural, multi-dimensional perspective. Additionally counselors should develop a range of culturally relevant skills and attain knowledge about their clients' culture and an understanding of the effects of oppression and discrimination on the psychological and career development of African Americans, thus enabling the provision of effective culturally relevant and individual specific service delivery.

Mental Illness in America

People with mental illness represent the largest single disability group in the state-federal vocational rehabilitation system (Ford, 1995). In any given year, more than five million Americans suffer from an acute episode of mental illness. One out of every five families is affected in their lifetime by a severe mental illness, such as bipolar disorder, schizophrenia, major depression, obsessive compulsive disorder and/or a combination (sometimes two) of any of the aforementioned. Statistics confirm that 23 percent of American adults aged 18 and older suffer from a diagnosable mental disorder in a given year. Of the total 1,012,582 hospital admissions in the

U.S. in 1998, 261,903 (25.8 %) were psychiatric admissions. In 1990 the total cost of mental health services in the U.S. was $148 billion. The direct cost of mental health services (treatment and rehabilitation cost) totaled $69 billion and the indirect costs (lost productivity at work, school, or home due to disability or death) were estimated at $78.6 billion.

Severe mental illness interferes with employment. The National Alliance for the Mentally Ill (2000) reports the following information:

1. An estimated 57 percent of adults with serious mental illnesses were not employed in 1990 compared to 29 percent of the general population.

2. Approximately one-third of the estimated 600,000 homeless people in the United States have a severe mental illness and only five to seven percent of homeless persons with a mental illness need to be institutionalized. Most can live in the community with appropriate housing supports.

3. In 1998, 283,800 people with mental illnesses were incarcerated in American prisons and jails. This is four times the number of people in state mental hospitals throughout the country. Sixteen percent of state prison inmates, seven percent of federal inmates, 16 percent of people in local jails and 16 percent of probationers have

reported a mental illness. Mentally ill offenders are more likely

than other offenders to have a history of substance

abuse/dependency and a higher rate of homelessness and

unemployment prior to incarceration.

Given this extensive data on mental illness in America, it is not

surprising that rehabilitation counselors are profoundly challenged by the

number of persons with severe and persistent mental disabilities. In order to

adequately cover this section, two themes have emerged, a discussion of

(1) Mental Illness Among African Americans and Other Minorities,

followed by (2) Rehabilitation Services to Persons with Severe Mental

Illness.

Mental Illness Among African Americans and Other Minorities

In recent years, there has been a greater recognition and realization of

the influence of culture in the individual expression of mental distress in

psychiatric diagnosis and treatment and in the delivery of care community

wide (Gaw, 1993). Culture influences how symptoms are manifested, family

and community supports, style of coping, and willingness of seek treatments.

Culture and social influences are not the only determinants of mental illness

but they do play important roles. Ethnic and racial minorities in the United

States face a social and economic environment of inequality that includes

greater exposure to racism, discrimination, violence, and poverty (Surgeon

General's Report/on Mental Health, Culture, Race, Ethnicity, 2001).

According to Korchin (1980), psychological disorders are most prominent

among the lowest socioeconomic classes and racial minorities are over-

represented among the low income population. The U. S. Surgeon General

still declares this to be true 20 years later. Ogbu (1987) pointed out that

those racial/ethnic groups that became minorities in the United States

involuntarily through slavery, conquest or colonization such as: Native

Americans, Native Hawaiians, and African Americans are among the very

lowest socioeconomic groups. The negative affects of poverty, which

include anxiety, depression, low self-esteem, poor school attendance and

loneliness have been documented for various ethnic minority populations

(Canino, Earley, & Roger, 1980; Chin, 1983; Torres-Matrullo, 1976).

Smith (1985) reviewed literature on race and psychopathology and

concluded that African Americans in particular and other minorities in

general have more psychological disorders than whites, except when class is

considered. Even then evidence revealed that African Americans and other

minorities are subjected to more stress than their white counterparts. In

conclusion, Smith asserted that prejudice, discrimination and hostility are

stressor stimuli experienced by African Americans and other racial/ethnic minorities that contribute to their mental health problems.

The Surgeon General's Mental Health Report (1999) indicated that historical experiences of racial/ethnic groups in the U.S. are reflected in differences in economic, social, and political status. The most measurable differences relate to income, which is limited for many racial ethnic groups. Income, education, and occupation have been strongly linked to mental illness. Decades of research have confirmed that people in the lowest socioeconomic strata are two and a half times more likely to have a mental disorder (Regier et al., 1993). Current data also confirms that there are significant differences in the prevalence of mental health problems between groups based on color, income, and residence.

Specifically, the prevalence of mental disorders among African Americans is estimated to be higher than among European Americans (Regier et al, 1993). The rate of utilization of psychiatric inpatient care for African Americans is double that of Whites (Snowden & Cheung, 1990), which is a higher difference than would be expected on the basis of prevalence estimates (Surgeon General's Mental Health Report, 1999).

In 1963, when President Kennedy enacted legislation to fund the establishment of community mental health centers, this policy was based on

views about the frequency of mental illness among African Americans and other urban populations (National Panel on Managed Mental Health Services for Consumers of African Descent, 1998). Accurate data, however, on incidence and prevalence relating African Americans and mental health is not available (Sanchez-Hucles, 2002). The problem this author cites is that "data about Blacks occur in race comparison studies that focus primarily on Whites. Information on African Americans is poorly documented and interpretations can be misleading because findings on White individuals are not interchangeable with the Black racial and cultural experience" (p.31).

Rehabilitation Services to Persons with Severe Mental Illness

The literature illustrates that there are many issues. Helping persons with mental illness find and keep employment has been problematic and is arguably one of the most significant failures of the public and private rehabilitation systems in the United States. Individuals with mental disabilities fair poorly in the labor market, despite a variety of efforts (Bond & McDowell, 1991). Persons with mental illness require extensive, creative support provided intermittently to acquire and maintain employment (Marrone,J., Balzell, A., & Gold, M. 1995). Assistance given to this population must be offered in the context of a caring, hopeful, supportive relationship between the counselor and the client (Byrne et al., 1994).

Further, persons with mental illnesses require coordinated efforts from an array of health and social service agencies. Frey (1994) conducted a survey of literature which supported the need for strategies to enhance vocational outcome for persons with mental disabilities and advocated for vocational rehabilitation to be considered as a critical element in the overall rehabilitation and treatment process.

Lack of substantial attachment to the labor market, educational qualifications, and functional competencies becomes a significant issue in spite of a strong desire to work. "Many rehabilitation counselors are overwhelmed because of the increased referrals and complexities of clients with a primary disability of a mental or emotional nature" (Garske, 1992, 1999, p.21). In comparison to persons with physical disabilities, who usually benefit from the methodology of the public rehabilitation agency, persons with psychiatric disabilities have a more difficult time. Individuals with severe mental illness experience limitations in everyday functioning. These may include difficulties with basic interpersonal relations, low stress tolerance, difficulty concentrating, and lack of energy or initiative (Bond, 1995). Despite the suffering and personal and financial costs resulting from mental illness, society has not always considered the needs of people with this mental disability, or their right to live independently. In contrast,

persons with physical disabilities evoke concern and recognition of their needs more readily (National Mental Health Strategy, Common Wealth of Australia, 1999).

As part of their professional training, rehabilitation counselors, acquire skills in vocational assessment, counseling strategies and job placement techniques (Katz, Geckle, Goldstein, & Eichenmuller, 1990). This generalist training limits knowledge and experience in working with persons with psychiatric disabilities. This lack of knowledge about psychiatric disabilities can be presumed to contribute to poor outcomes for persons with mental disabilities (Kress-Shull, 1999).

In a study involving over 600 mental health, vocational rehabilitation and provider agency staff from six states, Katz, Geckle, Goldstein and Eichenmuller (1990) asked participants to identify areas for needed training related to skill and knowledge. Among deficits identified for needed training were: psychiatric terminology, use of the Diagnostic and Statistical Manual, counseling methods in working with persons with severe mental illnesses, treatment modalities and identifying signs and symptoms of decompensation. A lack of experience and training in working with persons with serious mental illness was reported along with lack of knowledge about medication and its side effects. Similarly, staff from mental health agencies

reported a lack of knowledge and skill in areas related to vocational assessment, services and job placement. Vocational rehabilitation providers identified the same skill deficits basically as rehabilitation counselors. All three groups reported that it was the nature of the illness itself that presented a problem.

Participants in this study identified numerous barriers to serving clients with psychiatric disabilities that the investigators deemed were created by the respective agencies. These barriers included lack of staff, limited resources, and inadequate space. Differences in agency goals and mandates were identified by all three groups in the study as creating problems for them in service provision. Providers' attitudes towards mental illness and sharing of information also impacted services to clients across agencies participating in this study.

In a recent study by Shafer, Pardee, and Stewart (1999), participants in a six state region which included rehabilitation counselors and technicians, mental health therapists, employment counselors and job coaches, nurses, supervisors, and others were asked to rate their training needs from a list of 22 needs, and were also asked to rate their level of information/training need for each topic on a four point Likert scale. Items receiving the highest ratings were strategies for working with unmotivated

clients, assessing the vocational needs of persons with mental illnesses and planning and implementing job retention strategies. There were no between group differences examined but it can be speculated that training needs varied. Training needs identified in this study and in the Katz et al., 1990 study illustrate the need to address competencies in working with individuals with severe mental illnesses (Kress-Shull, 2000).

Multicultural Competencies for Rehabilitation Counselors

Working with Clients with Severe Mental Illness

"The understanding of mental illness is only one facet of the rehabilitation process. Each person has strengths, talents, personality, and life experiences which affect the experience of a mental illness and the rehabilitation process" (Hughes,& Weinstein 2000, p. 1).

The Surgeon General's report (2001), *Mental Health: Culture, Race, Ethnicity* is headlined, *Main Message: Culture Counts*. The report emphasizes that culture and society play pivotal roles in mental health, mental illness, and mental health services. Understanding the roles of culture and society enables the mental health field to design and deliver services that are more responsive to the needs of racial and ethnic minorities. Similar to outpatient mental health workers, counselors are challenged by the

increasing number of people with severe and lifelong psychiatric disabilities. Although rehabilitation counselor involvement with this population is difficult, it is necessary and appropriate. According to Bond (1995), "psychiatric rehabilitation provides individuals with mental disabilities the opportunity to work, live in the community and enjoy a social life, at their own pace, through planned experiences in a respectful, supportive and realistic atmosphere."

Because persons with psychiatric disabilities are the largest single disability group receiving services in the state-federal vocational rehabilitation system, and the Surgeon General of the United States has acknowledged disparities in the care of ethnic minority group members with mental illness, the fact that specific competencies are needed for this segment of the population can not be ignored. This section will be discussed under the headings of (1) General Cultural Considerations for Providing Rehabilitation Services to Racial/Ethnic Minority Group Members with Mental Illness and (2) Considerations for Providing Rehabilitation Services to African Americans with Mental Illness.

General Cultural Considerations for Providing Rehabilitation Services to

Racial/Ethnic Minority Group Members with Mental Illness

"Recognition of the complexity of cultural influences is more difficult than ignoring these influences or simplifying them in a singular dimension. But in the long run, can lead to a much deeper understanding of our clients and ourselves" (Hays, 2001).

Influences noted by Hays (2001), include:

1. age and generational influences

2. developmental and acquired disabilities

3. religion and spiritual orientation

4. ethnicity

5. socioeconomic status

6. indigenous heritage

7. national origin

8. gender.

Counselors are professionally and ethnically bound to "actively attempt to understand the diverse cultural background of the clients with whom they work. This includes but is not limited to, learning how the counselor's own cultural/ethnic/racial identity impacts her/his values and beliefs about the counseling process" (American Counseling Association

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1997, Section A.2b., p. 2). The possibility of treating culturally diverse

clients seeking mental health services is challenging service providers to

question their preparedness and competence to do so (Parham, 1989). In

cases where counselors consider themselves ill prepared to service culturally

different clients, it is not unusual for a counselor to refer the client to a

counselor who is "more competent" in working with a particular client (i.e.

African American) Brown, Parham& Yonker (1996). Although referral is a

consideration, the increasing number of culturally diverse clients seeking

professional mental health assistance (Lee, 1991) coupled with shrinking

resources may not always provide practitioners the luxury of referral.

Implications for a model to train rehabilitation counselors to work

effectively with culturally diverse clients with mental illness are well

documented in the literature. Brown, Parham& Yonker, (1996) conducted a

study to determine the influence of a cross-cultural course on the racial

identity of White graduate students. The authors' rationale for this study was

based on the following demographic information: by the year 2000, the

numbers of employed counselors were projected to increase by 33,000, yet

the increase in the number of counselors of color is uncertain (Axelson,

1999) and is projected to be insufficient. Further, the number of diverse

clients is projected to increase (Lee, 1991), continuing a scenario reflecting

more White counselors than counselors of color serving increased numbers of diverse clients (Brown, Parham & Yonker, 1996).

Participants for the study were recruited from students pursuing a master's degree enrolled in two 16-week graduate-level multicultural counseling courses taught in a mid-size mid-western university. A total of 41 White graduate counselors-in-training (28 women, 13 men) volunteered. Each participant was asked to complete a demographic scale, the White Racial Identity Attitude Scale (WRIAS) developed by Helms & Carter (1990), and an informed consent form. The students were exposed to experiences that (a) encouraged group bonding (b) promoted a nurturing and challenging learning environment, (c) raised consciousness of personal biases and oppressive behaviors, and (d) promoted relating knowledge of self (the person) to knowledge of self (the professional) in working with racially different clients. They also experienced guest speakers whose heritage was representative of five ethnocultural groups, (African American, Asian, Latin, Native American, and White American) and were required to interact with the speakers reviewing knowledge about issues history, and dynamics of the speakers' racial-ethnic heritage. Finally, the participants were required to submit a written project: "*Counseling the Culturally Diverse Client: From Awareness to Action*."

Of the 41 participants, 6 failed to complete either the pre- or post WRIAS, resulting in an 85% return rate which included 25 women and 10 men. The results indicated that a cross-cultural counseling course changed, on average, the racial identity attitudes of White counselors-in-training. The degree of influence seemed to be impacted by gender with females having been influenced to a greater degree than males, but males did exhibit significant attitude change. The findings suggested that the racial identity attitudes of White female and male counselors-in-training are significantly influenced by their enrollment in a cross-cultural course. The data also suggest that training emphasizing self-awareness as a step toward knowledge and skill development may enhance the way course content is received. These findings could be useful in developing curricula for training White counselors-in-training enrolled in multicultural counseling courses.

Considerations for Providing Rehabilitation Services to African Americans with Mental Illness

The status of an African-American person with mental illness was characterized by Judith Rabkin, (1979): "If we wished to describe one of the most stigmatized persons in our society, that person would be a mentally ill man, probably black, violent, who hears voices, shows bizarre behavior and lacks social ties in the community."

There are myths and stereotypes that resulted from racism and that influenced diagnoses, treatment, and research decisions. During reconstruction, census figures were falsified to show an increase in the incidence of mental illness in African Americans who had "lost the benefits of slavery" (Deutsch, 1944). For Blacks who were truly mentally ill in the 1800's , access to care was often a problem. It was noted by Prudhomme & Musto (1973) that only a few northern mental hospitals admitted African Americans, who were kept in segregated units, but the majority of mentally ill African Americans were admitted to almshouses or placed in jail. Psychiatric literature in the early 1900's characterized African Americans as "too emotional, sexually promiscuous, lazy, in need of authority, criminally inclined and unintelligent" (Bevis, 1921, p. 71). A review of literature by Wilson and Lantz (1957) revealed that reports written between 1868 and 1952 stated that African Americans were either too inferior or lacked the intrapsychic framework to become depressed.

In spite of a history of negative stereotyping, it is thought to be characteristic of African Americans to take pride in the ability to survive and endure adversity in a largely hostile, racist environment (Gaw, 1993). A general lack of understanding and awareness of what it means to be an African American can interfere with the counselor's effectiveness to work

with clients who are African American. Jereb (1982) contends that African American clients may be more resistant to social services due to a lack of counselor understanding regarding the African American perspective. Consequently, lack of both understanding and empathy on the part of the rehabilitation counselor may result. Specifically, how can a middle-class Anglo American rehabilitation counselor put him or herself in the place of a low income, African American, disabled client who complains about feelings of hopelessness relative to fatalism, lack of employment or education, or being discriminated against (Feist-Price & Ford-Harris, 1994).

Some of the challenges to providing appropriate rehabilitation services to culturally diverse individuals with mental illness, including African Americans is, (a) understanding that every racial/ethnic group does not share a particular measure of "normal" behavior, (b) the belief that everyone depends on linear thinking to understand the world around them, where each cause has an effect and each effect is tied to a cause, (c) believing that history is not relevant for a proper understanding of contemporary events, (d) clients are helped by formal counseling opposed to their natural support systems.

Some generic characteristics of counseling that may not be conducive to working with African Americans are:

1. verbal communication

2. individual centered

3. openness and intimacy

4. standard English

5. clear distinction between physical and mental well being

6. nuclear family

Bellini's (2002) study, although not about persons with mental illness, is an investigation providing an analysis of the relationship between race, vocational rehabilitation services and the rehabilitation outcomes for a specific disability (Mental Retardation). The sample consisted of 188 African American and European American consumers with severe or profound mental retardation closed in statuses 26 or 28 by VR agencies in a Midwestern state. African Americans made up 33% (62) and European Americans were 67% (126). Other racial ethnic groups were not included because of low numbers. Data were obtained from the RSA database for a Midwestern state. The results of the study identified race and job placement as variables significantly related to job placement. In other words, race and job placement appeared to positively affect closure success for persons with this specific disability. Findings suggest that Caucasians with this particular disability were more likely to achieve successful closure status. One

explanation for this may be as the particular disability becomes more severe, there is likewise a greater possibility that race will negatively affect the rehabilitation process. Bellini has named this possibility the "severity-race correlation theory". The counselor's level of cultural competencies has a greater possibility of negatively influencing the quality of services provided to consumers who are racial and ethnic members of underrepresented groups.

This study was the first to explore the relationships between rehabilitation outcomes for persons with a specific disability (mental retardation) and race and state VR services. The authors noted that in the complexity of relationships between race, VR services, and rehabilitation outcomes, this study is only the beginning (Moore, Feist-Price, & Alston, 2002).

Summary

The literature confirms that rehabilitation counselors working with African Americans with mental illness should be aware of the historical perspective, social and political influences, cultural influences and counselors' own biases. African Americans are the largest ethnic minority group in the U.S. and represent a disproportionate percentage of the disabled population. Considering that persons with psychiatric disabilities are among

the single most prevalent disability group being served in the state-federal

rehabilitation system, a significant number of African Americans with

mental illness are requesting VR services. There is extensive documentation

for the need for multicultural training of vocational rehabilitation counselors,

and an urgent call for VR counselors to receive psychiatric rehabilitation

training during graduate school, and/or in-service training provided by their

respective agencies.

Rehabilitation counselors working with African American clients with

mental illness must have an awareness of African American culture, the

relationship between culture and development, and the racism that has

affected African Americans. Even with the sharing of a common history and

basic cultural traditions, each client should be considered individually with

recognition of intra cultural differences, generational, socioeconomic and

geographic factors which are very relevant to effective service provision.

What we do know is that a disproportionate number of African

Americans, especially those in urban areas, are diagnosed with more mental

illnesses than any other racial/ethnic group including European Americans.

Appropriate culturally relevant strategies do need to be developed to

enhance the availability of effective mental health care and rehabilitation

services to this group. Counseling interventions that incorporate elements of

a group's cultural value system serve to motivate and empower the individual customer (Quinnones-Mayo, Wilson, & McGuire, 2000).

There is an increasing number of clients with severe and lifelong psychiatric disorders. Research suggests that vocational rehabilitation programs have demonstrated limited success for people with severe mental illness (Garske, 1999), and the racial/cultural influences manifested in the illness. This study will contribute to a body of information relating to vocational rehabilitation counselors working with African American clients who have mental illness and will provide implications for training current and future counselors. The methodology for this study is discussed in Chapter 3.

CHAPTER 3

Research Design and Methodology

This study surveyed rehabilitation counselors with regard to their perceived multicultural counseling competence in working with clients with mental disability, and specifically with African American clients with mental disability. The literature review strongly suggested that cultural values relating to the environment, family structure, and belief systems (political and spiritual) impacts treatment and rehabilitation issues for this population. It is imperative for counselors to have specific culturally responsive competencies, and that their skills are equally effective across ethnic groups. Three instruments and a demographic survey were used to collect data. The independent variables included the counselors' age, gender, ethnic background, formal multicultural training, and experience. Dependent variables were counselors' perception and self assessment of their multicultural counseling competence, their self-assessed multicultural counseling competence with diverse clients with mental illness and their self-assessed multicultural counseling competence with African-Americans with mental illness. In addition, one analysis concentrated on differences in counselors' competencies with individuals with mental disabilities across ethnic groups.

The following questions guided this study:

1. Is there a relationship between the following set of variables: rehabilitation counselors' age, gender, ethnic background, multicultural training, and years of experience, and their perception of :

   a) their multicultural knowledge?

   b) their understanding of multicultural terminology?

   c) their multicultural awareness?

   d) their multicultural skills?

   e) their self-assessed competence in counseling racial and ethnic minorities with mental illness?

2. In their work with racially and ethnically diverse clients with mental illness, how do White and African American rehabilitation counselors compare in:

   f) their verbal communication of acceptance of mental illness?

   g) their non-verbal communication of acceptance of mental illness?

   h) their success in producing desired outcomes?

   i) their perceived levels of difficulty in working with these client groups?

   j) their perception of the success of their rehabilitation training in preparing them to work with these client groups?

3. In their work with racially and ethnically diverse clients with mental illness, how do White and African American rehabilitation counselors compare in the extent to which they:

   a) make referrals for education about community resources?

   b) provide encouragement of family involvement in the rehabilitation process?

   c) make referrals for group therapy/counseling?

   d) make referrals to assist with socialization needs?

4. How do White and African American rehabilitation counselors compare in their attitudes toward African Americans given a number of social and personal incidents and situations?

To investigate rehabilitation counselors' self perceived multicultural competence in working with clients with mental illness across racial/ethnic groups and their attitudes toward African Americans, the following null hypotheses were tested:

Ho 1. There will be no significant relationship between counselors' age, gender, ethnic background, multicultural training and experience, and their perception of:

   a) their multicultural knowledge

   b) their understanding of multicultural terminology

c) their multicultural awareness

d) their multicultural skills

e) their self assessed competence in counseling racial ethnic minorities with mental illness,

Ho 2. No significant difference in comparison between African American and White rehabilitation counselors will be identified by their:

a) verbal communication of acceptance of mental illness

b) non-verbal communication of acceptance of mental illness

c) success in producing desired outcomes

d) perceived levels of difficulty in working with these client groups

e) perception of the success of their rehabilitation training in preparing them to work with these clients

Ho 3. No significant difference will be reported in comparison between African American and White rehabilitation counselors in their work with racially and ethnically diverse clients by the extent to which they:

a) make referrals for education about community resources

b) provide encouragement of family involvement in the rehabilitation process

c) make referrals for group therapy/counseling

  d) make referrals to assist with socialization needs

Ho 4. No significant difference will be reported by African American and

  White rehabilitation counselors in their attitudes towards African

  Americans given a number of social and personal incidents and

  situations.

Population and Sample

  The population of interest was rehabilitation counselors in the United

States. A random sample of 700 counselors was obtained from the National

Rehabilitation Association and the American Counseling Association. A

mailing was sent to all counselors on the lists. Based on responses to other

researchers' requests, it was anticipated that approximately 225 counselors

would respond.

Instrumentation

  Participants completed a demographic questionnaire, an adapted version

of the Multicultural Counseling Competence and Training Survey

(Holcomb-McCoy, 1999), a researcher-generated tool, the Mental Health

Self Assessment for Counseling Competencies, and the Situational Attitude

Scale Form B - Prejudice Against Blacks, (Sedlacek & Brooks, 1970).

Demographic Questionnaire

The demographic questionnaire consists of two parts, 1.personal information and 2.work experience (See Appendix A for complete questionnaire). Personal data include age, gender, ethnic background, highest degree earned, and income level. Work experience data include work setting, state where employed, years of rehabilitation counseling experience, years of experience working with persons with mental illness and percentage of clients with documented disability of mental illness, number of hours of rehabilitation counseling training, courses taken on mental illness, ethnic background of clients served, and licensures/certifications. It takes less than five minutes to complete.

Multicultural Counseling Competence and Training Survey

The Multicultural Counseling Competence and Training Survey (Rehabilitation Counselor Version) (MCCTS-R), an adaptation of The Multicultural Counseling Competence and Training Survey (MCCTS), (Holcomb-McCoy, 1996) was developed to assess rehabilitation counselors' perceived competence in providing services to clients from differing racial ethnic groups. Specifically, the ethnic groups are defined as African/Black, European/White, Hispanic/Latino, Asian, and Native American. It consists of three parts. The first section contains two items regarding rehabilitation

counseling education. The second part asks counselors to rate themselves, on a 10 point Likert scale, on five multicultural competencies. An additional item requests counselors to indicate their need for training, and in the case of multiple needs, rank their need for additional training in the following areas: awareness of own cultural biases, knowledge of other cultural groups, and skills related to multicultural counseling. Scoring procedures for part two consist of summing together the point value of the responses to the five multicultural competencies and the reversed score value assigned to the three training needs. The reversal is necessary since a score of "3" will indicate more need for training (therefore less competency) than a score of "0", which would indicate no training needed (more competency). Once reversed, the scores may be added together so that higher scores will consistently reflect greater competency. Part three provides 16 multicultural counseling competencies based on the AMCD model, and asks counselors to rate their own level of competency on a four-point scale from "not competent" to extremely competent." The point values assigned to the items are summed for a total part three score. Internal consistency to establish reliability will be assessed using Cronbach Alpha. (See Appendix B for the instrument). The survey takes approximately 20 minutes to complete.

The original Multicultural Counseling and Training Survey was developed to determine professional counselors' perception of their multicultural counseling competence and the adequacy of their training. Feedback from persons considered experts in multicultural counseling issues and 17 professional counselors who piloted the instrument contributed input which resulted in a final revision, thus establishing validity. The survey consists of 61 items divided into 6 areas: (a) multicultural counseling curriculum in an entry-level graduate program, (b) faculty and students in entry-level program, (c) multicultural clinical experiences in entry-level program, (d) post graduate multicultural training and experience, (e) demographic information, and (f) self assessment of multicultural counseling competence and training. Parts 1 through 4 required the participants to provide information on their entry level and post-graduate multicultural counseling training experiences. Part 5 included demographic information such as sex, age, ethnic background, year of graduation with highest degree, and accreditation status of graduate counseling program. Part 6 included 32 behaviorally based statements that were based on the AMCD's Operationalized Multicultural Counseling Competencies and Explanatory Statements developed to assess and report on three areas for each statement: (a) self-perceived competence, (b) adequacy of training received concerning

this specific competency, and (c) types of training received. Competence was rated using a 4-point Likert-type scale: 4 = extremely competent, 3 = competent, 2 = somewhat competent, and 1 = not competent. A 4-point Likert style scale: 4 = more than adequate training, 3 = adequate, 2 = less than adequate and 1 = no training received was developed to assess the adequacy of training, and options including: multicultural course(s) in entry level counseling program; core counseling courses involving multicultural content; informal professional development activities (e.g., workshops, seminars); and advanced degree programs, assesses where training is received (Holcomb-McCoy, 2000).

Factor analysis of the 32 behaviorally based statements in part 6 indicated the dominance of five factors. Based on the performance of an oblimin rotation, five factors emerged: factor I, awareness; factor II, knowledge; factor III, definitions of terms; factor IV, racial identity development; and factor V, skills. All are included in the multicultural competencies developed by AMCD. Results were analyzed using the SPSS statistical package. A principle components factor analysis was performed to investigate the underlying factors of the items in Part 6 of the survey. Frequencies, means and standard deviations were computed for all items. The internal consistency reliability of the factor scores were calculated.

One-way analyses of variance were computed using selected demographic

information, individual items and the five factor scores that emerged from

the data analyses.

The results suggested that racial identity development and definition of

terms (factors III and IV) along with awareness, knowledge and skills are

significant factors of multicultural competence and implied that there could

be a possible limitation in current multicultural training since most training

tends to focus primarily on multicultural competence – awareness,

knowledge, and skills (Holcomb-McCoy & Myers, 1999).

Mental Health Self Assessment for Counseling Competencies

The Mental Health Self Assessment for Counseling Competencies

(MHSACC) was generated by the researcher to assess counselors'

multicultural competencies across ethnic groups with regard to clients with

mental illness. This survey has two sections. The first consists of 10

competency statements contained within six items. Counselors were required

to rate each competency on a four-point Likert scale, as it applies to each of

the ethnic groups listed. Ethnic groups are categorized as follows:

African/Black, European/White, Hispanic/Latino, Asian, Native American,

and Other. Thus, there were multiple answers for each item. With regard to

the scoring of the items, item four was scored in reverse, since this item asks

about the degree of difficulty counselors perceive in working with the various ethnic groups, and a higher score reflected a greater degree of difficulty, thus a lesser degree of competency. Each counselor received a total score, based on the point value assigned to the items. Higher scores reflected a greater degree of competency. It should be noted that item seven was not included in the score. This item deals with the sources which most influence counselors' beliefs and attitudes toward multicultural counseling for clients with mental illness. These data were analyzed descriptively. The second section of the survey consists of 15 competencies. Counselors were asked to continue their self-evaluation of their competencies as related to working with mental health clients. These competencies are rated on a five-point Likert scale ranging from very low to very high. The total score for this section is obtained by summing the point values of each item. Once again, higher scores denote greater competency. The internal consistency reliability of the scores was assessed using Cronbach's alpha.

A review of the Multicultural Rehabilitation Competencies and Standards provided the foundation for development of the survey. Instruments reviewed included the Mental Health Attitude Scale, the Diversity Self Assessment, the Program Self-Assessment Survey for Cultural Competence and the Personal Assistance Services Study of Health

and Well-Being. The researcher requested volunteer counselors from the Division of Rehabilitation Services in Maryland to participate in a focus group to identify key words or phrases describing culturally relevant services for clients with severe mental illness. Eight counselors volunteered; all provided feedback which was compared with the competencies identified in the Endorsement of Professional Multicultural Rehabilitation Competencies and Standards (Middleton et al., 2000). Competencies involving working with persons of differing ethnic groups with mental illness are addressed as well as competencies in mental health service provision and descriptive statements, skills, knowledge and values.

Thirteen rehabilitation counselors pilot tested the instrument and slight changes were made in wording and scoring procedures as per their feedback. Thereafter, 16 experts, consisting of 14 rehabilitation counselors from state and private agencies, one rehabilitation educator from the Department of Health, and one former university professor of tests and measurements in rehabilitation established content validity.

The Situational Attitude Scale (SAS)

The Situational Attitude Scale (Sedlacek & Brooks, 1970) is a questionnaire which measures how people think and feel about a number of personal and social incidents and situations. The SAS was originally

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developed to measure attitudes of Whites towards Blacks, two forms, A and B, contained the same situations with 10 bipolar scales and instructions, except the word Black was inserted into each situation in Form B. Form A made no reference to race. In this current study only Form B is being utilized to compare White and African American counselor attitudes towards African Americans. Nine of the original ten personal and social situations, each with ten bipolar differential scales, were used, making a total of 90 items on this scale to be included in this study.

The SAS has been used in several studies, involving attitudes toward racial and ethnic groups, i.e., Blacks (Balenger, Hoffman, & Sedlacek, 1992), Hispanics (White & Sedlacek, 1987) and Jews (Gerson & Sedlacek, 1992). This instrument has also been used to measure attitudes toward persons with disabilities (McQuilkin, Freitag, & Harris, 1990); African American clients (Stovall, 1989); and counselor attitudes toward aging African Americans (Gill, 1993). The reliability and validity of the Situational Attitude Scale (Sedlacek & Brooks, 1970) has been established by the varied studies for which it has been utilized. Sedlacek (1996), and Engstrom and Sedlacek, (1991) cited that the "SAS has been designed to elicit both overt and less conscious feelings and to control socially desirable responses".

The reliability of the SAS was established at the .64 range for Form A and .65 for Form B. These levels of reliability are acceptable for each form. The validity was determined by the mean response differences between the two forms. According to the authors, the validity of the SAS is internal (Sedlacek & Brooks, 1972). In the original study, Forms A & B were randomly assigned to participants anonymously, to 405 students at the University of Maryland. The sample included students from various departments, some of which were Arts & Sciences, Education, Business and Public Administration. Black students were eliminated from the study by identification of race on the response sheets. The Form B mean was always somewhat closer to the negative end of the spectrum than Form A. "The insertion of the word Black into the situation led to a more negative response than the neutral Form-A with no mention of race" (Sedlacek & Brook, 1970).

Procedures

Permission was obtained from the IRB of University of Maryland to conduct the study. A list of names and addresses, randomly generated, was obtained from the NRA and the ACA of 700 rehabilitation counselors from the U.S. Each counselor was sent a package of materials containing the following items:

1. A cover letter (See Appendix E) which explained the purpose of the study, provided a contact phone number and address for any questions, and a confidentiality statement. In addition, it made clear that the return of completed materials denoted the counselor's consent to participate. Counselors who choose not to participate were asked to indicate so by checking the appropriate box at the bottom of the letter and return it. This was included so that in the case of a second mailing, these individuals would not be approached again. The letter requested that the surveys be completed and returned within ten days of receipt.

2. Demographic Questionnaire.

3. The Multicultural Counseling Competence and Training Survey-(MCCTS-R) Rehabilitation version.

4. Mental Health Self Assessment for Counseling Competencies

5. The Situational Attitude Scale, Prejudice Towards Blacks version.

6. A number coded, stamped, addressed return envelope, to assure that a second mailing would not be sent to counselors who agreed to participate, or those who indicated they did not wish to do so.

It was anticipated that approximately 210 surveys would be returned. E-mail reminders were sent to ARCA members for which addresses were

available and mailings were sent to a number of NAMRC members. All data was analyzed with the SPSS statistical program.

Data Analysis

Descriptive statistics were used to summarize all data. Frequency distributions will be constructed for all nominal data on the demographic form (gender, ethnic background, highest degree earned, income level, work setting, state where employed, ethnic background of clients served, and licensures/certifications). Means and standard deviations were calculated for ratio and interval data (age, years of rehabilitation counseling experience, and number of hours of multicultural counseling training)**.** In addition, descriptive statistics were used to summarize all scores of the survey subscales**.** These data are presented in tables in chapter 4.

The original authors of the SAS (Sedlacek & Brooks, 1970) and the MCCTS (Holcomb-McCoy, 1999) conducted a number of studies to determine the reliability and validity of their instruments. Therefore, internal consistency tests of reliability were not conducted on those instruments for this particular study. However, since this was the first time using the MHSACC, an exploratory factor analysis was conducted. Factor analysis is a data-reduction technique used to determine the number of dimensions underlying a measurement instrument (Girden, 1996). It allows one to

reduce a large number of items or variables to a much smaller set of measures. In this study, the principal-components method of factor analysis was used to determine the dimensionality of the 15 items (i.e., items 7 – 21 on the MHSACC), used to assess counselors' self-assessed competence in counseling racial and ethnic minorities with mental illness. The criteria used to determine the number of factors to extract were the eigenvalue-over-one criteria and the scree test. Only one factor emerged from the items 7-21. Therefore, it was feasible to sum and average these items to derive a single measure of counselors' self-assessed competence in counseling racial and ethnic minorities with mental illness. The results of the factor analysis are discussed in chapter 4.

Research question 1-a thru e was analyzed with five simultaneous multiple regression analyses. Preliminary tests were run in order to:

1. check tolerances to avoid the problem of multicollinearity, and

2. examine residual scatter plots to assess any violations of assumptions. Since this is an exploratory study, a simultaneous entry method was used as it is important to assess the relative contribution of all the variables. The beta weights associated with each variable was examined for their relative contribution to the prediction equation, in the case that any significant multiple R-squared values were obtained.

The second and third research questions were analyzed using a split-plot analysis of variance (ANOVA) for each subquestion. ANOVAS with a split-plot design are appropriate when there is a between-subjects variable and a within-subjects variable. The between subjects variable consisted of two independent groups, that is, White and African American counselors. The within-subjects variable consisted of repeated measures across groups, that is, White and African American counselors will have completed the same scale five times, once for each ethnic group. The Huynh-Feldt correction was used to determine the F-values for the within-subjects variables in order to control for any violation of the sphericity assumption (Girden, 1992). Significant F-tests were followed up by pairwise comparisons using the Bonferroni procedure to control Type I error.

Question four was answered using a multivariate analysis of variance (MANOVA) for each subquestion. MANOVA is used to compare group difference on two or more dependent variables simultaneously (Bray & Maxwell, 1985). Significant F results were followed up with univariate ANOVAS on each dependent variable. The Bonferroni procedure was used to control for Type I error. The alpha level was set at .05 for all analyses. The results of the data analysis for this study will be reviewed in Chapter 4.

It is important to note that the researcher was more concerned with controlling for Type I error than Type II error in this study since it was thought that it would have been more serious to determine that there were significant mean differences among rehabilitation counselors' perceptions and attitudes when there were really no differences. Therefore, the probability of Type I error was set at .05 for all statistical analyses. However, significant split-plot ANOVA and MANOVA analyses were followed by pairwise comparisons that used rigorous alpha levels derived by the Bonferonni method.

CHAPTER 4

Results

This study examines and describes rehabilitation counselors'

perceptions of their multicultural competence in working with African

American and other culturally diverse clients with severe mental illness. It

also explores African American and White rehabilitation counselors'

attitudes toward African Americans given a number of personal and social

situations. This chapter reports the results of the data analyses related to the

following research questions and hypotheses:

1) Is there a relationship between the following sets of variables:

   rehabilitation counselors' age, gender, ethnic background, multicultural

   training, and years of experience and their perceptions of:

   a) their multicultural knowledge?

   b) their understanding of multicultural terminology?

   c) their multicultural awareness?

   d) their multicultural skills?

   e) their self-assessed competence in counseling racial and ethnic

       minorities with mental illness?

2) In their work with racially and ethnically diverse clients with mental illness, how do White and African American rehabilitation counselors compare in:

   a) their verbal communication of acceptance of clients with mental illness?

   b) their non-verbal communication of acceptance of clients with mental illness?

   c) their perceived success in producing desired client outcomes?

   d) their perceived levels of difficulty in working with these client groups?

   e) their perception of the success of their rehabilitation training in preparing them to work with these client groups?

3) In their work with racially and ethnically diverse clients with mental illness, how do White and African American rehabilitation counselors compare in the extent to which they:

   a) make referrals for education about community resources?

   b) provide encouragement of family involvement in the rehabilitation process?

   c) make referrals for group therapy/counseling?

   d) make referrals to assist with socialization needs?

4) How do White and African American rehabilitation counselors compare in their attitudes toward African Americans given a number of social and personal incidents and situations?

Hypotheses

Ho 1. No significant part of the variance in counselors' perception of their:

    a) multicultural knowledge

    b) understanding of multicultural terminology

    c) multicultural awareness

    d) multicultural skills

    e) self assessed competence in counseling racial ethnic minorities with mental illness, will be explained by counselors' age, gender, ethnic background, multicultural training and years of experience.

Ho 2. No significant difference in comparison between African American and White rehabilitation counselors will be identified by their:

    a) verbal communication of acceptance of mental illness

    b) non-verbal communication of acceptance of mental illness

    c) success in producing desired outcomes

    d) perceived levels of difficulty in working with these client groups

    e) perception of the success of their rehabilitation training in preparing them to work with these clients

Ho 3. No significant difference will be reported in comparison between

African American and White rehabilitation counselors in their work with

racially and ethnically diverse clients by the extent to which they:

a) make referrals for education about community resources

b) provide encouragement of family involvement in the rehabilitation

process

c) make referrals for group therapy/counseling

d) make referrals to assist with socialization needs

Ho 4. No significant difference will be reported by African American and

White rehabilitation counselors in their attitudes towards African

Americans given a number of social and personal incidents and

situations.

Respondent Demographics

Seven hundred surveys were mailed to randomly selected members of

the National Rehabilitation Association NAMRC Division and the American

Counseling Association ARCA Division. Four hundred and eighty-nine

surveys were mailed to a complete membership list of the NAMRC division

members and 311 to the ARCA division members. The response rate was

37.7% as a total of 264 participants responded. Of the returned surveys, 116

were not fully completed; hence, a total of 148 surveys were useable. Most

of the 116 respondents who were not included in the analyses were

rehabilitation counselor educators, administrators, and practitioners from

other non-counseling disciplines who work in the rehabilitation field, but

have no direct client contact. The 116 respondents were very similar in age,

gender, race and ethnicity, level of education, and other demographics to the

148 participants who returned useable surveys. The following paragraphs

describe the demographics of the 148 participants used in the study.

Sixty-eight or 45.9% of the 148 respondents were ARCA members

and 80 respondents or 54.1% were members of NAMRC. Of the 148

respondents, 73 worked in state agencies (49.3%), 31 in private agencies

(20.9%), 44 in other work settings (29.7%). Other settings included

hospitals, universities, and federal and community rehabilitation agencies.

The average age of the respondents was 47.6 years and the average years of

experience in the rehabilitation field were 15.2 years. The gender make-up

of the sample was 57 male (38.5%), 90 female (60.8%), 1 missing (0.7%).

The racial and ethnic composition consisted of 50 and African American

(33.8%), 85White (57.4%), 3 Hispanic (2.0%), 1 Asian (0.7%), 5 Native

American (3.4%), and 4 who identified themselves as other (2.7%).

The majority of the counselors who participated in the study were

holders of Master's degrees; 121 had Master's (81.8%), 13 had Bachelor's

(8.8%), 8 had Doctorates (5.4%), and 6 Advanced Specialists (4.1%).

Among these, 86 or 58.1% were Certified Rehabilitation Counselors (CRC),

12 or 8.1% were Licensed Clinical Professional Counselors (LCPC); 4 or

2.7% were Certified Professional Counselors (CPC), 20 or 13.7% were

National Certified Counselors (NCC), 26 or 17.6% were Licensed

Professional Counselors (LPC), and 49 participants or 33.1% reported

holding other licensures and certifications.

Results of Regression Analyses Conducted to Answer Question One

Five regression analyses were conducted to answer parts a to e of

question 1. The dependent variables in question 1, parts a to d, (i.e.,

multicultural knowledge, multicultural terminology, multicultural

awareness, and multicultural skills), were composed from items on the

Multicultural Counseling Competence and Training Survey (Rehabilitation

Counselor Version) (MCCTS-R). Based on Holcomb-McCoy's and Day-

Vines (2003) study using the MCCTS, the items which loaded onto each of

the four factors, multicultural knowledge, multicultural terminology,

multicultural awareness, and multicultural skills, were summed and their

means calculated to provide measures of these dependent variables. The

dependent variable in question 1, part e (i.e., self-assessed competence in

counseling racial and ethnic minorities with mental illness), was derived

from items 7 to 21 on the Mental Health Self Assessment for Counseling

Competencies (MHSACC).

Question 1a: Is there a relationship between the following sets of

variables: rehabilitation counselors' age, gender, ethnic background,

multicultural training, and years of experience and their perceptions of their

multicultural knowledge? Multicultural knowledge was the dependent

variable in this question while age, gender, ethnic background, multicultural

training, and years of experience were the independent variables. Items from

the MCCTS-R which comprised the multicultural knowledge variable were

16, 19, and 20 – 31. Scores on these items were summed and the mean score

calculated to provide a measure of multicultural knowledge. Rehabilitation

counselors in this study perceived themselves as competent in multicultural

knowledge, $M = 2.92, SD = .58, N = 141$.

A simultaneous entry regression was conducted to determine the

relationship of the independent variables to counselors' perceptions of their

multicultural knowledge. The multiple regression equation was significant,

$R^2 = .125, F (6, 134) = 3.19, p = .006$. Being a female was significantly

positively related to multicultural knowledge, $\beta = .21, t = 2.48, p = .014$.

Also, being a person of color other than Black was positively related to

multicultural knowledge, $\beta = .29, t = 3.34, p = .011$, (See Table 1).

Question 1b: Is there a relationship between the following sets of variables: rehabilitation counselors' age, gender, ethnic background, multicultural training, and years of experience and their perceptions of their understanding of multicultural terminology? Multicultural terminology was the dependent variable and was derived by combining scores across items 13, 14, and 15 on the MCCTS-R and then calculating the mean score. Rehabilitation counselors perceived themselves as being competent in multicultural terminology, *M = 3.46, SD = .58, N = 141.* The independent variables age, gender, ethnic background, multicultural training, and years of experience were entered into the regression model simultaneously. The regression equation was not significant, $R^2 = .07$, $F (6, 134) = 1.75$, $p = .114$, (See Table 1). Based on these results, age, gender, ethnic background, multicultural training, and years of experience appeared to be unrelated to counselors' perceptions of their multicultural terminology.

Question 1c: Is there a relationship between the following sets of variables: rehabilitation counselors' age, gender, ethnic background, multicultural training, and years of experience and their perceptions of their multicultural awareness? Multicultural awareness was the dependent variable in this regression analysis. This variable was derived by summing and averaging responses on items 5, 6, 7, and 11 of the MCCTS-R. These

items corresponded with the items that loaded onto the multicultural awareness factor on the MCCTS. Rehabilitation counselors perceived themselves as having a competent level of multicultural awareness, $M = 3.50, SD = .49, N = 141$. Once again, a simultaneous regression was performed to determine the relationship of the independent variables to counselors' perceptions of their multicultural awareness. This regression equation was significant at the .10 level, $R^2 = .09, F (6, 134) = 1.75, p = .051$, (See Table 1). Years of experience was a significant predictor of counselors' perceptions of their multicultural awareness, $\beta = .29, t = 2.50, p = .014$.

Question 1d: Is there a relationship between the following sets of variables: rehabilitation counselors' age, gender, ethnic background, multicultural training, and years of experience and their perceptions of their multicultural skills? The dependent variable in this regression analysis was multicultural skills. The responses on items 8, 17, and 18 on the MCCTS-R were combined and the mean scores calculated to form this variable. Rehabilitation counselors rated themselves as competent in multicultural skills, $M = 3.24, SD = .54, N = 141$. Counselors' age, gender, ethnic background, level of multicultural training, and years of experience were entered simultaneously into the regression analysis. The regression equation

was significant at the .05 level, $R^2 = .09$, $F (6, 134) = 2.22$, $p = .045$, (See Table 1). Gender was the only significant predictor of multicultural skills; being a female counselor was positively related to competence in multicultural skills, $\beta = .21$, $t = 2.48$, $p = .014$.

Question 1e: Is there a relationship between the following sets of variables: rehabilitation counselors' age, gender, ethnic background, multicultural training, and years of experience and their perceptions of their self-assessed competence in counseling racial and ethnic minorities with mental illness? A preliminary factor analysis using principal-components analysis was conducted to determine the dimensionality of the 15 items (i.e., items 7 – 21 on the MHSACC), and was used to assess counselors' self-assessed competence in counseling racial and ethnic minorities with mental illness. The criteria used to determine the number of factors were the eigenvalue-over-one criteria and the screen test. The factor analysis indicated that there was one dimension underlying these items which accounted for 47.8 % of the item variance. Factor loadings ranged from .52 to .81. The Cronbach alpha for the items was .92. Therefore, items 7 to 21 were summed and averaged to provide a measure of counselors'

Table 1

Multiple Regression Analyses of Predictor Variables on Multicultural Knowledge,

Terminology, Awareness, and Skills and on Competence in Working with Minorities with

Mental Illness

Predictor Variables	B	SEB	β	R^2	F
Model for Multicultural Knowledge				.125	3.188**
Age	.002	.006	.031		
Female	.245	.099	.209*		
African American	.133	.105	.108		
Other Ethnic Minorities	.573	.171	.289***		
Years of Experience	.003	.007	.056		
Multicultural Counseling Credits	.009	.007	.110		
Model for Multicultural Terminology				.073	1.751 ns
Age	.005	.006	.084		
Female	-.043	.102	-.036		
African American	.210	.109	.170		
Other Ethnic Minorities	.376	.178	.188*		
Years of Experience	.008	.007	.133		
Multicultural Counseling Credits	.002	.007	.023		
Model for Multicultural Awareness				.088	2.153[a]
Age	-.001	.005	-.018		
Female	.123	.087	.122		
African American	.173	.092	.164		
Other Ethnic Minorities	.294	.150	.173		
Years of Experience	.015	.006	.289*		
Multicultural Counseling Credits	-.002	.006	-.026		

Table 1 continued

Regression Analyses of Predictor Variables on Multicultural Knowledge, Terminology,

Awareness, and Skills and on Competence in Working with Minorities with Mental Illness

Predictors	B	SEB	β	R^2	F
Model for Multicultural Skills				.090	2.221*
Age	.001	.006	.025		
Female	.234	.094	.213*		
African American	.185	.101	.161		
Other Ethnic Minorities	.310	.164	.167		
Years of Experience	.011	.006	.205		
Multicultural Counseling Credits	-.003	.007	-.039		
Model for Competence in Working with Minorities with Mental Illness				.074	1.773 ns
Age	.005	.006	.094		
Female	.102	.100	.089		
African American	.044	.107	.037		
Other Ethnic Minorities	.493	.174	.254		
Years of Experience	.005	.007	.080		
Multicultural Counseling Credits	.003	.007	.032		

*** $p < .001$. ** $p < .01$. * $p < .05$.

[a] $p = .051$, model significant at .10 alpha level.

self-assessed competence in counseling racial and ethnic minorities with mental illness. Rehabilitation counselors perceived themselves as having a high level of competence in counseling racial and ethnic minorities with mental illness, $M = 4.02, SD = .57, N = 140$.

A simultaneous regression analysis was conducted to answer question 1e. The regression equation was not significant, $R^2 = .07, F (6, 133) = 1.77, p = .109$, (See Table 1). This indicated that counselors' age, gender, ethnic background, level of multicultural training, and years of experience were not significant predictors of rehabilitation counselors' self assessed competence in counseling racial and ethnic minority clients with mental illness.

In summary, a number of findings emerged in answer to question one:

a) Being female and a person of color other than African American were related to multicultural knowledge.

b) None of the variables (rehabilitation counselors' age, gender, ethnic background, multicultural training, and years of experience) were related to multicultural terminology.

c) Years of experience was related to multicultural awareness.

d) Being a female was related to multicultural skills.

e) None of the variables were related to counselors' self-assessed competence in counseling clients with severe mental illness.

Results of Split-Plot Analyses of Variance Conducted to Answer Questions

Two and Three

Question 2, parts a to e and question 3, parts a to d were analyzed using split-plot analyses of variance (ANOVA) methods. Split-plot ANOVAs were used because for each of these questions there was a between-group variable and a within-subjects or repeated measure variable. The between-group variable for each part of questions 2 and 3 was counselor ethnic background (i.e., White counselors, African American counselors). Counselors of other races were not included in these analyses because of the small number in the sample. The within-subjects variables consisted of clients' perceptions of their competence in working with five racial and ethnic client groups; that is, rehabilitation counselors were measured repeatedly on their perceptions of their counselor competence or behavior with each of the racial and ethnic client groups (i.e., White, Black, Hispanic, Asian, and Native American). Items 1 through 6 on the Mental Health Self-Assessment for Counseling Competencies were used as indicators of rehabilitation counselors' perceptions of their counselor competence in working with clients with mental health issues.

The assumption of sphericity was violated in these models. Girden (1992) pointed out that sphericity is usually violated in these analyses and

that a number of adjustments approaches are available to correct for this violation (e.g., Huyhn-Feldt, Greenhouse-Geisser). Therefore, Huynh-Feldt correction was used to determine the F-value for the within-subject variables. The Huynh-Feldt adjusts the degrees of freedom for the repeated measures factor to correct for departures from sphericity (Girden, 1992).

Since 10 pairwise comparisons were made for each significant mean difference found, Type I error was controlled using the Bonferroni method. The alpha per comparison was .05/10 or .005. In addition, because the assumption of sphericity was not met, separate error terms were calculated for each comparison. SPSS 11.0 version automatically produced the separate error terms.

Question 2a: In their work with racially and ethnically diverse clients with mental illness, how do White and African American rehabilitation counselors compare in their verbal communication of acceptance of clients with mental illness? A split-plot ANOVA was conducted to determine whether White and African American rehabilitation counselors differed in their verbal communication of client acceptance to the five racial and ethnic client groups. Means, standard deviations, and the results of the between and within-subjects ANOVA are presented in Table 2. There was a significant difference between White and African American counselors in their reported

level of verbal communication with clients in general, *F (1, 114) = 4.72, p = .032.* White counselors had a significantly higher mean level of verbal communication, *M = 3.09,* when compared to African American counselors, *M = 2.73.*

Comparison of verbal communication of client acceptance across the five different racial and ethnic client groups also revealed significant mean differences, *F (2.74, 312.82) = 22.10, p = .000.* Pairwise comparisons at the .005 level revealed that counselors reported lower verbal communication with Asian and Native American clients when compared to their verbal communication with White clients. Counselors reported lower verbal communication with Hispanic, Asian, and Native American clients when compared to African American clients with mental illness. Counselors' verbal communication with Hispanic clients was significantly higher than that with Asian and Native American clients, but significantly lower than counselors' verbal communication with African American clients. There was no significant difference between verbal communication of client acceptance with White and African American clients among counselors. No significant interaction was found.

Table 2

Means, Standard Deviations, and Between and Within-Subjects Effects Comparing

African American and White Counselors' Perceptions of their Verbal Communication of

Acceptance of Clients with Mental Illness

Verbal Communication of Acceptance of Clients with Mental Illness	African American Counselors		White Counselors		Posthoc Comparison of Means[a]
	$n = 49$		$n = 85$		
	M	*SE*	*M*	*SE*	
Between Group Effect					
ANOVA F (1, 114) = 4.72*	2.73	.136	3.09	.097	
Within Subject Effect					
ANOVA F (2.74, 312.82) = 22.10***					
1. White clients	2.87	.134	3.35	.095	1 > 4, 5
2. African American clients	3.10	.133	3.31	.094	2 > 3, 4, 5
3. Hispanic clients	2.80	.160	3.16	.114	3 > 4, 5
4. Asian American clients	2.41	.183	2.86	.130	
5. Native American clients	2.46	.182	2.78	.129	

*** p < .001. ** p < .01. * p < .05.

[a] Post hoc comparisons of means were done at the .005 level using the Bonferroni method to correct for Type I error.

Question 2b: In their work with racially and ethnically diverse clients with mental illness, how do White and African American rehabilitation counselors compare in their non-verbal communication of acceptance of clients with mental illness? To determine whether African American counselors differed in their non-verbal communication of client acceptance across the five different racial and ethnic groups, a split-plot ANOVA was conducted. Means, standard deviations, and the results of the between and within-subjects ANOVA are presented in Table 3. Results revealed that White and African American counselors differed significantly in their non-verbal communication of client acceptance overall, $F (1, 113) = 10.41, p = .002$. The mean level of non-verbal communication was higher for White counselors, $M = 3.12$, when compared to African American counselors, $M = 2.59$.

There was also a significant main effect for non-verbal communication of client acceptance across the five client groups, $F (2.49, 281.61) = 24.40, p = .000$. Pairwise comparisons at the .005 revealed that non-verbal communication of client acceptance with both White and African American clients is significantly higher than that with Hispanic, Asian, and Native American client groups. Counselors' non-verbal communication with Hispanic clients was also significantly higher than that for both Asian and

Table 3

Means, Standard Deviations, and Between and Within-Subjects Effects Comparing

African American and White Counselors' Perceptions of their Non-Verbal

Communication of Acceptance of Clients with Mental Illness

Non-Verbal Communication of Acceptance of Clients with Mental Illness	African American Counselors		White Counselors		Posthoc Comparison of Means[a]
	$n = 49$		$n = 85$		
	M	*SE*	*M*	*SE*	
Between Group Effect					
ANOVA F (1, 113) = 10.41**	2.59	.133	3.12	.095	
Within Subject Effect					
ANOVA F (2.49, 281.61) = 24.40***					
1. White clients	2.80	.126	3.40	.091	1 > 3, 4, 5
2. African American clients	3.00	.130	3.33	.093	2 > 3, 4, 5
3. Hispanic clients	2.62	.156	3.16	.112	3 > 4, 5
4. Asian American clients	2.21	.181	2.87	.130	
5. Native American clients	2.33	.183	2.83	.131	

*** p < .001. ** p < .01. * p < .05.

[a] Post hoc comparisons of means were done at the .005 level using the Bonferroni method to correct for Type I error.

Native American clients. Once again, there was no significant difference between non-verbal communication of client acceptance with White and African American clients among counselors. There was no significant interaction.

Question 2c: In their work with racially and ethnically diverse clients with mental illness, how do White and African American rehabilitation counselors compare in their perceived success in producing desired client outcomes? A split-plot ANOVA was done to examine whether White and African American counselors differed in their reported level of success in producing client outcomes with the five racial and ethnic client groups. Means, standard deviations, and the results of the between and within-subjects ANOVA are presented in Table 4. White and African American counselors did not differ significantly in their perceived level of success in producing client outcomes, *F (1, 106) = .07, p = .794.*

A significant within-subjects effect was found in counselors' perceived level of success in producing desired client outcomes across the five racial and ethnic client groups, *F (1.51, 159.92) = 6.59, p = .004.* Follow-up pairwise comparisons indicated that reported level of success in producing desired client outcomes with Hispanic and Native American clients was significantly lower than level of success for both White and

Table 4

Means, Standard Deviations, and Between and Within-Subjects Effects Comparing

African American and White Counselors' Perceptions of their Success in Producing

Desired Client Outcomes

	African American Counselors		White Counselors		Posthoc Comparison of Means[a]
	$n = 49$		$n = 85$		
	M	*SE*	*M*	*SE*	
Between Group Effect					
ANOVA F (1, 106) = .07 ns	2.48	.124	2.52	.090	
Within Subject Effect					
ANOVA F (1.51, 159.92) = 6.59**					
1. White clients	2.78	.122	2.83	.088	1 < 3, 5
2. African American clients	2.76	.118	2.73	.085	2 < 3, 5
3. Hispanic clients	2.27	.140	2.54	.101	3 < 5
4. Asian American clients	2.51	.350	2.27	.252	
5. Native American clients	2.08	.151	2.24	.109	

*** p < .001. ** p < .01. * p < .05.

[a] Post hoc comparisons of means were done at the .005 level using the Bonferroni method to correct for Type I error.

African American clients. Level of counselor success was significantly

higher for Hispanic clients when compared to Native American clients.

There were no significant differences in reported success in producing

desired client outcomes with White, African American, and Asian clients.

Finally, there were no significant interactions between counselor ethnicity

and reported success.

Question 2d: In their work with racially and ethnically diverse clients

with mental illness, how do White and African American rehabilitation

counselors compare in their perceived levels of difficulty in working with

these client groups? The split-plot ANOVA which was performed to

compare White and African American perceived levels of difficulty with the

five racial and ethnic client groups, revealed no significant differences

between-group or within-group differences. Means, standard deviations, and

the results of the between and within-subjects ANOVA are presented in

Table 5. White and African American counselors did not differ significantly

in their perceived levels of difficulty overall. Neither were there any

significant differences in perceived level of difficulty across any of the five

racial and ethnic client groups.

Table 5

Means, Standard Deviations, and Between and Within-Subjects Effects Comparing

African American and White Counselors' Perceptions of Difficulty in Working with

Client Groups

	African American Counselors n = 49		White Counselors n = 85		Posthoc Comparison of Means[a]
	M	*SE*	*M*	*SE*	
Between Group Effect					
ANOVA F (4, 102) = 1.98 ns	1.91	.117	1.77	.087	
Within Subject Effect					
ANOVA F (3.18, 333.55) = 1.74 ns					
1. White clients	1.97	.130	1.70	.097	
2. African American clients	2.03	.130	1.81	097	
3. Hispanic clients	1.95	.141	1.83	.105	
4. Asian American clients	1.79	.149	1.78	.110	
5. Native American clients	1.79	.134	1.74	.099	

*** p < .001. ** p < .01. * p < .05.

[a] Post hoc comparisons of means were done at the .005 level using the Bonferroni method to correct for Type I error.

Question 2e: In their work with racially and ethnically diverse clients with mental illness, how do White and African American rehabilitation counselors compare in their perception of the success of their rehabilitation training in preparing them to work with these client groups? A split-plot ANOVA was performed to analyze whether White and African American counselors differed in their perception of the success of their rehabilitation training in working with the five racial and ethnic client groups. Means, standard deviations, and the results of the between and within-subjects ANOVA are presented in Table 6. No significant mean differences were found between White and Black counselors in their perceptions of the degree of success of their rehabilitation training in preparing them to work with clients with mental illness, $F (1, 115) = .16, p = .694.$

Within-group tests to compare differences in perceptions of success of rehabilitation training across the five racial and ethnic client groups revealed that there were significant mean differences in counselors' perceptions of the degree of success of their rehabilitation training in preparing them to work with these groups, $F (2.70, 310.06) = 26.55, p = .000.$ Counselors reported that their rehabilitation training was significantly more successful in preparing them to work with White clients with mental illness when compared to all other racial and ethnic client groups including African

Table 6

Means, Standard Deviations, and Between and Within-Subjects Effects Comparing

African American and White Counselors' Perceptions of the Success of their

Rehabilitation Training In Preparing them to Work with Client Groups

	African American Counselors		White Counselors		Posthoc Comparison of Means[a]
	n = 49		n = 85		
	M	*SE*	*M*	*SE*	
Between Group Effect					
ANOVA F (1, 115) = .16 ns	2.45	.121	2.39	.092	
Within Subject Effect					
ANOVA F (2.70, 310.06) = 26.55***					
1. White clients	2.79	.138	2.72	.105	1 > 2, 3, 4, 5
2. African American clients	2.61	.137	2.57	.104	2 > 3, 4, 5
3. Hispanic clients	2.33	.137	2.35	.104	
4. Asian American clients	2.23	.139	2.12	.106	
5. Native American clients	2.28	.143	2.18	.109	

*** p < .001. ** p < .01. * p < .05.

[a] Post hoc comparisons of means were done at the .005 level using the Bonferroni method to correct for Type I error.

American clients. Counselors also reported that their rehabilitation training programs were more successful in preparing them to work with Black clients with mental illness when compared to Hispanic, Asian, and Native American clients. There were no significant interactions between counselor ethnicity and counselor perceptions' of their degree of success.

In summary, a number of findings emerged from this study in response to question two:

a) White counselors had a higher mean level of verbal communication of acceptance of clients than African American counselors. Counselors had higher verbal communication of acceptance with White and African American clients when compared to clients of other ethnicities.

b) White counselors had a higher mean level of non-verbal communication of acceptance than African American counselors. Higher non-verbal communication of acceptance with White and African American clients when compared to clients of other ethnicities.

c) There was no difference between White and African American counselors in perceived level of success in producing desired

client outcomes. There were differences in perceived levels of success by clients' race and ethnicity.

d) There was no difference between White and African American counselors in level of difficulty. There were no differences in perceived levels of difficulty by client race and ethnicity.

e) There was no difference between White and African American counselors in the perceived degree of success of their rehabilitation training in preparing them to work with clients with mental illness. Counselors perceived that their rehabilitation training was significantly more successful in preparing them to work with White clients with mental illness when compared to all other racial and ethnic client groups.

Question 3a: In their work with racially and ethnically diverse clients with mental illness, how do White and African American rehabilitation counselors compare in the extent to which they make referrals for education about community resources? A split-plot ANOVA was conducted to compare the extent to which White and African American counselors refer five different racial and ethnic client groups for education about community resources. See Table 7 for the means, standard deviations, and the results of the between and within-subjects ANOVA. There were no significant

between group differences, *F (1, 108) = .02, p = .900.* This indicated that there were no significant mean differences between White and African American counselors in the reported extent to which they referred clients as a whole for education about community resources. However, a significant mean difference was found in the extent to which counselors referred different client groups, *F (2.75, 297.24) = 22.49, p = .000.* Counselors referred African American and White clients significantly more than Hispanic, Asian, and Native American clients with mental illness. They also referred Hispanic clients significantly more than they did Asian and Native American clients with mental illness.

Question 3b: In their work with racially and ethnically diverse clients with mental illness, how do White and African American rehabilitation counselors compare in the extent to which they provide encouragement of family involvement in the rehabilitation process? A split-plot ANOVA was conducted to examine mean differences in the extent to which White and African American counselors provided encouragement for family involvement among White, African American, Hispanic, Asian, and Native American clients with mental illness. See Table 8 for the means, standard deviations, and the results of the between and within-subjects ANOVA.

Table 7

Means, Standard Deviations and Between and Within-Subjects Effects Comparing the

Extent to Which African American and White Counselors Make Client Referrals for

Education about Community Resources

	African American Counselors		White Counselors		Posthoc Comparison of Means[a]
	n = 49		*n* = 85		
	M	*SE*	*M*	*SE*	
Between Group Effect					
ANOVA F (1, 108) = .02 ns	2.51	.131	2.53	.099	
Within Subject Effect					
ANOVA F (2.75, 297.24) = 22.49***					
1. White clients	2.78	.141	2.74	.107	1 > 3, 4, 5
2. African American clients	2.85	.141	2.77	.106	2 > 3, 4, 5
3. Hispanic clients	2.48	.159	2.61	.120	3 > 4, 5
4. Asian American clients	2.20	.165	2.27	.125	
5. Native American clients	2.23	.168	2.23	.127	

*** p < .001. ** p < .01. * p < .05.

[a] Post hoc comparisons of means were done at the .005 level using the Bonferroni method to correct for Type I error.

The analysis revealed no significant mean differences in encouragement of family involvement between White and African American counselors, $F (1, 108) = 2.86, p = .094$. There were also significant within-group differences, $F (2.69, 290.66) = 20.04, p = .000$. Counselor encouragement of family involvement varied across the five racial and ethnic client groups. Counselors encouraged family involvement significantly more among White and African American clients than among Hispanic, Asian, and Native American clients. They also encouraged family involvement among Hispanic clients than among Asian and Native American clients.

Question 3c: In their work with racially and ethnically diverse clients with mental illness, how do White and African American rehabilitation counselors compare in the extent to which they make referrals for group therapy/counseling? The split-plot ANOVA revealed no significant between group differences among White and African American rehabilitation counselors in the extent to which they make referrals for group therapy/counseling as a whole, $F (1, 109) = .152, p = .697$. However, there were significant within-group differences in the extent to which counselors referred different racial and ethnic groups for group therapy/counseling, $F (2.21, 241.24) = 25.42, p = .000$. See Table 9 for the means, standard deviations, and the results of the between and within-subjects ANOVA.

Table 8

Means, Standard Deviations, and Between and Within-Subjects Effects Comparing the

Extent to Which African American and White Counselors Encourage Clients' Family

Involvement in the Rehabilitation Process

	African American Counselors		White Counselors		Posthoc Comparison of Means[a]
	n = 49		*n* = 85		
	M	*SE*	*M*	*SE*	
Between Group Effect					
ANOVA F (1, 108) = 2.86 ns	2.75	.135	2.46	.102	
Within Subject Effect					
ANOVA F (2.69, 290.66) = 20.04***					
1. White clients	2.98	.136	2.70	.103	1 > 3, 4, 5
2. African American clients	3.03	.138	2.69	.104	2 > 3, 4, 5
3. Hispanic clients	2.75	.162	2.50	.122	3 > 4, 5
4. Asian American clients	2.50	.167	2.20	.127	
5. Native American clients	2.50	.175	2.23	.132	

*** $p < .001$. ** $p < .01$. * $p < .05$.

[a] Post hoc comparisons of means were done at the .005 level using the Bonferroni method to correct for Type I error.

Counselors referred White and African American clients for group therapy and counseling more than they did Hispanic, Asian, and Native American clients with mental illness. They also referred Hispanic clients for group therapy/counseling more than they did Asian clients.

Question 3d: In their work with racially and ethnically diverse clients with mental illness, how do White and African American rehabilitation counselors compare in the extent to which they make referrals to assist with socialization needs? The split-plot ANOVA conducted for this question revealed no significant mean differences between White and Black counselors in the extent to which they make referrals for socialization needs, $F (1, 107) = .633, p = .428$. See Table 10 for the means, standard deviations, and the results of the between and within-subjects ANOVA. There were significant mean differences in the extent to which counselors refer clients from the five different ethnic client groups, $F (2.66, 284.21) = 20.15, p = .000$. Counselors referred White clients significantly more for socialization needs than Asian and Native American clients with mental illness. African American clients were referred for socialization needs significantly more than Hispanic, Asian, and Native American clients while Hispanic clients were referred more than Asian and Native American clients with mental illness.

Table 9

Means, Standard Deviations, and Between and Within-Subjects Effects Comparing the

Extent to Which African American and White Counselors Make Client Referrals for

Group Therapy/Counseling

	African American Counselors		White Counselors		Posthoc Comparison of Means[a]
	n = 49		*n* = 85		
	M	*SE*	*M*	*SE*	
Between Group Effect					
ANOVA F (1, 109) = .152 ns	2.09	.127	2.15	.096	
Within Subject Effect					
ANOVA F (2.21, 241.24) = 25.42***					
1. White clients	2.43	.145	2.34	.109	1 > 3, 4, 5
2. African American clients	2.43	.145	2.32	.109	2 > 3, 4, 5
3. Hispanic clients	2.00	.145	2.17	.109	3 > 4
4. Asian American clients	1.78	.147	1.96	.110	
5. Native American clients	1.83	.147	1.97	.110	

*** p < .001. ** p < .01. * p < .05.

[a] Post hoc comparisons of means were done at the .005 level using the Bonferroni method

to correct for Type I error.

Table 10

Means, Standard Deviations, and Between and Within-Subjects Effects Comparing the

Extent to Which African American and White Counselors Make Referrals to Assist With

Client Socialization Needs

	African American Counselors		White Counselors		Posthoc Comparison of Means[a]
	n = 49		*n* = 85		
	M	*SE*	*M*	*SE*	
Between Group Effect					
ANOVA F (1, 107) = .633 ns	2.27	.137	2.41	.100	
Within Subject Effect					
ANOVA F (2.66, 284.21) = 20.15***					
1. White clients	2.55	.149	2.56	.109	1 > 4, 5
2. African American clients	2.63	.149	2.59	.109	2 > 3, 4, 5
3. Hispanic clients	2.24	.162	2.48	.118	3 > 4, 5
4. Asian American clients	1.95	.159	2.20	.117	
5. Native American clients	2.00	.172	2.21	.126	

*** p < .001. ** p < .01. * p < .05.

[a] Post hoc comparisons of means were done at the .005 level using the Bonferroni method

to correct for Type I error.

In summary, data analyses yielded a number of findings in answer to question three:

a) There were no differences between White and African American counselors in the extent to which they referred clients for education about community resources. Counselors referred African American and White clients more than Hispanic, Asian, and Native American clients.

b) There were no differences in encouragement of family involvement between White and African American counselors. Counselors encouraged family involvement significantly more among White and African American clients than among Hispanic, Asian, and Native American clients.

c) There were no differences between White and African American rehabilitation counselors in the extent to which they make referrals for group therapy/counseling. Counselors referred White and African American clients for group therapy/counseling more than they did Hispanic, Asian, and Native American clients.

d) There were no differences between White and African American counselors in the extent to which they make referrals

for socialization needs. Counselors referred White and African

American clients significantly more than Hispanic, Asian, and

Native American clients.

Multivariate Analyses of Variance Conducted to Answer Question Four

Nine multivariate analyses of variance (MANOVA) were conducted

to answer question 4. MANOVA is used to evaluate mean group differences

on two or more dependent variables simultaneously (Bray & Maxwell,

1985). The mean attitude scores of White and African American counselors

to nine personal and social situations involving African American persons

were compared. For each of these nine personal and social situations

presented on the Situational Attitude Scale (SAS) Form B, ten bipolar

semantic differential scales were used to assess attitudes of White and

African American rehabilitation counselors toward. One MANOVA was

conducted for each of the nine personal and social situations.

One must note that usually there are ten situations presented on the

SAS Form B, but that one of these, situation 6, was omitted in this study.

Therefore, this study only evaluated counselors' attitudes toward nine

situations involving African Americans. Responses to the ten bipolar

semantic differential attitudes were the dependent variables for each

question. The independent or grouping variable was counselor ethnicity (i.e.,

African American or White). Significant MANOVAs were followed by pairwise comparisons to investigate the mean differences between White and African American counselors on each of the bipolar semantic differential scales. These comparisons were conducted using the Bonferroni correction procedure to control for Type I error so that the alpha level for each comparison was .005.

Question 4: How do White and African American rehabilitation counselors compare in their attitudes toward African Americans given a number of social and personal incidents and situations? Of the nine MANOVA tests conducted, six of them were significant indicating significant mean differences in attitudes of White and African American rehabilitation counselors on six of the nine personal and social situations. See Table 11 for the means and standard deviations for both groups and the results of the between and within-subjects MANOVA for each situation.

Situation 1: A new African American family moves in next door to you. The MANOVA revealed a significant difference in attitudes between White and African American rehabilitation counselors toward situation 1, $F (10, 120) = 3.669, p = .000$. Follow-up comparisons revealed that White counselors felt significantly less positive about an African American family moving in next door than African American counselors. There were mean

differences on four of the attitudinal scales (See Table 11). White counselors tended to feel more sad, nervous, worse, and undesirable toward an African American moving in next door. The eta-squared, a multivariate strength of association, indicated that 23.4% of the variance on the attitudinal variables can be attributed to group membership.

Situation 2: You read in the paper that an African American man has raped a woman. The MANOVA for situation 2 was not significant indicating no mean differences in attitudes between White and African American rehabilitation counselors, $F (10, 117) = .528, p = .867$.

Situation 3: It is evening and an African American man appears at your door saying he is selling magazines. The MANOVA for situation 3 was significant, $F (10, 118) = 2.081, p = .031$. Fifteen percent (15%) of the variance in the attitudinal variables was a result of group membership. Follow-up pairwise comparisons using the Bonferroni procedure revealed no significant differences in attitudes at the .005 level (See Table 11). Therefore, although there was a significant MANOVA, attitudinal differences on individual variables were not substantive enough to be detected at the .005 level.

Situation 4: You are walking down the street alone and must pass a corner where a group of five young African American men are loitering. The

MANOVA for situation 4 indicated a significant mean difference in attitudes of White and African American rehabilitation counselors, *F (10, 119) = 4.909, p = .000*. Eta-squared indicated that 30.2% of the variance in attitudes could be attributed to group membership. Pairwise comparisons indicated that there were mean differences on two of the attitudinal variances at the .005 level (See Table 11). White counselors felt tenser and Whiter concerning situation 4.

Situation 5: Your best friend has just become engaged to an African American person. The MANOVA for situation 2 was not significant indicating no mean differences in attitudes between White and African American rehabilitation counselors, *F (10, 118) = 1.219, p = .286*.

Situation 7: A new African American person joins your social group. There were significant mean differences between White and African American rehabilitation counselors toward situation 7, *F (10, 119) = 2.522, p = .009*. However, follow-up analyses did not reveal any significant differences on any of the specific attitudinal variables at the .005 level (See Table 11). This indicates that attitudinal differences on individual variables were not substantive enough to be detected at the .005 level. The measure of association, eta-squared revealed that 17.5% of the variance in the attitudinal variables is accounted for by group membership.

Situation 8: You see an African American youngster steal something in a dime store. There were no significant mean differences between White and African American rehabilitation counselors toward situation 8, *F (10, 116) = 1.578, p = .122*.

Situation 9: Some African American students on campus stage a demonstration. The significant MANOVA revealed that there were mean attitude differences between African American and White rehabilitation counselors regarding situation 9, *F (10, 118) = 3.659, p = .000*. Eta-squared was .239; therefore, about 24% of the variance in the attitudinal variables could be attributed to group membership. Pairwise comparisons at the .005 level suggested that African American counselors felt worse, more understanding, and more love toward situation 9 (See Table 11)..

Situation 10: You get on a bus with all African American people on board and you are the only person who has to stand. There were significant mean attitudinal differences between African American and White counselors concerning situation 10, *F (10, 117) = 3.748, p = .000*. Follow-up comparisons at the .005 level indicated that African Americans felt less conspicuous regarding situation 10 (See Table 11). About 20.4% of the variance in attitudes toward situation 10 was accounted for by group membership.

Table 11

Means, Standard Deviations, and Multivariate ANOVA Results Comparing Attitudes of

African American and White Counselors on Ninety Items on the SAS Form B

Situations Bipolar Adjectives	African American Counselors $n = 45$		White Counselors $n = 84$		
	M	*SD*	*M*	*SD*	η^2

1. New African American family moves in next door					
MANOVA F (10, 120) = 3.669***					
1. good-bad[a]	1.60	0.95	2.14	0.85	.234
2. safe-unsafe	1.89	1.13	2.14	0.88	
3. angry-not angry	4.34	1.09	4.36	0.89	
4. friendly-not unfriendly	1.79	1.08	1.87	0.82	
5. sympathetic-not sympathetic	2.79	1.44	2.57	0.88	
6. nervous-calm[b]	4.30	0.93	3.85	0.92	
7. happy-sad[a]	1.75	0.92	2.37	0.92	
8. objectionable-acceptable	4.34	0.92	4.08	0.92	
9. desirable-undesirable[b]	1.85	0.98	2.37	0.93	
10. suspicious-trusting	3.96	1.08	3.75	0.86	

2. African American man has raped a woman					
MANOVA F (10, 117) = .528 ns					
11. affection-disgust	4.57	0.66	4.57	0.66	.043
12. relish-repulsion	4.59	0.62	4.44	0.75	
13. happy-sad	4.75	0.53	4.70	0.60	
14. friendly-hostile	4.11	0.81	4.12	0.87	
15. uninvolved-involved	3.27	1.11	3.21	1.00	
16. hope-hopelessness	3.25	1.04	3.18	0.79	
17. aloof-outraged	3.93	0.95	3.93	0.83	
18. injure-kill	2.82	0.95	2.60	0.93	
19. safe-fearful	3.45	1.07	3.26	0.91	
20. empathetic-can't understand	3.93	1.11	3.62	1.14	

Table 11 continued

Means, Standard Deviations, and Multivariate ANOVA Results Comparing Attitudes of

African American and White Counselors on Ninety Items on the SAS Form B

Situations Bipolar Adjectives	African American Counselors		White Counselors		
	$n = 45$		$n = 84$		
	M	SD	M	SD	η^2
3. African American man appears at your door selling magazines					
MANOVA F (10, 118) = 2.081*					
21. relaxed-startled	3.33	1.33	3.11	1.03	0.150
22. receptive-cautious	3.76	1.38	3.56	1.05	
23. excited-unexcited	3.56	1.14	3.64	0.93	
24. glad-angered	3.13	0.76	3.20	0.62	
25. pleased-annoyed	3.84	1.00	3.86	0.88	
26. indifferent-suspicious[b]	3.33	1.15	2.88	1.03	
27. tolerable-suspicious	2.91	1.12	2.87	0.94	
28. afraid-secure[b]	2.91	0.92	3.37	0.88	
29. friend-enemy	2.78	0.82	2.96	0.63	
30. unprotected-protected	3.00	0.95	3.26	0.78	
4. Group of five young African American men are loitering					
MANOVA F (10, 119) = 4.909***					
31. relaxed-tensed[a]	3.29	0.92	3.78	0.78	0.302
32. pleased-angered	2.98	0.54	3.09	0.45	
33. superior-inferior	3.13	0.63	3.11	0.38	
34. smarter-dumber	2.98	0.54	3.01	0.39	
35. whiter-blacker[a]	3.29	0.66	2.54	0.75	
36. aggressive-passive	3.04	0.67	3.19	0.68	
37. safe-unsafe	3.24	1.00	3.41	0.85	
38. friendly-unfriendly	2.82	0.81	2.88	0.64	
39. excited-unexcited	3.16	0.77	3.15	0.70	
40. trivial-important	3.18	0.78	3.00	0.77	

Table 11 continued

Means, Standard Deviations, and Multivariate ANOVA Results Comparing Attitudes of

African American and White Counselors on Ninety Items on the SAS Form B

Situations Bipolar Adjectives	African American Counselors		White Counselors		
	$n = 45$		$n = 84$		
	M	SD	M	SD	η^2
5. Best friend has just become engaged to an African American					
MANOVA F (10, 118) = 1.219 ns					
41. aggressive-passive	3.62	0.98	3.61	0.92	.094
42. happy-sad	1.67	0.83	1.63	0.88	
43. tolerable-intolerable	1.76	0.88	1.76	1.48	
44. complimented-insulted	2.82	0.61	2.42	0.85	
45. angered-overjoyed	4.02	0.92	3.87	0.86	
46. secure-fearful	2.02	0.97	1.96	0.95	
47. hopeful-hopeless	1.78	0.90	1.67	0.81	
48. excited-unexcited	1.80	0.94	1.81	0.84	
49. right-wrong	1.96	0.88	1.96	0.90	
50. disgusting-pleasing	4.13	0.94	4.10	0.89	
7. New African American person joins your social group					
MANOVA F (10, 119) = 2.522**					
61. warm-cold	1.41	0.69	1.56	0.75	0.175
62. sad-happy	4.46	0.89	4.33	0.83	
63. superior-inferior	2.80	0.50	2.90	0.43	
64. threatened-neutral	3.89	1.18	4.18	1.00	
65. pleased-displeased	1.59	0.80	1.81	0.88	
66. understanding-indifferent	1.85	1.09	2.02	1.03	
67. suspicious-trusting	4.02	1.04	3.98	0.89	
68. disappointed-elated[b]	4.04	1.05	3.60	0.76	
69. favorable-unfavorable	1.74	0.93	1.88	0.94	
70. uncomfortable-comfortable	4.26	1.02	4.10	0.91	

Table 11 continued

Means, Standard Deviations, and Multivariate ANOVA Results Comparing Attitudes of

African American and White Counselors on Ninety Items on the SAS Form B

Situations Bipolar Adjectives	African American Counselors $n = 45$		White Counselors $n = 84$		
	M	SD	M	SD	η^2

8. African American youngster steal something in a dime store

MANOVA F (10, 116) = 1.578 ns

	M	SD	M	SD	η^2
71. surprising-not surprising	2.56	1.22	2.88	1.01	.120
72. sad-happy	1.65	0.81	1.80	0.83	
73. disinterested-interested	3.70	0.99	3.50	0.92	
74. close-distant	2.72	1.03	3.11	0.82	
75. understandable-baffling	3.42	0.79	3.17	0.90	
76. responsible-not responsible	3.05	1.17	3.26	1.10	
77. concerned-unconcerned	1.81	0.98	2.01	0.96	
78. sympathy-indifference	2.49	1.05	2.76	0.83	
79. expected-unexpected	3.63	0.79	3.43	0.80	
80. hopeful-hopeless	2.47	0.93	2.86	0.81	

9. African American students on campus stage a demonstration

MANOVA F (10, 118) = 3.659***

	M	SD	M	SD	η^2
81. bad-good[a]	3.84	0.99	3.22	0.84	0.239
82. understanding-indifferent[a]	2.07	1.00	2.43	0.94	
83. suspicious-trusting[b]	3.43	0.90	3.06	0.73	
84. safe-unsafe	2.48	1.05	2.68	0.95	
85. disturbed-undisturbed	3.55	0.97	3.27	0.82	
86. justified-unjustified[b]	2.48	0.95	2.81	0.80	
87. tense-calm[b]	3.61	1.08	3.16	0.90	
88. hate-love[a]	3.57	0.76	3.11	0.46	
89. wrong-right[b]	3.61	0.78	3.25	0.67	
90. humorous-serious	3.59	1.01	3.48	0.67	

Table 11 continued

Means, Standard Deviations, and Multivariate ANOVA Results Comparing Attitudes of

African American and White Counselors on Ninety Items on the SAS Form B

Situations Bipolar Adjectives	African American Counselors $n = 45$		White Counselors $n = 84$		
	M	SD	M	SD	η^2
10. Bus with African Americans on board and you are the only person standing					
F (10, 117) = 3.748***					
91. fearful-secure[b]	4.00	0.95	3.58	1.02	0.204
92. tolerable-intolerable	2.16	1.17	2.15	1.09	
93. hostile-indifferent	3.74	0.93	3.80	0.84	
94. important-trivial[b]	3.28	1.18	3.75	0.94	
95. conspicuous-inconspicuous[a]	3.37	1.13	2.45	1.14	
96. calm-anxious[b]	2.30	1.12	2.78	1.12	
97. indignant-understanding	3.79	0.99	3.67	0.84	
98. comfortable-uncomfortable	2.56	1.12	2.79	1.17	
99. hate-love	3.44	0.85	3.25	0.72	
100. not resentful-resentful	2.16	1.11	2.13	1.00	

Note. Post hoc comparisons of means were done at the .005 level using the Bonferroni

method to correct for Type I error.

[a] Post hoc comparison significant at the .005 level.

[b] Post hoc comparison significant at the .05 level.

*** $p < .001$. ** $p < .01$ * $p < .05$.

In summary, data analyses revealed a number of findings for question four:

a) There were significant differences in attitudes of White and African American rehabilitation counselors in response to the following situations:

i) New African American family moves in next door

ii) African American man appears at your door selling magazines

iii) Group of five young African American men are loitering

iv) New African American person joins your social group

v) African American students on campus stage a demonstration

vi) Bus with African Americans on board and you are the only person standing.

b) There were no differences in attitudes of White and African American counselors in response to the following situations:

i) African American man has raped a woman

ii) Best friend has just become engaged to an African American

iii) African American youngster steals something in a dime store.

CHAPTER 5

Discussion

The purpose of this study was to examine rehabilitation counselors'

perceived multicultural competence in working with persons with severe

mental illness, and specifically African Americans with severe mental

illness. The researcher sought to explore the impact of counselors' own

cultural heritage and perceptions of their counseling skills in working with

this population. Counselors' race, gender, training, and experience were

examined in terms of their multicultural knowledge, understanding of

terminology, multicultural awareness, and their self assessed competence in

counseling racially and ethnically diverse clients with mental illness.

This chapter will review a) major findings, b) general conclusions, c)

limitations of the study, and d) implications for practice, training and future

research.

Major Findings

The major findings of this study were generated by scales on the three

instruments used for the research, the Multicultural Counseling Competence

and Training Survey-Rehabilitation Version (MCCTS-R), the Mental Health

Self Assessment for Counseling Competencies (MHSACC), and the

Situational Attitude Scale (SAS) – Form B. The MCCTS-R identified four

factors for measuring counselor competence: multicultural knowledge, terminology, awareness, and skills. The MHSACC reported competence in counseling six racial/ethnic groups and the SAS was used to compare African American and White counselors' attitudes toward African Americans.

Findings indicated significantly that rehabilitation counselors perceived themselves to be competent in areas of multicultural knowledge, terminology, awareness, and skills. This is consistent with Holcomb-McCoy and Myers' study (1999) which suggested that counselors as a group perceive themselves to be multicultural competent and they are most competent in areas of awareness, skills, and definition. Granello and Wheaton, (1998), found that rehabilitation counselors perceived themselves to be multiculturally competent in areas of skills, awareness, knowledge, and relationship. Further, findings by Pope-Davis and Ottavi (1994) with university affiliated graduate students and Sodowsky et al. (1996) comparing university affiliated counselors concluded that counselors perceive themselves to be multiculturally competent, in most areas.

Findings from the regression analyses in the current study indicated that being a female was significantly related to multicultural knowledge and being a person of color other than African American was significant for

multicultural knowledge. Hence, multicultural knowledge was significantly higher for female counselors and counselors of color other than African American. Age, gender, ethnicity, multicultural training and years of experience were not related to counselors' perception of their competence in multicultural terminology. Rehabilitation counselors attributed years of experience to their competence in the area of multicultural awareness. Therefore, counselors with more years of experience were more multiculturally aware. Being a female was significantly related to counselors' perceived competence in the area of multicultural skills. This indicated that female counselors perceived themselves to be more multiculturally skilled than male counselors. Multicultural training received during one's counselor education programs was not a significant predictor of any type of multicultural competence.

These findings diverge from findings by Granello and Wheaton (1998) who examined self perceived competencies of African American and White counselors and found that there was no significant difference in multicultural competence between races and there was no mention of gender. Granello and Wheaton reported that both African American and White counselors perceived themselves to be multiculturally competent in areas of skills, awareness, knowledge and relationship with emphasis on

multicultural skill competence. However, White counselors identified awareness and relationship as strong areas, but no significant difference was found in areas of skills and knowledge.

When working with racial and ethnic minorities with mental illness, rehabilitation counselors perceived themselves as highly competent in counseling clients across racial/ethnic groups. Age, gender, ethnic background, level of multicultural training, and years of experience were not significant predictors of counselor self-assessed competence in working with clients with mental illness. These findings are consistent with Holcomb-McCoy's (2001) who found no significant effects of years of experience and multicultural training on elementary school counselors' level of multicultural competence.

White and African American rehabilitation counselors were significantly different in their verbal and non-verbal communication of acceptance of clients with mental illness. White counselors reported significantly higher levels of verbal and non-verbal communication of acceptance. Counselors reported lower verbal communication with Asian and Native American clients when compared to communicating with White clients. Both groups perceived lower verbal and non-verbal communication with Hispanic, Asian, and Native American clients when compared to

African American clients with mental illness. It is notable that verbal and non-verbal communication with White and African American clients did not differ. However, verbal and non-verbal communication was significantly higher with Hispanic clients than with Asian and Native American clients with mental illness. The fact that there was no significant difference in verbal and non-verbal communication of acceptance of mental illness with White and African American clients corroborates existing literature which reports that overuse of universally accepted views about mental health in the counseling profession can lead to an unethical imposition of values when working with people from culturally diverse client populations (Daniels, Arredondo, & McAndrea, 2001). Further, several other researchers agree that traditional counseling approaches perpetuate cultural bias by imposing the dominant culture on minority clients (McGinn, Flowers & Rubin, 1994; Cayleff, 1986; Pedersen, 1991). This current study indicates that rehabilitation counselors do not see themselves as communicating acceptance any differently in their counseling approach with African American or White clients.

While White and African American counselors did not differ in their reported success in producing desired client outcomes, they both reported higher levels of success with White, African American, and Asian clients

when compared with Hispanic and Native American clients. This could be due to the geographic regions where counselors practice. Many respondents indicated limited to no contact with minority clients other than African Americans. One respondent even noted that, "In my 16 years of practice I have never had an African American client".

Rehabilitation counselors reported no significant differences in their perceived level of difficulty in working with racially and ethnically diverse clients with mental illness. African American and White counselors did not differ significantly in perceived levels of difficulty overall and there were no differences in perceptions of difficulty across any of the five racial ethnic groups. These findings are surprising and inconsistent with prior research that reveals rehabilitation success rates for African Americans and other minorities are significantly lower than for White clients. Literature consistently documents that African Americans and other minorities' rehabilitation successes are unequal compared to the success of White clients (Atkins & Wright, 1980; Herbert & Matinez, 1992; Wilson, 2002, Cappello, 2002). This concurs with past research. This study revealed that a significant number of respondents had no multicultural training which leads one to believe that cultural considerations are not acknowledged in the counseling process. Thus, seemingly there is no difference in perceived level

of difficulty in working with clients from diverse ethnic groups (seeing all clients as having the same needs).

It is noteworthy that counselors did report that their rehabilitation training was significantly more successful in preparing them to work with White clients with mental illness when compared with all the other racial/ethnic groups including African American clients. Similarly, counselors indicated that their training was more successful in preparing them to work with African American clients when compared to Hispanic, Asian and Native American clients. This is surprising, as research confirms that at every level of the rehabilitation process the field of rehabilitation has not been successful in developing culturally responsive rehabilitation services for minority group clients (Rehabilitation Acts Amendments, 1992; Middleton et.al., 2002).

There were no significant differences in the extent to which African American and White counselors made referrals for education about community resources for clients as a whole, encouraged family involvement, made referrals for group therapy/counseling, and made referrals for socialization needs. However, once again, counselors provided these services differentially for clients. There were significant differences in the extent to which referrals were made for the different client groups. In

general, African American and White clients received more referrals for education about community resources and for group therapy/counseling than the other three racial groups and Hispanic clients received more than Asian and Native American clients. The same pattern of results occurred for encouragement of client family involvement. Specifically, in making referrals for socialization needs, White clients were referred more so than Asian and Native American clients, African American clients more so than Hispanic, Asian, and Native American clients, and Hispanic clients more so than Asian and Native American clients.

This study seems to imply a hierarchical order in the receipt of services across ethnic groups since counselors continually reported providing higher levels of services, training, and client outcomes with White and African American clients followed closely by Hispanic clients, and then Asian and Native American clients. Research consistently documents the hierarchy of service delivery in the rehabilitation process from acceptance through post employment services (Cappello, 2002; Wilson, 2001, 2002). The Rehabilitation Act Amendments of 1992 reported an inequitable provision of rehabilitation services to racial minorities at every level of the rehabilitation process. Ten years later, Middleton et.al. (2002) developed professional multicultural rehabilitation competency standards and noted

that these were "minimal competencies for serving historically under-represented racial and ethnic populations." However, while the indication that a hierarchy of service delivery may exist in the rehabilitation process is strongly supported by previous research (Cappello, 2002; Wilson, 2001, 2002), one must be cautious in accepting this as conclusive given the small sample size used in this study, the newness of the MHSACC instrument, and the fact that the sample is drawn from the rehabilitation professional associations.

Existing research confirms that attitudes and expectations of the society can impact quality of life and how people react toward a perceived minority. The attitudes of others are often the most significant barriers encountered by persons with disabilities and can have serious implications for service delivery (Gething, 1991; Havravek, 1991). In this current study the attitudes of White and African American counselors toward African Americans varied depending on the type of situation. The attitudes of White and African American counselors differed significantly in six of the nine social and personal situations presented. The situations on which counselors' attitudes differed were: an African American family moves in next door, an African American man comes to the door selling magazines, young African American boys loitering, an African American joins your social group,

African American students stage a demonstration on campus, and you're on a bus full of African Americans and you're the only one standing. In general, White American counselors had less positive attitudes toward these racial situations than African American counselors except in the case of an African American man comes to the door selling magazines. In that situation, post hoc comparisons were not significant at the .005 level; however, at the .05 level White counselors would have felt more positive.

A common characteristic of each of the situations which produced different attitudes in White and African American counselors appears to be their social distance. The greater the personal and social closeness of the situation involving African Americans, the less positive were attitudes of White counselors. It is possible that White counselors in this study were less positive toward situations that they perceived as socially closer and more threatening. Sedlacek and Brooks (1970) found that the closer and more intimate the situations involving African Americans, the less positive were participants' attitudes. In their study, the situation, an African American man comes to the door selling magazines, was highlighted as one which involved a social role, and so was not as close and threatening. However, situations such as, an African American family moves in next door, were closer and

more threatening and therefore, produced less positive attitudes in participants.

Limitations of the Study

There are several limitations to this study that must be noted. The most important is the self report measurement and the length of the combined survey instruments. In this type of study, there is always the possibility of bias caused by participants wanting to appear socially desirable in their responses, thus portraying the halo effect. Another limitation was the low overall response rate of 38% and the low response rate of ethnic minority counselors 42.6%, which included African Americans, Hispanic, Asian, Native American and Other. Even though there were 264 respondents, 148 (56%) felt that they were qualified to answer the entire combined survey packet. Many of these noted that they were rehabilitation educators, administrators and others who work in the field, but have no direct client contact.

It may also be noted that the sensitivity of the subject matter may have been a deterrent for participants. In addition, the pressure to give socially desirable responses on Form-B of the SAS, is also likely to have affected the responses to the survey. Previous studies have controlled for the social desirability effect by using both forms A and B. Future studies should

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include both versions so as to control for this social desirability effect.

Finally, it is important to note that since the participants were members of

professional rehabilitation associations, their views may not have been

representative of the general population of rehabilitation counselors. Future

research should use a more nationally representative sample so as to improve

the generalizability of the results.

Implications of the Study

Implications for Training

The variables gender, years of experience, and ethnicity - specifically

persons of color other than African American, were related to different

aspects of multicultural competence. Being a female counselor as opposed to

a male counselor was significantly related to multicultural knowledge and

multicultural skills. This may be due to the fact that rehabilitation counselors

are more likely to be female. Being a counselor of color of an ethnicity other

than African American was significantly related to multicultural knowledge.

Holcomb-McCoy (1999) attributes this to the in vivo learning experiences

that one gains from being around persons of color and which may increase

one's multicultural competence. The variable, years of experience, was

significantly related to multicultural awareness. It is possible that as

rehabilitation counselors work more over the years with clients of color and

are exposed to in-service training, that they become more multicultural aware on a personal and a client level. This seems to indicate that rather than waiting for years of experience to train counselors, counselors need to be exposed to training that develops this awareness prior to or early in the profession.

However, one must note that multicultural training received in counselor education programs was not related to any of the aspects of multicultural competence. This leads one to wonder why multicultural training is not influencing the multicultural competence of rehabilitation counselors. It is clear from the demographics of the participants that rehabilitation counselors tend to be more mature than those in other counseling professions. The average age of counselors in this study was 47.5 years. Therefore, it is possible that counselors may have been trained when multicultural training was not yet provided in their master's counselor education programs. Alternately, it is possible that rehabilitation counselors may not be receiving adequate training in their master's counselor education programs.

Training may be such that it allows counselors to gain knowledge without becoming aware of their own worldview or understanding the worldviews of culturally diverse clients and how these affect the counseling

process. If counselors are not trained to be reflective practitioners, they may not translate knowledge and experiences during training to their work. Efforts should be made to expose counselors to more in vivo experiences such as suggested by Holcomb-McCoy (1999). For example, during pre and in-service training in multicultural counseling, rehabilitation counselors should be required to do an internship in a culturally diverse community. Multicultural training needs to focus more on developing multicultural self and other awareness and to help counselors to reflect on rather than run away from intense emotions that they may experience. The potential for multicultural training to be emotionally laden may cause counselor educators to teach from a purely didactic rather than inculcating the experiential. Therefore, in-vivo experiences in culturally diverse communities, journaling, and self-reflection exercises to develop counselors' awareness of their worldview and those of culturally diverse clients, should be a central part of training.

On examining the split-plot analyses of variances three patterns seemed to emerge from this study: (1) that there were very few differences between White and African American rehabilitation counselors in their perceptions of their competence and service provision; (2) that there is a hierarchical order of service provision to clients with mental illness with

White and African American clients receiving a greater extent of services than Hispanic clients who receive a greater extent of services than Asian and Native American clients; and (3) there are no differences in the level of services provided to White and African American clients. Rehabilitation counselors perceived their training as preparing them best to work with White clients foremost, followed by African American clients, and then Hispanic, Asian, and Native American clients. This is likely to be a reflection of the fact that counselors are mostly trained in Eurocentric settings in counseling approaches with as Eurocentric focus. Also, it is more than likely that the rehabilitation settings in which they work are Eurocentric.

Given the Eurocentric focus of their training, it is not surprising that most rehabilitation counselors are more prepared to work with White clients with mental illness. The next client group addressed in training is likely to be African American clients since the African American population has been the largest racial minority group in this country until recently. This may explain why rehabilitation counselors in this study reported having higher levels of success with White and African American clients than with Hispanic, Asian, and Native American clients with mental illness. The finding that, in terms of counselor perceptions' of their preparation for

working with client populations, Hispanic clients are next in line after African American clients, is not surprising given that more attention has been turned to the Hispanic population in recent years due to the large increase of Hispanics in the population. Therefore, structure of training in counselor education programs may have created a hierarchy of service provision to rehabilitation clients.

Another significant finding of this study is that there were no significant differences in the level of referrals and services provided to White and African American clients with mental illness. This seems to suggest that counselors in general are working with White and African American counselors the same way. Yet the literature suggested that African American clients need more encouragement for family involvement, and more referrals for education about community resources, for group therapy/counseling, and for socialization needs. It would be important to train rehabilitation counselors in understanding the specific needs of clients from all of the various racial and ethnic groups and the recommended ways for addressing these needs. For example, family and community involvement are a significant component of treatment for Hispanic and African American families.

The findings from the SAS are consistent with Sedlacek's and Brooks' (1970) findings. White counselors have less positive attitudes toward more socially/personally close situations, and more positive toward situations involving social roles. This diverges from previous literature. Gill (1993) examining African American and White counselors' attitudes toward aging African Americans, concluded that race alone was not a determining factor in the attitudes of counselors. Future training of rehabilitation counselors should involve some work regarding attitudes toward minorities including African Americans. Counseling is a socially and personally close situation/relationship; therefore, hidden attitudes and assumptions affect client-counselor relationships and consequently may negatively impact client outcomes. In-service training and professional development opportunities must focus on helping rehabilitation counselors examine their racial attitudes and stereotypes and how these may impact the counseling process.

In summary, the following recommendations are made for training rehabilitation counselors based on this study:

1. Multicultural training needs to focus on developing multicultural self and other awareness and to help counselors to reflect on rather than avoid intense emotions that they may experience in considering their cultural values and assumptions

2. Counselor educators need to help students reflect on and challenge the Eurocentric theories and approaches of counseling

3. Trainees need to be exposed to in vivo experiences so as to better facilitate multicultural awareness in White and minority trainees and to help students reflect on working in multiple contexts

4. Training should expose rehabilitation counseling trainees to the specific orientations and worldviews of culturally diverse groups with mental illness with an equal focus on broad racial and ethnic groups

5. Professional bodies need to mandate and endorse multicultural competency training for rehabilitation counselors

Implications for Research

Further research is needed in the area of multiculturalism and rehabilitation counseling, the factors that influence counselors' multicultural competence in working with clients with mental illness, and best practices and training methods for developing multicultural competence in rehabilitation counseling trainees. Exploration of competence and gender, influence of counselors' racial attitudes on service delivery, and specific

disability group multicultural training is needed. More research should focus on counselor multicultural competence and service delivery to ethnic minority groups as it relates to the hierarchy of service delivery which seems to be a consistent finding in this study. However, in future studies, it is important to recognize that issues of counselors' multicultural competence, service delivery in the rehabilitation process, and racial attitudes of rehabilitation counselors are all very comprehensive and wide-ranging issues. Therefore, it is imperative that each of these be studied separately in order to facilitate manageability and interpretation. In addition, the value of qualitative research cannot be underscored in studying issues of counselors' multicultural competence, service delivery in the rehabilitation process, and racial attitudes of rehabilitation counselors. Qualitative research would provide breadth and depth of knowledge and understandings about these areas of research.

Finally, it would also be important to use a more nationally representative sample in future research. Future studies should use national and individual state databases such as, Rehabilitation Services Administration (RSA), to gain access to a more representative sample of rehabilitation counselors.

APPENDIX A

DEMOGRAPHIC QUESTIONNAIRE

DEMOGRAPHIC QUESTIONNAIRE

Please complete the following identifying background information. Incomplete answers may invalidate the results of the study. DO NOT WRITE YOUR NAME ON THIS INFORMATION.

<u>**Section 1: Demographic Information:**</u>

1. **Age** _____

2. **Gender**
   _____Male
   _____Female

3. **Racial/ethnic background**
   _____African American/Black
   _____European/white
   _____Hispanic/Latino
   _____Asian
   _____Native American
   _____Other (Specify_____)

5. **Highest degree earned**
   _____B.S., B.A.
   _____M.A., M.S., M.Ed.
   _____PH.D., ED.D.
   _____Other (Specify_____)

6. **Income Level**
   _____15,000 or less
   _____15,001 - 25,000
   _____25,001 - 35,000
   _____35,001 - 50,000
   _____50,001 or more

4. **Most important influence on your beliefs and attitudes involving multicultural awareness**
   _____ Parents   _____Teachers   _____Peers
   _____Profession   _____Priest, minister   _____Other (Specify_____)

<u>**Section 2: Work Experience Information:**</u>

1. **Please check the rehabilitation setting in which you work**
   _____State Agency
   _____Private Agency
   _____Hospital
   _____Federal Rehabilitation Agency
   _____Community Rehabilitation Agency
   _____Other (Specify_____)

2. **State where you are employed_____**

3. **Years of rehabilitation counseling experience _____**

4. **Ethnic background of clients served in individual case load**
   _____%European/White
   _____%African American/Black
   _____%Hispanic/Latino
   _____%Native American
   _____%Other (Specify_____)

5. **Licensures and certifications**
   _____CRC   _____NCC
   _____LCPC   _____LPC
   _____CPC
   _____Other (Specify_____)

*You do not need to fill out the rest of the survey if you are not a rehabilitation counselor with client contact.

<u>**Section 3: Training Information:**</u>

1. Years working with clients with mental illness _____.

2. Number and credit value of colleged base courses taken in mental illness _____ and how many credits each course was worth _____, _____, _____, _____.

3. Have you had in-service training on mental illness? _____ Yes   _____ No

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If so, total number and credit value of continuing education hours (CEU's) _____.

4. Number of hours spent in-service training which no credits were given, _____.

5. What percentage of your caseload is with clients who have documented disability of mental illness ? (0-100%) _____.

APPENDIX B

THE MULTICULTURAL COUNSELING COMPETENCE AND

TRAINING SURVEY (REHABILITATION VERSION)

This instrument was developed by Cheryl C. Holcomb-McCoy, University of Maryland, College Park, Maryland (1996) who granted permission to adapt the instrument for the purposes of this study.

This survey is being conducted to assess rehabilitation counselors perceived competence in providing services to clients from differing racial/ethnic groups.

The terms "multicultural" and "multicultural counseling" refer to counseling when applied to clients and/or counselors from the five ethnic groups listed by the Association for Multicultural Counseling and Development (AMCD)--African/Black, European/White, Hispanic/Latin, Asian, and Native American. The term ethnic minority refers to all ethnic groups except European/White.

Part 1: <u>MULTICULTURE COUNSELING CURRICULUM IN MASTER'S LEVEL COUNSELING PROGRAM</u>

Please provide the following information about the rehabilitation program where you received, or are receiving, your entry level counseling degree (e.g., M.Ed., M.S.)
_____

1. **Graduate Program Accreditation:**
   _____CORE
   _____CACREP
   _____NON-ACCREDITED
   _____Other (Specify_____)

2. **How many multicultural counseling credits did you accrue while a student in your counseling program?**
   _____

Part 2: <u>PERCEPTION OF MULTICULTURAL COMPETENCE</u>

3. **Based on the competencies listed below, on a scale of 1 to 10, one being the least competent and ten being the most competent, do you believe that you are a multiculturally competent rehabilitation counselor?**

   (a) Use techniques and skills appropriate for work with persons from specific populations.

   1   2   3   4   5   6   7   8   9   10

   (b) Understand potential barriers to effective counseling with specific groups.

   1   2   3   4   5   6   7   8   9   10

   (c) Receives and accurately analyze feedback from persons of other cultures.

   1   2   3   4   5   6   7   8   9   10

(d) Maintain current awareness of multicultural and specific populations counseling and guidance.

      1   2   3   4   5   6   7   8   9   10

(e) Follow professional ethnic guidelines for counseling persons of multicultural and specific populations.

      1   2   3   4   5   6   7   8   9   10

4. In what areas of multicultural competence do you need further training? (If more than one area, please rank with "1" being most needed and "3" being least needed and "4" being no training)

    a.   _____awareness of your own cultural biases, perceptions, and values
    b.   _____knowledge of other ethnic/cultural groups' perceptions, values, and norms
    c.   _____skills related to counseling ethnically/culturally different clients
    d.   _____no further training needed

Part 3: SELF-ASSESSMENT OF MULTICULTURAL COUNSELING COMPETENCE

Directions: Listed below are competency statements based on AMCD's Multicultural Counseling Competencies and Explanatory Statements. *Please read each competency statement and evaluate your Multicultural competencies using the following 4-point scale.*

    1   - Not competent (Not able to perform at this time)
    2   - Somewhat competent (More training needed)
    3   - Competent (Able to perform competently)
    4   - Extremely competent (Able to perform at a high level)

5. I can discuss my own ethnic/cultural heritage   1   2   3   4

6. I am able to discuss how my culture has influenced the way I think   1   2   3   4

7. I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes.   1   2   3   4

8. I can recognize when my attitudes, beliefs, and values are interfering with providing the best services to my clients.   1   2   3   4

9. I verbally communicate my acceptance of culturally different clients.   1   2   3   4

10. I non-verbally communicate my acceptance of culturally different clients.   1   2   3   4

11. I can discuss my family's perspective regarding acceptance codes of conduct.   1   2   3   4

12. I can discuss models of White Racial Identity Development   1   2   3   4

13. I can define racism.   1   2   3   4

14. I can define prejudice.   1   2   3   4

15. I can define discrimination.   1   2   3   4

16. I can identify the cultural biases of my communication style.   1   2   3   4

17. I can identify my negative and positive emotional reactions toward   1   2   3   4

persons of other racial and ethnic groups.

18. **I can identify my reactions that are based on stereotypical beliefs about**   1   2   3   4
     different ethnic groups.
19. **I can give examples of how stereotypical beliefs about culturallly**   1   2   3   4
     different persons impact the counseling relationship.

20. **I can discuss with-in group differences among ethnic groups**   1   2   3   4
     (e.g., how SES African American client vs. High SES African American
     client).

Please read each competency statement and evaluate your Multicultural competencies using the following 4-point scale.

> 1   - Not competent (Not able to perform at this time)
> 2   - Somewhat competent (More training needed)
> 3   - Competent (Able to perform competently)
> 4   - Extremely competent (Able to perform at a high level)

21. **I can discuss how culture affects a client's vocational choices.**   1   2   3   4

22. **I can discuss how culture affects the helping-seeking behaviors of**   1   2   3   4
     clients.

23. **I can discuss how culture affects the manifestations of psychological disorders**   1   2   3   4

24. **I can describe the degree to which a counseling approach is appropriate**   1   2   3   4
     for a specific ethnic or racial group.

25. **I can explain how factors such as poverty, and powerlessness have**   1   2   3   4
     influenced the current conditions of a least two ethnic groups that have
     been separated and isolated on the basis of culture.

26. **I can discuss how the counseling process may conflict with the cultural**   1   2   3   4
     values of two ethnic groups.

27. **I can list at least three barriers that prevent ethnic minority clients**   1   2   3   4
     from using mental health services.

28. **I can discuss the potential bias of two assessment instruments**   1   2   3   4
     frequently used in rehabilitation counseling.

29. **I can discuss family counseling from a cultural and/or ethnic perspective.**   1   2   3   4

30. **I can anticipate when my helping style is inappropriate for a**   1   2   3   4
     culturally different client.

31. **I can help clients determine whether a problem stems from racism or**   1   2   3   4
     bias in others.

APPENDIX C

MENTAL HEALTH SELF-ASSESSMENT FOR COUNSELING

COMPETENCIES

This additional survey deals with REHABILITATION COUNSELORS' competencies toward clients of differing ethnic backgrounds who have mental illness.. There are no right or wrong answers. Please answer honestly.

Part 1: Self -assessed competencies are listed below. Please read each statement and indicate from the four (4) point continuum the extent to which you perceive your <u>Counseling Competencies</u> as related to assisting persons with mental health issues. Give an answer for each ethnic group listed.

1. **I verbally communicate my acceptance of clients with mental illness who are:**

    1 - Not at all   2 - Sometimes   3 - Frequently   4 - All of the time

    _____European/White
    _____African American/Black
    _____Hispanic/Latino
    _____Asian/Pacific Islander
    _____Native American
    _____Other (Specify_____)

2. **I non-verbally communicate my acceptance of clients with mental illness who are:**

    1 - Not at all   2 - Sometimes   3 - Frequently   4 - All of the time

    _____European/White
    _____African American/Black
    _____Hispanic/Latino
    _____Asian/Pacific Islander
    _____Native American
    _____Other (Specify_____)

3. **In your opinion, how successful are you in producing desired outcomes such as employment readiness**
    and links to appropriate services in the community for the following group of clients who are mentally   ill?

    1 - Not successful   2 - Somewhat successful   3 –Successful   4 - Extremely successful

    _____European/White
    _____African American/Black
    _____Hispanic/Latino
    _____Asian/Pacific Islander
    _____Native American
    _____Other (Specify_____)

4. **How difficult do you find it to work with the following groups of clients with mental illness?**

1 - Not difficult   2 - Somewhat difficult   3 - Difficult   4 - Extremely difficult

_____European/White
_____African American/Black
_____Hispanic/Latino
_____Asian/Pacific Islander
_____Native American
_____Other (Specify_____)

5. **To what degree has your rehabilitation training been successful in preparing you to work with the following groups of clients with mental illness?**

1 - Not successful   2 - Somewhat successful   3 -Successful   4 - Extremely successful

_____European/White
_____African American/Black
_____Hispanic/Latino
_____Asian/Pacific Islander
_____Native American
_____Other (Specify_____)

6. **To what extent do you provide and/or make referrals for mental health services**

1 - Not at all   2 - Sometimes   3 - Frequently   4 - All of the time

6a._____Education about community resources
    _____European/White
    _____African American/Black
    _____Hispanic/Latino
    _____Asian/Pacific Islander
    _____Native American
    _____Other (Specify_____)

6b._____Encourage family involvement
    _____European/White
    _____African American/Black
    _____Hispanic/Latino
    _____Asian/Pacific Islander
    _____Native American
    _____Other (Specify_____)

6c._____Group therapy/counseling
    _____European/White
    _____African American/Black
    _____Hispanic/Latino
    _____Asian/Pacific Islander
    _____Native American
    _____Other (Specify_____)

6d._____Medication needs/changes

        _____European/White
        _____African American/Black
        _____Hispanic/Latino
        _____Asian/Pacific Islander
        _____Native American
        _____Other (Specify_____)

6e._____Socialization needs

        _____European/White
        _____African American/Black
        _____Hispanic/Latino
        _____Asian/Pacific Islander
        _____Native American
        _____Other (Specify_____)

Part 2: Below are Mental Health Counseling Competence statements. Please continue to evaluate your perception of your competencies involving mental illness issues.

VERY LOW	LOW	MEDIUM	HIGH	VERY HIGH
1	2	3	4	5

7. I am aware of institutional barriers that prevent individuals from   1   2   3   4   5
    historically underrepresented racial/ethnic groups from using vocational
    rehabilitation or independent living services.

8. I believe that I have specific knowledge about my own racial culture   1   2   3   4   5
    heritage and how it personally and professionally affects any biases
    and orientation toward mental illness.

9. I can identify strengths for underrepresented racially/ethnically diverse   1   2   3   4   5
    clients with mental illness through the rehabilitation process.

10. I can advocate for resources for underrepresented racially/ethnically   1   2   3   4   5
    diverse clients with mental illness through the rehabilitation process.

11. I am aware of my own values, biases, and prejudices and how they may   1   2   3   4   5
    affect clients from other culturally diverse backgrounds.

12. I possess specific knowledge and information about beliefs, customs, and   1   2   3   4   5
    norms of clients from diverse groups.

13. I am aware of any emotional reactions that may negatively effect   1   2   3   4   5
    rehabilitation intervention with clients with mental illness.

14. I understand how race/ethnicity, culture, status, and disability may   1   2   3   4   5
    affect vocational choices and help-seeking behaviors of clients.

15. I understand the appropriateness of career development theories   1   2   3   4   5
    and models, and the use of evaluation instruments.

16. I seek to gain future knowledge regarding the culture of clients with   1   2   3   4   5
    whom I work.

17. I am aware of how stereotypic attitudes and preconceived notions may   1   2   3   4   5
    affect other racial and ethnic groups acceptance or entrance into a needed
    program.

18. I respect the client's religious and spiritual beliefs and values, including   1   2   3   4   5
    attributions and taboos.

19. I am able to plan, implement and utilize institutional intervention skills   1   2   3   4   5
    proposed by my agency on behalf of the client; such skills may include:

   (a) Develop awareness of culturally relevant issues and values

   (b) Develop awareness of common rehabilitation issues specific to
        the culture of certain groups
   (c) Maintain effective community liaisons to help multicultural clients

20. **I am not opposed to seeking consultation with traditional healers or religious/spiritual advisors, advocacy and/or self-help groups, community leaders, and other services providers that the client may be involved with during the rehabilitation process.**   1   2   3   4   5

21. **I take responsibility for making appropriate referrals for other needed services**   1   2   3   4   5

THANK YOU FOR YOUR PARTICIPATION!!!

APPENDIX D

SITUATIONAL ATTITUDE SCALE

This questionnaire measures how people think and feel about a number of social and personal incidents and situations. It is not a test so there are no right or wrong answers. The questionnaire is anonymous so please DO NOT SIGN YOUR NAME.

Each item or situation is followed by 10 descriptive word scales. Your task is to select, for each descriptive scale, the rating which best describes YOUR feelings towards the item.

Sample item: Going out on a date

   happy   O   O   O   O   O   sad

You would indicate the direction and extent of your feelings, (e.g., you might select the second bubble in by indicating your choice on your response sheet by darkening in the appropriate space for that world scale. DO NOT MARK ON THE BOOKLET. PLEASE RESPOND TO ALL WORD SCALES.

Sometimes you may feel as though you had the same item before on the questionnaire. This will not be the case, so DO NOT LOOK BACK AND FORTH through the items. Do not try to remember how you checked similar items earlier in the questionnaire. Make EACH ITEM A SEPARATE AND INDEPENDENT JUDGEMENT. Respond as honestly as possible without puzzling over individual items. Respond with your first impressions wherever possible.

I. A new (**African American**) family moves in next door to you.
1. good   ○ ○ ○ ○ ○   bad
2. safe   ○ ○ ○ ○ ○   unsafe
3. angry   ○ ○ ○ ○ ○   not angry
4. friendly   ○ ○ ○ ○ ○   unfriendly
5. sympathetic ○ ○ ○ ○ ○   not sympathetic
6. nervous   ○ ○ ○ ○ ○   calm
7. happy   ○ ○ ○ ○ ○   sad
8. objectionable ○ ○ ○ ○ ○ acceptable
9. desirable   ○ ○ ○ ○ ○   undesirable
10. suspicious ○ ○ ○ ○ ○   trusting

II. You read in the paper that a (**African American**) man has raped a woman.

11. affection ○ ○ ○ ○ ○   disgust
12. relish   ○ ○ ○ ○ ○   repulsion
13. happy   ○ ○ ○ ○ ○   sad
14. friendly   ○ ○ ○ ○ ○   hostile
15. uninvolved ○ ○ ○ ○ ○   involved
16. hope   ○ ○ ○ ○ ○   hopelessness
17. aloof   ○ ○ ○ ○ ○   outraged
18. injure   ○ ○ ○ ○ ○   kill
19. safe   ○ ○ ○ ○ ○   fearful
20. empathetic ○ ○ ○ ○ ○   can't understand

III. It is evening and a (**African American**) man appears at your door saying he is selling magazines.

21. relaxed   ○ ○ ○ ○ ○   startled
22. receptive ○ ○ ○ ○ ○   cautious
23. excited   ○ ○ ○ ○ ○   unexcited
24. glad   ○ ○ ○ ○ ○   angered
25. pleased   ○ ○ ○ ○ ○   annoyed
26. indifferent ○ ○ ○ ○ ○   suspicious
27. tolerable ○ ○ ○ ○ ○   intolerable
28. afraid   ○ ○ ○ ○ ○   secure
29. friend   ○ ○ ○ ○ ○   enemy
30. unprotected ○ ○ ○ ○ ○   protected

IV. You are walking down the street alone and must pass a corner where a group of five young **(African American)** men are loitering.

31. relaxed	O O O O O	tensed
32. pleased	O O O O O	angered
33. superior	O O O O O	inferior
34. smarter	O O O O O	dumber
35. whiter	O O O O O	blacker
36. aggressive	O O O O O	passive
37. safe	O O O O O	unsafe
38. friendly	O O O O O	unfriendly
39. excited	O O O O O	unexcited
40. trivial	O O O O O	important

V. Your best friend has just become engaged **(to an African American person).**

41. aggressive	O O O O O	passive
42. happy	O O O O O	sad
43. tolerable	O O O O O	intolerable
44. complicated	O O O O O	insulted
45. angered	O O O O O	overjoyed
46. secure	O O O O O	fearful
47. hopeful	O O O O O	hopeless
48. excited	O O O O O	unexcited
49. right	O O O O O	wrong
50. disgusting	O O O O O	pleasing

VI. A new **(African American)** person joins your social group.

61. warm	O O O O O	cold
62. sad	O O O O O	happy
63. superior	O O O O O	inferior
64. threatened	O O O O O	neutral
65. pleased	O O O O O	displeased
66. understanding	O O O O O	indifferent
67. suspicious	O O O O O	trusting
68. disappointed	O O O O O	elated
69. favorable	O O O O O	unfavorable
70. uncomfortable	O O O O O	comfortable

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VIII. You see a **(African American)** youngster steal something in a dime store.

71. surprising	○ ○ ○ ○ ○	not surprising
72. sad	○ ○ ○ ○ ○	happy
73. disinterested	○ ○ ○ ○ ○	interested
74. close	○ ○ ○ ○ ○	distant
75. understandable	○ ○ ○ ○ ○	baffling
76. responsible	○ ○ ○ ○ ○	not responsible
77. concerned	○ ○ ○ ○ ○	unconcerned
78. sympathy	○ ○ ○ ○ ○	indifference
79. expected	○ ○ ○ ○ ○	unexpected
80. hopeful	○ ○ ○ ○ ○	hopeless

IX. Some **(African American)** students on campus stage a demonstration.

81. bad	○ ○ ○ ○ ○	good
82. understanding	○ ○ ○ ○ ○	indifferent
83. suspicious	○ ○ ○ ○ ○	trusting
84. safe	○ ○ ○ ○ ○	unsafe
85. disturbed	○ ○ ○ ○ ○	undisturbed
86. justified	○ ○ ○ ○ ○	unjustified
87. tense	○ ○ ○ ○ ○	calm
88. hate	○ ○ ○ ○ ○	love
89. wrong	○ ○ ○ ○ ○	right
90. humorous	○ ○ ○ ○ ○	serious

X. You get on a bus **(with all African American people on board)** and you are the only person who has to stand.

91. fearful	○ ○ ○ ○ ○	secure
92. tolerable	○ ○ ○ ○ ○	intolerable
93. hostile	○ ○ ○ ○ ○	indifferent
94. important	○ ○ ○ ○ ○	trivial
95. conspicuous	○ ○ ○ ○ ○	inconspicuous
96. calm	○ ○ ○ ○ ○	anxious
97. indignant	○ ○ ○ ○ ○	understanding
98. comfortable	○ ○ ○ ○ ○	uncomfortable
99. hate	○ ○ ○ ○ ○	love
100. not resentful	○ ○ ○ ○ ○	resentful

CONSENT AND DISCLOSURE LETTER

Principal Investigator: Dorothy C. Whitehead, Doctoral Candidate
                           Department of Counseling and Personnel Services
                           University of Maryland, College Park

Dear Colleague:

Your support is being requested in a research study entitled "Rehabilitation Counselors'
Perceived Competence in Working with African Americans with Serious Mental Illness"
being conducted to examine and describe rehabilitation counselors' perception of their
multicultural competence in working with clients with severe mental illness and
specifically African American clients with severe mental illness.

Enclosed you will find, a Demographic Questionnaire, the National Multicultural
Counseling Competence, and Training Survey (Rehabilitation Version), the Mental
Health Self Assessment for Counseling Competencies, and the Situational Attitude Scale,
along with a self addressed stamped envelope. The combined time for completion is
approximately 30 minutes. If you decide to participate by completing the surveys, you are
invited to return the enclosed flyer under separate cover, which will entitle you to be
eligible to participate in drawings for a one year membership in the National
Rehabilitation Association and the multicultural division (National Association of
Multicultural Concerns), an APA Style-Helper Software Kit, and a $50.00 gift certificate
for Barnes and Nobles respectively.

The information you provide is confidential. Your honesty in answering the questions
will ensure that the study will provide meaningful and useful information. This study
poses no risks. You are not required to answer questions that you feel uncomfortable
with answering.

Your voluntary participation in this study will contribute to the field of rehabilitation
counseling by helping to clarify and respond to the need for multicultural and specific
group training when working with clients with mental illness.

Please return your completed survey within 10 days of receipt.

Authorization: I have read and understand the above information and understand that I
have the right to refuse. My right to withdraw from the study at any time will be
respected.

If you decide not to participate, please check the box below and return this letter so that you will not receive another survey in the case of a second mailing.

I will not participate

Thank you for your time and participation.

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