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UMI
A NATIONWIDE ASSESSMENT OF MULTICULTURAL COUNSELING
COMPETENCIES OF REHABILITATION PRACTITIONERS
IN THE PRIVATE SECTOR

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the
Graduate School of
The Ohio State University

By
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ABSTRACT

With the increasing diversity of the United States, rehabilitation service providers must be prepared to work with a more multicultural client base. The shift in cultural and ethnic composition of the United States is visible throughout society. Thus, rehabilitation service providers must be responsive to the socio-cultural implications of planning treatment for an increasingly diverse workforce.

This study assessed the self-perceived multicultural competencies of private-sector rehabilitation service professionals nationwide. Possessing the skills, knowledge, awareness and relationship building abilities to work effectively outside a counselor’s own cultural group indicates multicultural counseling competence.

The target population was the membership of the National Association of Rehabilitation Professionals in the Private Sector. From a population of 2800, 500 subjects were randomly selected, of whom 211 returned survey packets, for a response rate of 42.2%.

The respondents’ level of multicultural competence was assessed using the Multicultural Counseling Inventory, which comprises four subscales: skills, knowledge, awareness, and relationship (counseling). Respondents were also asked to complete a demographic form and the Marlowe Crowne Social Desirability Scale.
The multicultural counseling competence of rehabilitation service professionals in the private sector was the study's dependent variable. The independent variables included gender, race, age, educational level, number of courses taken in multicultural counseling, number of continuing education courses in multiculturalism or diversity, length of experience as a rehabilitation service professional, geographic location of current practice, and perceived adequacy of academic preparation to work with persons from another cultural group upon completion of a degree program.

The data was analyzed using a series of one-way analysis of variance and univariate multiple regressions. Results revealed that training had a positive effect on the multicultural competencies of skills, awareness and knowledge. The counseling relationship was less affected by training. The majority of rehabilitation service professionals surveyed stated that they were not adequately trained to work with a multicultural population and would be interested in further multicultural training.
This dissertation is dedicated to the loving memory of

my Grandfather H. R. Kirksey Sr.,

Grandmother Lula May Holloway, Cousin Gia Kirksey Lewis,

Brother-in-law Patrick Augustin, Great-grandmothers Mary Clark and Mabel Dexter

and close family friend Charles Brown, all of whose collective spirits have watched

over me and inspired me during many phases of my life.
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day. Research and fundraising to eradicate diabetes is my new goal in life. Through this transition in our family system, I have watched the effects that this illness has had on my entire family, and I am convinced that counselors must assist families in dealing effectively with life and chronic illness. On a more basic note, I thank my children for all their love, support, and hugs.

I must also thank my parents, who are the most incredible people I know. My mother, Annette Kirksey, taught me to create the life that I want and to live my dreams. Her compassion towards others inspired me to do what I do. Her motto has always been, “You can do it!” My father, H.R. Kirksey, Jr. (Hank), taught me the value of being self-sufficient and handling your own business. He also showed me that there is nothing in life that you cannot do. Try it; if it doesn’t work, move on. You have learned a valuable lesson. His motto is “Nothing beats a failure but a try.”

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FIELDS OF STUDY

Major Field: Counselor Education

Minor Field: Psychology

Subspecialty: Rehabilitation Services and Multicultural Counseling
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CHAPTER 1

INTRODUCTION

Statement of the Problem

"If what you (the rehabilitation counselor) are going to do to a client is unacceptable to other members of his/her culture, you can't do it, even if you consider it common rehabilitation practice." (National Institute on Disability and Rehabilitation Research, Rehab Brief, 1993 p.1) For successful rehabilitation outcomes to occur, culture must be considered an integral component of the rehabilitation equation. Given that we live in a pluralistic society, rehabilitation service providers are likely to interact with persons from diverse cultures (Wilson, 1997; Havranek & Stewart 1997). Counselors may encounter situations in which they have limited knowledge, skills, and awareness of the client or client group (Sodowsky, 1996) Issues that affect quality of service will arise based on the counselor's level of multicultural sensitivity, expertise and actual practice in working through cross-cultural dynamics (Feist-Price, 1995).

Assessing multicultural counseling competence in the field of private sector rehabilitation is the first step towards ensuring that providers are trained and proficient in the multicultural competencies that are necessary to achieve an optimal outcome for the wide range of clients they serve.
Multiculturalism is a complex and dynamic construct (Pedersen, 1994; Myers et al., 1991; Reynolds & Pope, 1991; Sue et al., 1991), which comprises a person's multiple cultural identities, including ethnicity, race, gender, age, disability identity, sexual orientation, language, social class, family type, among others. Myers (1987), Sue (1991), Ponterotto (1998), Wyatt and Parham (1985), and Sodowsky (1997), are all staunch supporters of multiculturalism and have created research that could assist counselors in preparing for the changing demographics of our country. Thomas and Weinrach (1998), on the other hand, believe that racism is at the heart of multiculturalism and liken the concept to reverse discrimination. They state that multiculturalism, affirmative action, quotas, and cultural diversity are vehicles that divide people and give unfair advantage to certain groups (p.127). However, putting multiculturalism in the same context as affirmative action and quotas may result in incendiary rhetoric that detracts from the more salient issue of professional competence across cultures.

The push for multicultural and cultural diversity programs has at its base the demographic shift that is occurring in the United States. As we move into the future, the United States will become increasingly more multicultural. According to projections of the United States Census Bureau (1996), by 2050, the current majority population, those of European descent, will become a minority population as the numbers of Latinos, African Americans, Native Americans, and immigrants continue to grow. The largest cultural group will be the Latino population. This shift in the cultural composition of the United States will result from immigration, increased birth
rates of some cultural groups, decreased birth rate among European Americans, and extended life span (U.S. Census Bureau, 1996).

The rapidly changing demographics will severely impact service delivery in our country. More specifically, Havranek and Stewart (1997) suggest that the increasingly more multicultural society could have a profound impact on the delivery of rehabilitation services. Because a number of educational and rehabilitation test instruments were created to assess European Americans, they may not be appropriate for members of other cultural groups. Insufficient multicultural competencies of rehabilitation service providers could present problems in the areas of testing, diagnosis, training, and job placement (Feist-Price, 1995). The key to successful rehabilitation and adjustment is to change the way rehabilitation counselor educators are training future service providers and to assess the competencies of current providers (Havranek, & Stewart, 1997). Rehabilitation counselors must ensure a high level of competence when working with persons that are culturally different from themselves (Sue & Sue, 1990). Research demonstrates that multiculturalism is not a totally value-laden concept. It is a reality with implications for individuals who will be using social service-agencies, including those who provide vocational rehabilitation (Ehiobuche, 1995).

Persons of color have not received the same level of services from rehabilitation counselors as their European American counterparts, even though persons of color are disproportionately injured on the job (Wilson, 1997; Ehiobuche, 1995; Atkinson, Morton, & Sue, 1989; Sheppard, 1995). The critical question to be answered is
whether rehabilitation counselors currently working in the field possess the
multicultural counseling competencies necessary to work with an increasingly more
multicultural society. If not, are they receptive to participating in the training
necessary to obtain the knowledge required to assist people from culturally different
backgrounds?

The assessment of multicultural competencies is long overdue. In the field of
rehabilitation services, an amendment to the Rehabilitation Act of 1990 called for
greater cultural sensitivity and an increased effort to provide services to minority
consumers. Counselor educators and psychologists alike have incorporated the
importance of multicultural competencies into their professional standards (Sue, et al.,
1992; Atkins, 1988). Moreover, leaders of each sector of the helping professions have
stated that multiculturalism and multicultural competencies must be attained, with
appropriate courses implemented and inserted into training programs, not as electives,
but as an integral component of the curriculum (Schaller, Parker, & Garcia, 1998).

Wheaton and Granello (1998) conducted a seminal study in the field of
rehabilitation services when they assessed the self-reported multicultural counseling
competencies of rehabilitation professionals in the public sector. The researchers
surveyed rehabilitation service providers at a state-operated vocational rehabilitation
facility in a large Midwestern city and demonstrated the proactive ability of a state
agency to self regulate and assess the possible need for change. In their study, 180
vocational rehabilitation counselors completed the Multicultural Counseling Inventory
(MCI, Sodowsky, Taffe, Gutkin, & Wise, 1994). Results indicated that training had a
positive effect on the MCI subscales of skills, awareness, and knowledge, as well as the full-scale scores. Experience had a positive effect on the relationship subscale score, which relates to the counselor’s ability to connect and establish a relationship with the client (Wheaton & Granello, 1998).

Havranek and Stewart (1997) found that “private rehabilitation organizations are not fully addressing ADA (Americans with Disability Act, 1990) and multicultural issues. One would expect other private entities to be even less prepared. ... In general, public agencies were more responsive than private rehabilitation agencies” (p.8). Havranek and Stewart’s findings further support the critical need for this investigation.

**Purpose of the Study**

The purpose of this study is to investigate the multicultural counseling competencies of rehabilitation service providers in the private sector. Assessing the multicultural competencies of rehabilitation service providers in the private sector is important not only because private rehabilitation is often utilized as a support and adjunct to public sector rehabilitation, but because of the phenomenal growth of private sector rehabilitation. When legislation was passed in Ohio that required the state Bureau of Workers Compensation to contract with outside case management services (Growick, 1994), the need for rehabilitation service practitioners in the private sector increased. As a result of this legislation, health management organizations (HMOs) in Ohio are also contracting the services of rehabilitation professionals in the private sector at an increased rate.
Because those who need rehabilitation represent a microcosm of society (Feist-Price & Ford-Harris, 1994; Rubin, Pusch, Fogarty, & McGinn, 1995; Sue, 1994) the rehabilitation practitioner in the private sector is likely to serve an extremely diverse clientele. Rehabilitation practitioners in the private sector stand on their reputations and the success of their businesses: how many injured workers are being returned to work expediently (Dunn, Finch, & Growick, 1992) and how much money employers are saving in the process. Therefore, understanding the culture of an injured client may have implications for enhanced job placement based on matching that worker with a more appropriate work environment. The issue of culture is a nonexertional phenomenon that can easily be overlooked in the rehabilitation process (Herbert & Cheatham, 1988). If understanding the culture of a worker means better placement, then economically speaking, multiculturalism should be set forth as a “best business practice” imperative.

This investigation is worthwhile because the preponderance of research in assessing multicultural competencies was completed using a pre-service graduate student population (Sodowsky, 1996; Pope-Davis, 1995) and focused on general counseling. Not a single study could be found that investigated the multicultural competencies of rehabilitation service providers in the private sector. Wheaton and Granello (1998) came the closest to investigating this population. This study is a follow-up to their work. The objective of this follow-up study is to add to the limited body of research on multicultural counseling competencies. While Wheaton & Granello investigated the competencies of state vocational rehabilitation workers in
the Midwest, this study will focus on rehabilitation workers in the private sector nationwide.

Information from this study can also ascertain if previous training had an impact on selected competency variables.

**Significance of the Problem**

In the past decade the concepts of multiculturalism and cultural sensitivity have become an integral part of the professional standards in counseling, particularly rehabilitation services. Although many studies have demonstrated the importance of being a multiculturally competent service provider and how the lack of such competency impacts both service delivery and outcomes (Atkins, 1988; Chan, Lam, Wong, & Leung, 1988; Dziekan & Okacha, 1993; Walker, 1991; Wright, 1988), very few researchers have gone into the field to assess the actual multicultural competency level of currently practicing rehabilitation service providers. The most recent study, Wheaton and Granello (1998) was conducted on the actual multicultural competency levels of rehabilitation workers in the state of Ohio’s vocational system.

The continued health of any system requires periodic assessments of how the organization is functioning (Riggar, Eckert, & Crimaldo, 1993). Functional assessments are also necessary in the field of rehabilitation, particularly because of the rapid growth of private-sector rehabilitation (Dunn, Finch, & Growick, 1992). Successful service delivery must assess multicultural competencies, including the cultural awareness, of rehabilitation counselors and service providers on all levels.
The notion that counselors increasingly will be dealing with clients who are culturally different from themselves is directly related to the changing demographics of the United States. At present, many cities no longer have a European American majority population (U.S. Census Bureau, 1996).

As the population continues to grow in diversity, rehabilitation service providers can no longer afford to ignore the issue of culture. "Rehabilitation administrators and supervisors must realize that cultural diversity is a business and economic imperative. ... it is not a social program." (Overman, 1991, p. 34). If rehabilitation providers want to continue to deliver effective services without a disparity to minority groups, their knowledge, skills, awareness, and ability to build relationships with individuals who are culturally different from themselves must be assessed.

Harley et al. (1996) conducted a 10-year (1984–1994) content analysis of five rehabilitation journals to surmise the level of interest in issues of multiculturalism and diversity. Out of 1,601 articles in the five refereed rehabilitation journals, only 128 or 8% addressed the issue of multiculturalism at even a minimal level. The presence of journal articles on the topic of multiculturalism may or may not have a direct relationship to the competency level of practitioners in the field.

The need for multicultural competence in the field of rehabilitation services is not a novel concept. Smart and Smart's (1993) research was discussed in the NIDRR Rehab Brief, "Culturally Sensitive Rehabilitation." They support the position that training must include both theoretical and clinical experiences with culturally diverse populations.
This study, therefore, has the potential to provide such training programs with information necessary to evaluate the effectiveness of the multicultural curriculum of rehabilitation counselors, as well as to provide organizations with a baseline for training needs in the area of multicultural competence.

**Primary Research Questions**

*Research question one.* Is there a relationship between the selected demographic characteristics of rehabilitation service providers in the private sector — sex, age, race, highest degree earned, major area of study, and geographic location of current practice—and their multicultural counseling competencies?

*Research question two.* Do rehabilitation service providers in the private sector differ from those in the public sector with respect to multicultural counseling competency?

*Research question three.* Is the amount and type of training in multiculturalism related to multicultural competency? (Independent variables are (a) workshops, (b) training sessions, (c) mandatory multicultural counseling courses, (d) satisfaction with past multicultural training, and (e) self-perceived adequacy of multicultural preparation. (Dependent variables are the subscales of the MCI: knowledge, awareness, relationship, skills, and total).

*Research question four:* Is self-perceived adequacy of multicultural preparation related to multicultural competency?

*Research question five:* Is satisfaction with training in multiculturalism related to multicultural competency?
Research question six. Is the number of years of different types of experience in rehabilitation related to multicultural competency?

Research question seven. What combination of demographics, training, satisfaction with training, perceived adequacy of preparation, and experience variables best predicts multicultural counseling competency?

Research Objectives

The following research objectives will be addressed in this study:

1. Describe selected demographic characteristics of the rehabilitation practitioner in the private sector.
2. Describe the rehabilitation practitioner’s level of multicultural competencies based on skills, awareness, knowledge, and relationship.
3. Determine the level of college preparation of the rehabilitation practitioner necessary to work with multicultural populations.
4. Determine the relationships, if any, between rehabilitation counselors’ demographic characteristics and their multicultural competencies.
5. Identify demographic factors that may be significant predictors of the extent of multicultural competencies.

Definition of Terms

The following definitions are provided to assist the reader in clarifying terms used in this study:

Multicultural: A person’s multiple cultural identities, including variables such as ethnicity, race, gender, age, disability identity, sexual orientation, language, social
class, family type, and other identities (Fukuyama, 1990; Myers et al., 1991; Reynolds & Pope, 1991; Sue et al., 1992). For the purpose of this study, multicultural awareness, skills, relationship, and knowledge were measured as participant's scores on the MCI.

*Rehabilitation service provider in the private sector:* A member of the National Association of Rehabilitation Professionals in the Private Sector (NARPPS) engaged in rehabilitation services with the goal of return to work and/or increased quality of life.

*Skills:* A counselor's ability to actively develop and practice appropriate, relevant, and sensitive intervention strategies in working with culturally different clients (Sue & Sue, 1992) as measured on the MCI skills subscale; one of four areas of multicultural competency.

*Awareness:* A counselor's ability to demonstrate cognizance of one's own assumptions about human behavior, values, biases, preconceived notions, and personal limitations (Sue & Sue, 1990) as measured on the MCI Awareness subscale; one of four areas of multicultural competency.

*Knowledge:* A counselor's ability to demonstrate an understanding of the worldview of others without negative judgments (Sue & Sue, 1990) as measured on the MCI knowledge subscale; one of four areas of multicultural competency.

*Relationship:* A counselor's ability to construct a therapeutic alliance with a client of a differing cultural group. It also pertains to the trustworthiness of the counselor and his or her ability to recognize the worldview of persons from other
cultures, demonstrate a comfort level with other cultures, and to suspend stereotypical thinking (Sue & Sue, 1990) as measured on the MCI relationship subscale, one of four areas of multicultural competency.

Chapter Summary

There is little empirical information on rehabilitation counselors' perceptions of their multicultural competencies. With no information about rehabilitation counselors' multicultural training levels, it is challenging, at best, to know where to begin in multicultural competency training programs or to determine if they are even necessary. This study addresses an under-researched area in the professional literature regarding rehabilitation counselors in the private sector and their perceptions of their multicultural competencies.

Multiculturalism is a skill, a knowledge base, an ability to create an effective relationship, and the awareness that culture profoundly impacts the individual. Cultural issues cannot be removed from the business equation. To thrive, businesses must be adept at serving the entire population.

Are rehabilitation counselors in the private sector prepared to meet the challenges of multiculturalism? It has been said that rehabilitation counselors in the private sector have not been responsive to issues of culture. (Havranek & Stewart, 1997) There will come a day when not being responsive to issues of culture will result in poor rehabilitation outcomes, lack of arrival at case closure with clients returning to work fully rehabilitated, and consequently a decrease in client base. Ignoring culture or discounting culture could also result in poor job placements, inaccurate
assessments, and ineffective individualized written rehabilitation plans based on stereotypes and preconceived notions.

Professionals in all industries must have the capacity to work effectively across cultures. No one will be immune to the effects of immigration, longer life spans, decreased birth rates of European Americans, and an overall increase in the numbers of those in what are currently considered minority populations. Multicultural competencies will be essential for businesses and individuals to be competitive.

The next chapter will focus on the following:

- The role and functions of rehabilitation professionals.
- The historical development of private-sector rehabilitation.
- Similarities and differences between public- and private-sector rehabilitation.
- The importance of multiculturalism in the helping professions.
- Multiculturalism and its impact on rehabilitation.
- Multicultural counseling competencies
- Legislation and multiculturalism
- The presence of multiculturalism in training programs
CHAPTER 2

REVIEW OF THE LITERATURE

The intent of this chapter is to present an overview of private-sector rehabilitation and to review literature relevant to multicultural counseling competencies of rehabilitation professionals in the private sector. This chapter will also explore the impact of multiculturalism within the helping professions in general, and more particularly how it relates to training in the field of rehabilitation. This review will therefore evoke numerous questions: Why should rehabilitation practitioners in the private sector be concerned or interested in developing multicultural counseling competencies? Why would individuals working on a fee-for-service basis surrender their valuable time to learn more about the dynamics of working across cultures? And how would increased multicultural counseling competence augment the earning capacity of rehabilitation service practitioners in the private sector?

Private-sector rehabilitation is a broad-based, fee-for-service business whose services are expanding everyday (Mercer, 1983; Dinwoodie, 1991; Switzer Monograph, 1993). The services of a rehabilitation practitioner in the private sector range from life-care planning to income-loss analysis. To maintain a competitive edge, a practitioner in the private sector needs a thorough knowledge of rehabilitation strategies. The changing demographics of this country dictate that cultural diversity is
"a business and economic imperative ... it is not a social program" (Overman, 1991). Therefore, rehabilitation service providers in the private sector should view multicultural counseling competencies as a best-practice business initiative. In an increasingly competitive marketplace, additional competencies of any kind can give a practitioner a needed competitive edge. Possessing additional skills (i.e., multicultural counseling competencies) could make the difference between keeping and maintaining business contracts.

Most proprietors of for-profit rehabilitation practices would take time away from the office to learn about the new computerized transferability of skills or forensics software systems. These forms of training lead to increased skills and an increased knowledge base and subsequently to increased billable hours. Multicultural counseling competencies should be viewed in the same way, as a skill-acquisition activity. Increased multicultural competencies mean that persons from diverse populations may enter services more regularly, not terminate services prematurely, and, thus, display an increased rate of successful closure status. Therefore, an increase in multicultural competence could lead to increased billable hours and revenue for the rehabilitation practitioner in the private sector. Multicultural competence is a marketable skill, which offers practitioners the opportunity to expand their scope of practice and increase their profit margin. There is remunerative value in being able to work effectively with all persons.

While public sector rehabilitation has been more proactive and responsive to the changing demographics of this country, Havrenek and Stewart (1997) found that
private-sector rehabilitation facilities and their providers were lacking in the area of cultural diversity. Hence, an investigation into the current level of multicultural counseling competencies of rehabilitation service professionals in the private sector and their self-perceived training needs are both timely and warranted.

A discussion of rehabilitation in general must precede a discussion of private-sector rehabilitation. Rehabilitation is such a fascinating field because it touches upon all areas of life. All persons undergo some form of rehabilitation at some point in their lives, either formal or informal. The most rudimentary element of rehabilitation pertains to the successful navigation of life transitions and subsequent adjustment.

**The Role and Functions of Rehabilitation Service Professionals**

In the introduction to his book *Total Rehabilitation*, Wright (1980), describes rehabilitation as a

Facilitative process enabling a person with a disability to attain usefulness and satisfaction in life. The individual's disability may result from any type of disablement (i.e., physical, mental, or emotional) and from various causes (e.g., birth defects, sickness and disease, industrial and road accidents, or the stresses of war, work, and daily life). People are likewise disabled by cultural disadvantage (i.e., social, financial, or educational). Whenever any of these conditions cause difficulties in life adjustment, the person is disabled. Operationally defined, rehabilitation is the provision of any kind of service provided to individuals to correct, avoid or compensate for their disabling condition (p. 8).

Based on Wright's definition of rehabilitation, the field is extremely broad and quite expansive. The rehabilitation process has several general phases, which depend on the needs and issues of the client. He describes various forms of rehabilitation that may be utilized by professionals in the field. Wright developed the following list which demonstrates the breadth of rehabilitation options:
Physical Rehabilitation – treatment of a disease or disorder using prescriptions of medication, corrective surgery, physical agents such as sound, light, cold, electricity, manipulation, and the use of mechanical devices, physical therapy and physiotherapy.

Vocational Rehabilitation – involves counseling, testing, occupational and work adjustment training, placement, and evaluation; "the provision of any rehabilitative service (including medical, educational, social, etc) to a vocationally disabled person for the purpose of occupational (re) adjustment in work that may or may not be financially remunerative.

Social Rehabilitation – involves discussion groups, sociotherapy, independent living, sex counseling, advocacy activities, recreation etc.

Psychological Rehabilitation – involves personal counseling, psychotherapy, personal adjustment, and supportive and motivational measures directed toward increased self-acceptance and full cooperation in the entire rehabilitation effort. (p.8)

Rehabilitation is an integrated, holistic and multidisciplinary process that calls for the skills of many specialists in the rehabilitation of a disabled person. A multidisciplinary rehabilitation team could consist of a rehabilitation counselor, cardiologist, orthopedic surgeon, recreational therapist, physical therapist, and social worker. The composition of the team depends solely on the needs of the individual with a disability.

The job description of a rehabilitation service professional is as broad as the rehabilitation process itself. Hershenson (1990) describes the role of the rehabilitation counselor as assisting individuals with disabilities in restoring, replacing, or compensating for lost assets and skills; reintegration of the self-image; reformulating goals; and restructuring the environment so that it facilitates rather than impedes coping and goal attainment, especially as it pertains to the world of work. A successful
rehabilitation counselor needs to be adept in both counseling and coordinating (Dunn, Finch, & Growick, 1992).

For the multiple phases of the rehabilitation process to be successfully carried forth, the rehabilitation counselor must serve as a case manager over the entire process. He or she must ensure that the claimant is moving successfully through the program and is receiving the best possible care, to increase the possibility of the claimant’s return to work. Dunn et al. (1992) describe case management as “a method of providing comprehensive, unified, coordinated, and timely services to people in need of them through the efforts of a primary agent who, together with the client, takes responsibility for providing or procuring the services needed” (p. 616).

Depending on the employment setting, a rehabilitation counselor’s duties and responsibilities may vary. In [the] state [and] federal systems, Dunn et al. (1992), found that rehabilitation counselors are working with persons who do not have a substantial work history and may be categorized as severely disabled. The majority of the counselor’s time may be spent on the development of the client’s prevocational skills (i.e., work adjustment).

On the other hand, industrial rehabilitation calls for counselors to focus on vocational evaluation, job placement and work hardening because of the clients extensive work history. Facility-based case management calls for the same counseling and coordination skills as field based case management, but is more focused on facilitating the integration of required services among various health care providers within the same facility (Dunn, et al., 1992).
Rehabilitation counselors in a hospital setting or rehabilitation facility monitor the injured worker's treatment plan, provide overall vocational direction for the case, communicate closely with the referral source, and provide adjustment and vocational counseling for the injured worker. The vocational rehabilitation counselor ensures that all treatment efforts are directed toward return to work—the most important focus for both the injured worker and the payer of the treatment (i.e., employer insurance carrier or state workers compensation). (p. 618)

Dunn et al. (1992) suggest that a rehabilitation professional must also be multidimensional, with knowledge of psychology, the functional aspects of disabling medical conditions, guidance and counseling, and the world of work. Because of the multidimensionality of the rehabilitation process, counselors must also be diplomatic.

A rehabilitation counselor must have thorough knowledge of the client’s progress in all phases of the rehabilitation process. They will need to interface with other professionals for updates, staffing, progress reports etc.

Rehab counselors may request medical information from physicians, information on the client’s psychological adjustment from a psychologist, functional limitations and capacities information from occupational and physical therapists, and other pertinent information that could impact upon an individual’s ability to find and keep regular employment.” (p. 619)

According to Domore-Tabor and Cohen-Siskind (1990) a rehabilitation counselor must first assess the client clinically; then create an individualized written rehabilitation plan in conjunction with the client; create a relationship with the client’s employer, physician, insurance company and union; conduct a vocational evaluation; analyze potential jobs; perform work hardening; counsel the client to adjust to work; develop a job and place the client in it; and undertake vocational follow-up (p. 49).

Growick (1991) says the Americans with Disabilities Act of 1990 has increased the roles and functions of a rehabilitation counselor. Counselors are now charged with
the duty of promoting client awareness, client advocacy and empowerment, potential employer awareness and education, rehabilitation /health care agency selection or referral, and the identification and recommendation of reasonable accommodations. With the ADA, which Growick (1993) describes as the civil rights act for the disabled, comes greater accountability. Fisher and Bender (1995) say the ADA gives clear guidelines for employers to follow for the prevention of discrimination against the disabled in addition to clearly delineating the rights of individuals with disabilities. “Empowering employees with disabilities and avoiding discrimination litigation are roles the rehabilitation counselor offers business and industry” (p. 64). They explain the goal of the ADA of 1990 “is to provide a clear and comprehensive national mandate for the elimination of discrimination against persons with disabilities and to bring persons with disabilities into the economic and social mainstream of American life” (p. 65). Hence, the rehabilitation counselor will be called upon to assume a proactive role toward the goal of making the ADA’s mandate, a reality for Americans with disabilities (p. 65).

**Historical Development of Private-Sector Rehabilitation**

Fee-for-service rehabilitation has been called by many names: for-profit rehabilitation, insurance rehabilitation, proprietary rehabilitation and private-sector rehabilitation. Regardless of the label chosen, this form of rehabilitation is growing at a phenomenal rate. For the purpose of this study, the term private-sector rehabilitation will be used. Private-sector rehabilitation is defined as the provision of case management and/or rehabilitation support services on a fee-for-service basis that will
yield the most timely and cost effective rehabilitation outcome for all concerned parties.

Crystal (1993) found that the origins of private-sector rehabilitation stemmed from changes in the insurance system that generated the need for a new field of expertise that allowed for both cost containment and interpersonal contact between the claimant and the insurance company. Switzer (1993) saw that the focus of insurance systems in the 1960s and 1970s was cost reduction.

Changes were made to reduce cost, such as disposing of company cars for claims adjusters and resorting to telephonically recorded statements from insurance claimants. These changes resulted in appreciable savings in operational expenses, but the loss of personal contact created a vacuum for individuals who were injured or encountered a significant disability."(p. 63)

In the 1970s, because of increases in the length of disability contracts, insurers began to add “rehabilitation clauses,” which integrated paid wages with disability payments to persons attempting to return to work. In the beginning, these clauses were rarely used because few claimants sought jobs independently, and fewer became involved in the vocational rehabilitation system. But the creation of private-sector rehabilitation allowed for the rehabilitation clause to be used in a way that enabled more injured workers to return to gainful employment.

Without the genesis of private-sector rehabilitation these claims would have continued uninterrupted (Holt, 1993). No one was available within the insurance system to help individuals qualify for Social Security benefits, or demonstrate that return to work was possible. The insurance system greatly needed individuals who
could manage the mounting disability claims; hence the advent of case management and private-sector rehabilitation.

By the early 1970s in several states, workers' compensation could not cover lost wages. Some states had implemented maximum healing periods in which claimants received benefits for one year and were able to get their medical expenses paid. As the labor movement of the 1970s progressed, workers' compensation laws were rewritten to provide substantial increases in benefits and to eliminate healing periods. During this time the focus shifted from the welfare of the employer to the welfare of the claimant at the time of settlement and if there is a job for the injured worker to return to? Some states went on to implement mandatory vocational rehabilitation and laws, such as California AB 760 were passed to uphold this ruling.

George Welch, the founder of the Cigna Insurance Company has been credited with the creation of private-sector rehabilitation. He used rehabilitation nurses for several years prior to the 1970s. Their job description included medical care coordination, medical cost containment, and vocational rehabilitation. He is credited for making rehabilitation consulting services a fee-for-service business "blending a business with a profession."

By 1975, vocational rehabilitation by master credentialed counselors gained popularity. Insurance company nurses did not always feel comfortable with vocational cases and called for more vocational supervision. With the passage of AB 760 in California mandating the involvement of master credentialed vocational counselors,
vocational rehabilitation emerged as a significant facet of the case management process.

These historical and legislative events necessitated the creation of private sector rehabilitation. Since its beginnings in the 1960s and 1970s, private sector rehabilitation has flourished and continues to thrive. Public- and private-sector rehabilitation are two trains to the same station. The discussion that follows reveals where the two practices converge and diverge.

Similarities and Differences between Public and Private-Sector Rehabilitation

The first governmentally driven rehabilitation efforts began in 1914 with the passage of the War Risk Insurance Act. This Act provided rehabilitation and vocational training to injured military veterans. In 1917, the Smith-Hughes Act signaled the beginning of the vocational rehabilitation movement by providing funds for vocational education. Congress later amended the act to assist World War I veterans (Weed & Field, 1986). From the earliest rehabilitation legislative efforts to the ADA (1990), rehabilitation as a profession has continued to expand.

As stated earlier, the growth of private sector rehabilitation has had at its foundation the employer’s fiscal need for cost containment and the injured employee’s need for a timely return to work (Mercer, 1983; Holt, 1993). Insurance companies found that state rehabilitation counselors were placing injured workers into long-term training programs, which obligated insurance carriers to continue compensation payments until clients had completed these programs (Holt).
The treatment plans of state rehabilitation counselors were neither cost effective nor time conscious. Utilizing rehabilitation counselors in the private sector offered employers an alternative to the state system. Griswold and Scott (1979) called for state agencies to “seek out all resources available, public or private, profit or non-profit, to afford comprehensive services to all handicapped [disabled] citizens” (p. 70). Private services provided more alternatives for those individuals who were striving to return to work. Large insurance companies had employed nurse case managers to assist in the return to work effort. This system seemed to help reduce insurance companies’ costs and to place people in gainful employment faster (Holt, 1993) Thus, private rehabilitation proved its effectiveness.

In an exploratory study conducted on privatization practices in rehabilitation services, Dinwoodie (1991) asked directors of state rehabilitation agencies about the extent of privatization, motivation, methods and problems they encountered in privatizing. The results answered the question, what factors prompted the decision leading to privatization? The directors’ responses to Dinwoodie’s survey were clustered into three categories: financial, governmental, and strategic.

Financial reasons included cost effectiveness, limited ability to increase staff internally, inability to attract competent staff with specialized skills at public-sector pay, and the desire to minimize vulnerability to fiscal reductions in the public sector.

Governmental reasons included policy changes that encouraged the use of private sector resources, legislation restricting competition with the private sector, decreased willingness by the government to fund purchased services, federal
legislation encouraging consumer participation, and the perceived opportunity for increased control outside the civil service system or union agreement.

Strategic reasons, rather than having been imposed by budget or policy, were undertaken to increase the organization's ability to function in a competitive environment. Ability to expand services to clients was also mentioned by some respondents. (p. 196)

The rise of private sector rehabilitation was also associated with changing workers' compensation laws, reduced public funding, and greater public awareness of the cost of injured employees (NIDRR, 1985). Because employers were paying a high cost for injured workers, they realized the economically soundness of employing a mechanism that would return employees to the job in a shorter time with increased savings. As the state system suffered from governmental fiscal issues, the private sector began to flourish. Chase (1983) stated that the challenges of public-sector rehabilitation go beyond those of bureaucratic issues. "In addition, there appears to be role strain and frustration associated with rehabilitation counseling in the public sector and many persons in the profession appear to be interested in practicing in their own business" (p.57). Thus, while public sector rehabilitation may offer more stability, private sector rehabilitation can offer the flexibility that many professionals desire. As a result, Dinwoodie found that "Private-sector rehabilitation has proliferated at an ever increasing rate, and public sector agencies are finding themselves in the middle of a rapidly growing industry (p. 194)."
Because of the vast differences in philosophy and goals of the public and private rehabilitation sectors, private-sector rehabilitation has become distinguishable from the public sector in many ways. Weed and Field (1986) identify 17 distinct differences within the public and private sectors of rehabilitation. The private sector is primarily composed of many small companies and is funded on a fee-for-service basis, whereas the public sector relies upon funding from government allocations and is part of a large governmental agency. Private rehabilitation is staffed by professionals with diverse educational backgrounds who serve smaller caseloads (20-30) that largely consist of injured workers. Public rehabilitation counselors, in contrast, usually have vocational counseling degrees and serve larger caseloads and a more diverse population of persons with disabilities, particularly individuals with severe disabilities. Counselors in the public sector advance in their career primarily through tenure, while in the private sector advancement is determined mainly by professional achievement. Private-sector rehabilitation counselors are more likely to be involved in professional organizations and are attuned to marketing and business practices, while public-sector practitioners are less involved in these activities. Private-sector personnel may be called upon to give expert vocational testimony in a court of law, while this is rare in the public sector. Case management and recording in the private sector may be altered based upon the needs of the referring agency, while case management in the public sector is largely determined by the guidelines of the governmental program. Medical management is an element of the private sector along with medical billing review, but these requirements are not found within the public sector. Public sector counselors
often arrange basic medical diagnostic testing, but this is not common practice in the private sector. Persons in the public sector with disabilities must meet certain criteria to be eligible for services, which are geared toward maximizing the worker’s potential. The private sector, however, has few if any eligibility requirements and seeks to return an individual to a level of vocational functioning as near as possible to the pre-injury level. This characteristic is related to a greater emphasis on job placement within labor market conditions in the private sector.

Despite the numerous differences cited between public- and private-sector rehabilitation, Weed and Field (1986) have also identified 11 specific similarities in the two systems, based on the rehabilitation counselor competencies set forth by the Council on Rehabilitation Education (CORE, 1983). Both sectors are grounded in rehabilitation pedagogy. They recognize the importance of disability’s medical aspects, and they require knowledge of the psychological aspects of disabilities and vocational adjustment. Counselors in both public- and private-sector rehabilitation must know about vocational assessment and its use, standard occupational information and its application to job placement for persons with disabilities. They must also know how to use community resources, counseling theory and technique, and relevant research, and how to deliver rehabilitation services to persons with disabilities.

Weed and Field (1986) reported that “Public-sector rehabilitation jobs are becoming more difficult to find while the growth of private-sector employment is on the rise. The growth of private-sector rehabilitation has affected universities, professional associations, businesses, insurance companies, state agencies, persons in
training programs and those working in the public-sector" (p. 15). Because rehabilitation as a profession is so broad and its potential clients so numerous and diverse, it is imperative that practitioners can forge relationships with their clients that will allow for the most successful outcome.

Therefore, it is evident that rehabilitation professionals, particularly in the private sector, need to know everything that will help them in meeting their rehabilitation goals. In working with an increasingly diverse public, those in the helping professions must be keenly aware of the cultural nuances that may either help or hinder the rehabilitation process. It is critical to understand how a lack of multicultural counseling competencies could drastically affect professional outcomes. The following discussion will assist in demonstrating that point.

The Importance of Multiculturalism in the Helping Professions

Mental health and social service providers worldwide are faced with a multitude of challenges presented by an increasingly more multicultural world. No longer can clinicians be content to use traditional models of assessment and treatment. Practitioners are not only stating that it is time to learn how better to serve populations that are culturally different from themselves, they are also disclosing professional experiences that have challenged their own multicultural training or lack thereof (Parker, 1988; Chiu, 1996; Kiselica, 1998; Lark & Paul, 1998). Because the majority of treatment modalities were created for individuals of a certain cultural and ethnic background, it is imperative that practitioners be skilled in utilizing those modalities with the utmost sensitivity to cultural nuances in more diverse populations.
Practitioners are stating clearly and publicly (Kiselica, 1998; Lark & Paul, 1998; Chiu, 1996; Parker, 1988) that multicultural counseling competencies are indispensable, and they are requesting an educational system that develops awareness of multicultural counseling, relationship building, knowledge and skills.

The preparation of practitioners for the future must include the development of multicultural counseling competencies and the ability to serve a diverse market professionally and ethically. The challenges and potential problems to be encountered when working with a multicultural population can only be minimized through education and experience. This sentiment has not only been perceived throughout the counseling and psychological community, but also by various branches of the medical community as well, particularly psychiatry (Chiu, 1996).

Chiu (1996) sought to illustrate the potential challenges of working with a multicultural population and how to minimize those challenges. To demonstrate his point, he describes the case of an Orthodox Jewish American male who presented with paranoid ideation and vegetative signs of depression. He was prescribed medication but refused to take it. After consulting the client’s rabbi, the counselor discovered that the client had consulted a Hebrew pharmaceutical book and found that the ingredients in the 50-mg medication were not kosher for Passover, and therefore, he could not take it at that time. The physician was able to prescribe the 25-mg version of the medication, which was kosher. A practitioner who was not adept in factoring culture into the treatment plan could have perceived this as a case of resistance to therapy, and
a subsequent breakdown in the therapeutic alliance could have occurred. Chiu (1996) offers several proactive solutions for increasing the ability to work across cultures:

1. Practitioners must learn to be aware of the clients’ differences in verbal and nonverbal communication to prevent misunderstandings; and, should engage in cultural self-analysis to alleviate counter transference of problems.

2. Practitioners must take a thorough patient history, including religious and cultural norms, beliefs and values, particularly of those clients whose values and understanding of health are formed by local folk culture, before initiating treatment.

3. Practitioners must read articles and books that describe and analyze the impact of cross-cultural factors on mental health.

4. Practitioners must discuss the impact of socio-cultural variables with peers.

5. Institutions of higher learning and other educational organizations that train social service and mental health professionals should establish more educational courses and workshops that instill heightened awareness as to how people from different nations experience and exhibit mental and emotional disorders. (p. 138)

As early as the 1960s, counselors were realizing that the training they received at the university level may not have been sufficient to work with a diverse clientele. Parker (1988) gives three pertinent examples of how being a more culturally competent counselor could have alleviated some of his initial challenges as a recent graduate of a counselor training program. In the first case, an 18-year old female Cuban college student was experiencing anxiety in deciding whether to move into the dorms or to stay in the overcrowded home of her parents where she was distracted from her work and had limited opportunities to participate in campus life. After assessing the situation, Parker developed a treatment plan with the developmental task of leaving her parents’ home and developing a separate life of her own. The treatment plan was consistent with mainstream American values. Upon further reflection, Parker
realized that he had negated her culture in the process. "I offered this suggestion completely ignorant of Cuban cultural practices and family traditions, in which children stay at home until marriage. I also did not consider the student's individual outlook on life, her stage of assimilation into the American culture, nor her individual needs" (p.1).

Parker's second case both challenged and questioned his ability to work effectively within his own cultural group. His goal was to train African American peer counselors to work with other African American students. He attempted to teach them the client-centered approach of reflecting feelings and active listening. The trainees were very resistant to the process, stating that it was too intellectual and a waste of time. The trainees suggested that what African American students needed was concrete advice on how to survive on a predominantly white campus, meet financial obligations, achieve academically and relate to the opposite sex. This response from the students left Parker feeling frustrated, angry, and defensive. "I persisted in trying to make them buy into my point of view until the group finally self-destructed" (p.1).

When service providers lack cultural awareness and are, thus, unable to build a therapeutic relationship, clients will leave counseling services and possibly never receive the type of assistance they need or desire. It has been well documented that persons from diverse cultural groups have a tendency to terminate services prematurely (Alston & Bell, 1996, Baker & Taylor 1995). A lack of cultural competency can lead to a series of missed opportunities to assist those who require the most acute services.
The third case that Parker (1988) presented involved an African American doctoral student. The client presented with anxiety in relating to his all-white doctoral committee. He perceived his committee as being unsupportive both personally and academically and felt he was being asked to deny his African American identity. Parker thought, "How can anyone achieve a doctoral degree without following the directions of the committee?" (p.1). He did agree that the committee could possibly hold racist attitudes, but he also urged the client to explore how he might have been contributing to the problem. The client never returned for services. Parker later learned that the client felt he was insensitive to the needs of African American students.

From these three incidents that occurred relatively early in his career, Parker (1988) concluded that he had not been adequately prepared to work with ethnic minorities nor did he know what direction to take to increase his skills in that area. He subsequently attended a national conference on counseling ethnic minorities that taught him three key concepts that assisted him in becoming a multicultural counselor:

1. Counselors must become aware of their own attitudes, feelings and behaviors toward minorities and should work through any negative issues before working with multicultural populations.

2. Counselors need to acquire cultural knowledge about ethnic minorities if they hope to understand and counsel them more effectively.

3. Counselors must develop counseling skills that are consistent with the goals, cultural practices, lifestyles and identity development stages of minority clients.

(p. 67)
Parker (1988) also found that building a rapport with clients outside the office, modeling ways of surviving, forming partnerships toward problem solving, teaching students the nature of counseling and using culturally relevant techniques were also effective procedures for working with ethnic minority clients. As a professor, Parker not only challenges himself to be a more multiculturally competent service provider but also challenges his trainees to do the same. He urges his graduate students to actively acquire the skills and knowledge necessary to serve a multicultural society. His students are required to become personally involved with ethnic minority groups, read ethnic literature, practice counseling ethnic minorities, and explore their personal feelings and beliefs about ethnic minorities. As a mental health professional, Parker engages in the very rigorous, yet necessary, activity of self-analysis in order to remain aware of his personal biases. Of even greater importance is that he challenges future counselors to examine how they view themselves as cultural entities as well as how they view those from other cultures.

One of the most excruciating aspects of developing multicultural competencies is that of stepping outside one’s comfort zone to a place of professional, emotional and social vulnerability. As Kiselica (1998) reflected on his own multicultural journey, he stated, “I will share publicly, thoughts and emotions that are deeply personal. Although this form of disclosure is unusual in psychological journals, articles in which Anglos describe the real and highly human experience of engaging in cross-cultural encounters are sorely needed in the psychological literature” (p. 7). Kiselica discloses his own challenges on the road to greater multicultural competencies. One experience took
place during his pre-doctoral internship. The client was a 13-year-old African American girl who was suffering from suicidal depression following a miscarriage. During his process of working with this client, Kiselica was frequently contacted by members of the client’s church, “Although the gentleman was not an ordained minister, he repeatedly reported his efforts to ‘minister’ to the girl’s needs” (p. 15). During supervision, Kiselica expressed concern over the man’s evangelical fervor. His supervisor responded by asking him to consider the man’s actions from a cultural perspective and to read about the role of the African American church in the lives of African American families and the characteristic manner of expressing faith within the African American culture. Despite Kiselica’s defensiveness at the suggestion, and the implication that he was responding ethnocentrically, he did follow up and learned that the African American church historically has been a source of support for African American families in crisis. “Based on this new information,” he reported, “I realized that the behavior I had questioned might not only be normal within my client’s culture, but helpful towards my client’s recovery. Indeed, over time, this gentleman and many other members of his congregation played an active role in assisting the girl and her family with their problems” (p. 16). This self-disclosure reiterates that simply because you have arrived at a certain stage in your academic career does not mean that you have acquired all the skills needed to work effectively and holistically with your clientele. Kiselica uses this example to let trainees know that you never arrive, but that the journey of multicultural competencies is just that, a journey and a striving towards increased competencies.
Few practitioners would be willing to disclose their own challenges in multiculturalism or in any other arena. Kiselica (1998), on the other hand, has made self-disclosure a consistent practice in working with counselor trainees, a practice that is far removed from the academic rituals of teaching what is tried and true. Disclosing one’s challenges in multicultural counseling competencies illuminates the need for increased training on both the pre- and post-training level. The disclosures also encourage practitioners to move past personal insecurities that may be hindering them from seeking further training opportunities. Ponterotto (1998) has co-authored several books on multicultural counseling and considers himself a student of multiculturalism. Even at this point in his career, he too, shares a personal challenge that took place not during his pre-service training, but once he was on the faculty of a major university. Ponterotto (1998) shared his experience of reviewing the literature for the empirical study on multicultural counseling literature he conducted with H.B. Sabnani, (1989). They found that the Cross’s article in the *Negro to Black Conversion Experience* (Cross, 1971) was the most frequently cited. Ponterotto assumed the author was African American based on his writings. Yet at a conference, he saw Dr. Cross deliver the keynote address.

I remember the time well, as Cross’s classic book, *Shades of Black: Diversity in African American Identity* (1991), had just been published. As I sat in the audience, I was struck by his stature — tall, thin, and very light-skinned — “Caucasian looking.” I remember thinking, “Wow, I should not have assumed he was African American — I guess White people can write great stuff about the African American experience.” (p.44)

After some time, a colleague in a multicultural networking group asked about Cross’s racial background, and Ponterotto responded by saying he was White. Days
later he was corrected by Dr. Janet Helms and told that Dr. Cross was indeed African American. Later, he chided himself, asking how could he forget that the skin shade and tone of African Americans vary widely (p. 46). This example illustrates that multiculturalism is truly an ongoing experience, a life-long process.

These disclosures demonstrate that professionals are willing to become vulnerable to show the importance of these competencies. These real-life cases reveal how multicultural counseling competencies affect relationships as well as professional outcomes. The lack of multicultural competence has not only caused embarrassment, but also serious challenges to appropriate service delivery.

Any individual who is working in an environment where cultural dynamics are a variable—generally, all helping professions—needs multicultural counseling competencies. Training should focus on understanding oneself as a cultural entity who can be more culturally sensitive to the idiosyncrasies and worldview of others. The need for multicultural counseling competencies is not based on race or ethnic identity. Persons from all racial and ethnic groups need to engage in this proactive process.

The discussion that follows extends the conversation to include multiculturalism as it relates to rehabilitation.

Multiculturalism and Its Impact on Rehabilitation

The opponents (Thomas & Weinrach, 1998) of multiculturalism in rehabilitation would say that successful work with those of cultures other than the counselor is merely a question of having a user-friendly environment and being able to get along well with others. A review of the literature demonstrates that the issue is deeper than
simple work place etiquette. The impact of multiculturalism on rehabilitation runs the
gamut from persons of color not being accepted for rehabilitation services to
disparities in treatment planning (Wheaton, 1995).

Flowers and Edwards, (1996); Pernell-Arnold (1998); Riggar, Eckert and
Crimaldo, (1993); Rubin, Pusch, Fogarty and McGinn (1995) Schaller (1998); and
Wright (1988) have all discussed issues of multiculturalism, cultural diversity and
rehabilitation. They do not depict the research that opponents of multiculturalism say
feeds into stereotypes and cultural encapsulation, (Thomas & Weinrach) but rather
look at the fundamental importance of multiculturalism and cultural competencies in
the vast field of rehabilitation.

The literature reveals that multicultural counseling competencies are indeed
important in the field of rehabilitation. Articles have been written suggesting how to
better serve Asian Americans, African Americans, Native Americans, Latino/Latina
Americans and countless other ethnic and racial group members (Alston, & McCowan,
1994; Black, et al., 1994; Braswell & Wong, 1994; Feigin, 1995; Herbert & Cheatham,
1988; McFarlane, Galea'I, Farley, & Guerrero 1995; Smart & Smart, 1994). The
preponderance of research in this area highlights the need for effective service delivery
to multicultural populations. Yet despite the number of “how-to” articles, practitioners
in the field of rehabilitation are not meeting the needs of the diverse clients they serve.
“Lack of sufficient service provider cultural sensitivity has been seen as resulting in
persons with disabilities who are members of ethnic and racial minority groups being
disproportionately rejected for rehabilitation services. When accepted, minority clients
have been provided less effective services resulting in poorer rehabilitation outcomes compared to their Caucasian counterparts” (Rubin, et al., 1995, p.253).

Schaller (1998) explored the issue of multicultural counseling competencies in the provision of rehabilitation services. He looked at how and by whom disability is defined and how services are offered and made accessible for individuals and families from culturally diverse backgrounds. In addressing how disability is defined, he contends that disability is a culturally based construct which varies from one cultural group to another. Because the concept of disability is the main thrust of rehabilitation, the practitioner must understand how the client views disabilities. In one culture, disability may be considered a punishment from God. In another, there may not even be a word in the language to define disability.

The greatest need for increased multicultural counseling competencies is evidenced in the considerable disparity in rehabilitation services to persons of color (Atkins & Wright, 1980; Ross and Biggi, 1986). The literature has consistently shown that rehabilitation service providers lack sensitivity and awareness when working with individuals who are culturally different from themselves. Some theorists say that this lack of sensitivity and awareness is due to “enculturated” racism (Alston & Mngadi, 1992; McIntosh, 1986) that is embedded in the psyche. Smart & Smart (1994) attribute the disparity to the service provider’s lack of expectation, which impedes the counseling relationship and provides the client with a substandard individualized written rehabilitation plan (IWRP) resulting in undertraining and underemployment.
Wright (1988) discusses past research that spoke to the “identifiably unique characteristics and special challenges to the rehabilitation counseling profession that ethnic minorities present.” (p. 4). In addition to presenting data on the rising presence of persons of color in the work force and their consequent involvement in rehabilitation services, Wright discusses the expanding role of rehabilitation counselor-education programs and the additional functions they must assume to provide the necessary pre-service and in-service training which enhances the ability of rehabilitation counseling professionals to provide rehabilitation services. “The appropriate knowledge, skills and experiences which will be required must be identified and integrated into the training curricula” (p. 4). These include knowledge of ethnic minority cultures, values, life-styles, economic conditions, and vocational/career development among others (p. 4). Wright does not talk about the awareness aspect of multicultural competencies, because they were not emphasized until Sue (1992) elaborated on the necessary components of multicultural competencies. Wright, however, does underscore the responsibility of rehabilitation counseling professionals and rehabilitation agencies for identifying potential training needs and service delivery issues by reviewing existing training and service delivery programs, identifying research needs, developing alternative service patterns, establishing ethnic minority advisory groups and providing the necessary funding mechanism that will enhance the rehabilitation of ethnic minorities with disabilities (p. 4).

Wright goes directly to the center of the multicultural competency issue. He challenges all rehabilitation counseling professionals to behave ethically by assuming
the responsibility to “educate, inform and prepare rehabilitation counselors and administrators to identify and provide the most appropriate and efficient services available to eliminate the indefinable obstacles to rehabilitation success” (p. 9) for ethnic minorities.

Wright (1988) offers several recommendations for preparing rehabilitation professionals to serve persons of color with disabilities:

1. The preparation of professionals to serve ethnic minorities with disabilities must be understood and accepted as a rehabilitation education issue – not as a minority issue to be addressed only by African American, Hispanic/Latinos, Asian-Americans and Native Americans.

2. This initiative must be accepted as being as necessary a knowledge and skill as knowledge of job placement, communication, assessment, characteristics of disabilities, etc.

3. The council of Rehabilitation Education (CORE) must insure that all rehabilitation counselor education training programs include appropriate curricula in accreditation standards for programs; and

4. The National Rehabilitation Association (NRA), the National Council on Rehabilitation Education (NCRE) and the American Rehabilitation Counseling Association (ARCA), as well as other professional organizations must encourage the development and incorporation of ethical standards which address the rehabilitation of ethnic minorities with disabilities (p. 8)

The recommendations were set forth in 1988 and reiterated in 1990 by the passage of the Americans with Disabilities Act. Yet the profession, in general, has been very slow to act on the critical need for multiculturalism to be infused into the curriculum of rehabilitation counselor education. Pape, Walker and Quin (1983) recommended that “Educators should continue to make certain that rehabilitation curriculums are structured to include discussion and information about cultural diversity factors in the context of courses such as psycho-social aspects, group
dynamics, introduction to rehabilitation, counseling theories, communication
skills/techniques, case studies, practicum, testing and evaluation (p. 22). This concept
has been a pipe dream within the field. More than 15 years later, multiculturalism may
be allocated only one course, if any, in most training programs, and this is often an
elective.

The field has to move away from the notion that multiculturalism has to do with
others. Multiculturalism is inherently about all people being seen as multifaceted,
multicultural entities. Greater self-knowledge will lead to greater awareness of the
unique characteristics of others (Myers, 1991), and will greatly assist in the
communication and overall rehabilitation process.

Wright's review of the literature on enhancing the professional preparation of
rehabilitation counselors certainly reflects the times. In the late 1980s the discussion
was centered on trying to get white persons to learn about people of color in an attempt
to improve services to ethnic groups. If the same article had been written today, the
review of the literature would certainly reflect the importance of rehabilitation
professionals' becoming more aware of both cultural diversity and of themselves as
cultural beings, facing their own biases as they work with persons of color. This is the
dialogue of a new consciousness of greater awareness and the integration of that
awareness within the counseling relationship.

One of the many challenges to embracing and treating multicultural
competencies as a valuable skill is the preponderance of qualitative research in this
topic area. Many researchers believe that if information is not quantifiable, it is not
scholarly (Kiselica, 1998; Ponterotto, 1998). However, the qualitative research in this area is worth serious consideration. Often the subtle nuances of an issue are lost in a barrage of quantitative statistics. Kiselica and Ponterotto present a strong case for multiculturalism from a practitioner's perspective. Most of the articles in this review are qualitative, which should help the reader to understand the practical reasons for acquiring multicultural counseling competencies.

As rehabilitation counselors are trained, little attention has been given to any preconceived notions or stereotypical views they may hold about persons unlike themselves. These subconscious views may have a positive or negative impact on the counseling relationship. Rubin et al., (1995) examine the “negative impact and effects of enculturated stereotypes on the performance/behavior of rehabilitation counselors with clients from minority groups” (p. 254) and discuss the implications for rehabilitation counselor education.

“A negative stereotype has been formed when members of one culture, through enculturation, perceive the characteristics of another culture as both different from their own and undesirable, and attribute those characteristics to all members of the other culture (Skillings & Dobbins, 1991, cited in Rubin, et al, 1995 p. 253).” If this stereotypical view of an individual is brought into the counseling relationship, the likelihood of receiving equitable services is minimal at best. The stereotype-based expectation will fuel the interaction at every level, thus allowing for misinterpretation in communication at both verbal and non-verbal levels. If a counselor trainee does not challenge his/her stereotypes, inevitably, these views will be incorporated into their
personal belief system as a service provider. These stereotypical views can also lead to decreased contact with persons different from themselves and lead to the perpetuation of false beliefs. "Whether a rehabilitation counselor's behavior is influenced by a stereotype can depend, in part, on whether that individual has experienced a fundamental conflict between the prejudicial belief and exposure to minority group members whose characteristics and behavior are incompatible with that belief (p. 255)." This is an important point to consider. When a long-held stereotype is challenged by a member of a majority group, the majority group member may respond by stating that the minority group member is different from others in their cultural group, when in fact, the member of the majority group has little experience with persons of that minority group, but many stereotypical assumptions. Rehabilitation counselors need exposure to persons unlike themselves to challenge their stereotypes and learn to see real individuals instead of perceived stereotypes.

Skillings & Dobbins (1991) have observed that in the rehabilitation process, enculturated stereotypes frequently affect (a) the selection of helping intervention, (b) the selection and interpretation of assessment data from evaluation instruments, (c) the development of trust in the counselor-client relationship, and (d) and their comfort in working with minority groups clients. "Culturally insensitive responses by counselors can negatively affect the type and quality of services provided throughout the entire rehabilitation process" (p. 256). This may have something to do with premature termination of services which is prevalent among people of color. (Wilson, 1997)
Cultural sensitivity is a critical factor in the rehabilitation process. Rubin et al, (1995) cite examples of cultural communication styles that could be misinterpreted because of a lack of cultural awareness. A Navajo client may exhibit a downward glance or lack of eye contact, which in the Navajo culture denotes a sign of respect. Someone who is not aware of the cultural nuances of the Navajo people could interpret the downward glance as a lack of motivation. African American clients may be more emotionally expressive, which may be interpreted as hostile or angry. The culturally unaware rehabilitation counselor may experience discomfort and terminate services or misdiagnosis the client (p. 257). “The successful facilitation of minority clients through the rehabilitation process requires the counselor’s awareness and consideration of the client’s values, family structure, and community structure, in addition to an awareness and consideration of the functional limitations resulting from the disabling condition” (p. 257).” Culture cannot be deduced from the rehabilitation equation. From intake to job placement, awareness of and inclusion of cultural sensitivity is necessary to the rehabilitation process.

According to Skillings and Dobbins (1991), “Rehabilitation counselors should be aware that vocational assessment aptitude measures can be biased against minority group members as they have been developed synonymously with intelligence test, and are subject to the same set of validity concerns when being used with minority clients” It is unethical and inherently biased to use test instruments on individuals they were not normalized on. The results must be interpreted with cultural sensitivity.
Wright (1988) raised significant points regarding the direction of multicultural competence in the field of rehabilitation. Rubin (1995) went one step further, benefiting from the multicultural competencies set forth by Sue (1990). This expansion of multicultural competencies emphasized the need for self-awareness and self-exploration by the service provider. Speight, Myers, Cox, and Highlen (1991) suggested that the “opportunity for self-exploration is a necessary step for developing the ability to create an effective relationship with minority clients. It enables majority counselors to obtain self-knowledge and conscious awareness of their own assumptions, biases, thoughts and feelings regarding themselves and others” (p.32).” Rubin (1995) says that much cultural sensitivity can occur via positive experiential contact with persons from different cultures. This allows counselors the opportunity to explore their own racism and resultant behavior that may affect their counseling relationship with minority group clients. This suggests that the multicultural models of the past must be expanded to understand the worldview of self and others to create a bridge of understanding between client and counselor.

Multicultural competence is not only needed by practitioners. The concept and practice also need to be embraced on an administrative and/or agency level (Feist-Price, 1994; Havranek & Stewart 1997; Schaller, 1998). This is particularly important in private-sector rehabilitation where fewer government mandates and training requirements are imposed or recommended. Whether public- or private-sector rehabilitation, current levels of multicultural counseling competencies must be assessed to provide appropriate training opportunities and curriculum development.
rehabilitation, current levels of multicultural counseling competencies must be assessed to provide appropriate training opportunities and curriculum development. Multicultural competency assessment has emerged in the decade of the 1990s. The discussion that follows highlights the most current test instruments available.

**Measurement of Multicultural Counseling Competencies**

Relative to the total amount of literature on multicultural issues, little attention has been directed toward developing psychometrically sound and conceptually anchored instruments for evaluating multicultural counseling training. Furthermore, much of the attention devoted to multicultural issues has focused on awareness (of one's own biases) and knowledge (of culturally diverse values), but little attention has focused on specific skill development and evaluation (Ponterotto, 1994 p. 316).

The helping professions have called for greater multicultural competencies for more than 30 years. But only in the past decade have researchers sought out a means to measure the multicultural competencies of helping professionals. The development of such test instruments is critical in that they serve as a measure of the effectiveness of training programs, demonstrate a need for further training, and provide a baseline for the specific training needed. These assessment instruments assist in answering the following question: Are practitioners in the helping professions multiculturally competent, and if not, what type of training do they need?

Presently, four test instruments measure multicultural counseling competencies: the Cross-Cultural Counseling Inventory-Revised (CCCI-R), the Multicultural Counseling Awareness Scale-Form B (MCAS:B), the Multicultural Awareness-
Knowledge-and Skills Survey (MAKSS) and the Multicultural Counseling Inventory (MCI). Each has been evaluated for its utility, format, psychometric properties and item development (Ponterotto et al., 1994; Pedersen, 1994).

The Multicultural Counseling Awareness Scale-Form B: Revised Self-Assessment (MCAS) was developed by Ponterotto, Sanchez, and Magids (1990). The purpose of the MCAS is to assess multicultural counseling awareness, knowledge and skills. It consists of a 45-item scale, revised from an earlier 70-item version, that includes several social desirability questions as a component of the scale. In terms of reliability, coefficient alphas have been reported in two studies, and content validity was established through experts' judgment of items for clarity, appropriateness, and conciseness (Ponterotto et al., 1990). The instrument has yet to be tested using a large sample. According to Ponterotto (1994), the instrument needs to be tested using concurrent validity studies, including further evaluation of the two dimensional structure (awareness/skills factors) of the instrument (Ponterotto et al., 1994).

The CCCI-R, a 20-item instrument, was developed by LaFramboise, Coleman, & Hernandez (1991) and has as its goal assessing the effectiveness of counseling with clients of diverse cultures.

The scale is completed by an evaluator who rates how the 20 items describe the counselor. The CCCI-R is reported as having adequate reliability with internal consistency and moderate evidence for criterion related, construct and content validity (Ponterotto et al., 1994). Currently it is the only multicultural counseling assessment tool that does not rely on self-reported data collection. Additional testing is needed on
the scale’s test-retest reliability and inter-rater reliability. Because questions have been raised about the factor structure of the CCCI-R, its developers suggest that users score it only as a unidimensional (total score) scale. It also needs to be tested with a widespread geographical base, in addition to needing factor analytic studies.

The MAKSS, which comprises three subscales, was developed by D’Andrea, Daniels, and Heck (1991) to assess multicultural counseling competencies of students based on the effects of multicultural counseling instruction. The instrument is a 60-item self-reporting questionnaire that asks for counselors’ perceptions of their multicultural awareness, knowledge and skills. Research on the MAKSS has not been extensive, however it does have satisfactory internal consistency (Cronbach’s alphas were computed with .75, .90, and .96 respectively for the awareness, knowledge, and skills subscale scores). The MAKSS can discriminate between groups of counselors who have and have not been trained in multicultural counseling issues. Based on research conducted by Ponterotto (1994), this instrument could benefit from concurrent validity checks with related instruments.

Sodowsky, et al., (1994) developed the MCI, a 40-item self-reporting instrument whose purpose is measuring multicultural counseling competencies. It is composed of four subscales: multicultural counseling, awareness, knowledge, and the multicultural counseling relationship. It is the only assessment instrument of its kind that has a counseling relationship subscale.

The creation of these instruments for assessing multicultural counseling has made it possible for the rehabilitation profession to answer the ethical and professional
mandate of legislation. The following discussion will highlight legislation that supports the inclusion of multicultural competencies into the field of rehabilitation.

Legislation and Multiculturalism within the Field of Rehabilitation

Growick (1993) called the American with Disabilities Act (ADA) the Civil Rights Act for the disabled. The primary function of the ADA is the “elimination of discrimination against individuals with disabilities.” (Middleton, Flowers, & Zawaiza, 1996, p. 21). Since the passage of this legislation, there has been much controversy over its implementation. Racial and ethnic minority groups are faced with a double stigma because of their heritage and disability status. The primary assumption of the ADA is that all Americans with disabilities, including persons of ethnic/racial minority groups, will benefit from voluntary compliance. The goal of ending discrimination for this segment of the population of persons with disabilities may continue to be an unfulfilled promise (Middleton et al, 1996). Because racial/ethnic minorities are the fastest growing segment of American society, this promise to end discrimination must become a promise realized.

Members of ethnic and racial minorities are much more likely to experience disability (Walker, Adbury, Maholmes & Rackley, 1992). Factors relating to increased risk of disability include poor prenatal and perinatal care, inadequate nutrition and diet, greater risk for injury because of living conditions and types of employment situations, inaccessible health care, and lack of proper health care knowledge and education (Walker, et al, 1992). Because of this preponderance of racial and ethnic minorities
disabilities, the ADA is a critical piece of legislation that both encourages and supports increased and ethical service to all persons.

Leung (1993) set forth a list of recommendations aimed at encouraging practitioners to rethink the objectives of the ADA in such a way that its implementation will have a greater impact on traditionally underserved populations:

1. Adopt a broader, more comprehensive educational program, to include use of “cultural/ethnic” press. There needs to be recognition that cultural/ethnic values, etc., affect how individuals may respond to legislation related to disability, and that language may also affect understanding legislation and compliance.

2. Change some of the strategies currently utilized to involve “brokers” or individuals, and organizations, which have facility with language, and values of both mainstream and the specific ethnic/minority group. These include grass roots organizations, individuals, churches, etc.

3. Intensity efforts to identify and reach the different ethnic/racial organizations to highlight issues related to ADA. These include organizations such as the National Association for the Advancement of colored people (NAACP), the Japanese American Citizens League (JACL), Service, Employment, and redevelopment (SER), etc.

4. Target efforts through use of “indigenous investigators” who can survey areas higher in density for ethnic/cultural minorities, locating problem areas for education, and assistance in correcting non-compliance or deficiencies.

5. Increase funding to include expertise of persons with disabilities available within ethnic/racial communities in exploring solutions. Minority ethnic/racial communities have survived because they have found alternative ways to cope with the larger society. These communities can provide creative ways to deal with ADA compliance if given the task and resources to do so. In reality, this is a further extension of empowerment.

6. Focus efforts, utilizing visibility of spoke persons of minority populations targeted, and in context of culturally accepted ways of approaching compliance issues. This recommendation follows the strategies employed by marketing specialist in targeting products to specific audiences (Leung, p. 97)

The ADA is not the only legislative attempt to end discrimination within the disabled community. The Rehabilitation Act Amendments of 1992, specifically
Section 21, also attempted to provide legislation that would encourage practitioners to meet the needs of all persons. "The goal of Section 21 was to affirm, value, and ensure that governmental policies represented all Americans. Congress included various underrepresented populations, such as individuals with disabilities, people of color, persons with limited English proficiency, and members of other culturally diverse groups. Diversity was viewed as a national strength, not as a liability, and as something precious that celebrated culture, heritage, traditions, and contributions of all people. Congressional and governmental leaders sought to reform rehabilitation by encouraging more diversity and the inclusion of underrepresented populations in the rehabilitation system (Middelton, Flowers, & Zawaiza, 1996, p 13)."

The need to include diversity initiatives in the rehabilitation system directly correlates with the fact that "members of underrepresented racial and ethnic groups experience disabling conditions at a disproportionately higher rate when compared with majority populations. They are the subjects of inequitable treatment at all major junctures of the vocational rehabilitation process (Atkins, 1988, p 14)." Atkins suggests that the disproportionate number of ethnic minorities with disabilities coupled with changing demographics encouraged the creation of the National Rehabilitation Cultural Diversity Initiative.

The N-RCDI was designed, in part, to increase the capacity and participation of targeted members of traditionally underrepresented racial and ethnic groups at the preservice, inservice, and continuing education levels of the public rehabilitation program. A major focus of the N-RCDI was to bring more individuals from these groups into the profession to provide knowledge, role models, and a sufficient workforce to address the clearly changing demography of vocational rehabilitation (p. 18)."
This document was created to assist in paving the way for the necessary changes that must occur within the rehabilitation system.

Despite the mandates, legislation and prompting of professional organizations, the challenge to fully infuse multicultural practices and understanding into the field of rehabilitation has been left unmet. Riggar et al. (1989) recommend a five-step proactive change management process to introduce the intercultural exchanges necessary for attaining multiculturalism:

1. Begin by determining the need for change and the degree of choice present about whether to tolerate change.

2. Set goals and define a common vision for a future that extends beyond the boundaries of each individual’s own cultural interpretations;

3. Diagnose the present condition of the organization in relation to the desired future state and establish person-organization value congruency;

4. Define the transitional activities and commitments required to reach each goal; activities may include acquiring reciprocal intercultural communication skills related to speaking, writing, and receptive language skill;

5. Develop and carry out strategies for effectively managing cultural diversity (p.23).

It is clear that rehabilitation service providers need to be more proactive in the area of multiculturalism. These competencies will not be gained through osmosis, but rather through further training and the development of a curriculum that will effectively train practitioners to work with diverse populations. Riggar states that “Rehabilitation organizations will not find the attributes necessary for attaining multiculturalism without preparation. Opportunities for greater multiculturalism must be created using strategies such as face-to-face interviews, talk-outs, focus groups, written survey questionnaires and in-service training that allows people to meet, learn,
and form better working and socially relevant relationships. A new attitude and renewed sense of mutual responsibility are needed by all rehabilitation personnel to achieve multiculturalism in a culturally diverse rehabilitation workforce" (p.42).

Riggar et al., (1989) also believe responsibility for cultural understanding should go beyond the individual counselor.

Human resource managers, rehabilitation organization leaders, and educators have a responsibility to become a) more aware of the complexity of cultural identity patterns, which may or may not include the obvious indicators of race, ethnicity, and nationality; b) more aware of their own culturally learned perspectives and the way in which these perspectives predispose them toward particular expectations and decisions that can disparately affect the rehabilitation student or consumer; c) more effective in recognizing and tracking the ever changing salience of individuals’ different, interchangeable cultural identities within the educational and rehabilitation setting; and d) more effective in matching instructional modalities and communication styles with the individual’s culturally based expectations, learning modalities, lifestyles, and behavior (p.26).

The dialogue on multiculturalism is not new. Training programs within the helping profession have begun to move towards cultural pluralism but the road ahead is long. The discussion that follows will delve into the seeming receptivity of multiculturalism within the helping professions and give an overview as to where multicultural competency training and attainment stands.

**Multiculturalism within Counselor Training Programs**

This segment will look at the reasons and rationale behind the receptivity of rehabilitation counseling, psychology and other counselor training programs toward multicultural education or the lack thereof. It will also explore the challenges and strengths of the counseling discipline in regard to educational pluralism.
Over the past 20 years, the term *multicultural* has slowly come to life out of the cross-cultural movement. From a historical perspective, cross-cultural counseling described the process of counseling American minorities who were labeled as culturally different (Das, 1995). This definition of cross-cultural counseling is an antecedent of multiculturalism, and has consequently been understood in these terms. Das states that "multicultural counseling has been broadly described as any counseling relationship in which the counselor and the client belong to different cultural groups, hold different assumptions about social reality, and subscribe to different world views." (p.37) Pedersen (1988) stated that multicultural counseling was a situation in which two or more people with different ways of perceiving their social environment are brought together in a helping relationship.

The decade of the 1990s seems to have brought variation to the definition of multicultural counseling. In Axelson's (1994) definition, multicultural counseling is "the interface between counselor and client that takes personal dynamics of the counselor and client into consideration alongside the emerging, changing, and/or static configurations that might be identified in the cultures of the counselor and the client." (p.13).

In 1991, Speight et al. redefined multicultural counseling as basic to all forms of helping relationships, drawing their construct from the school of transpersonal thought that arose with the development of optimal theory (Myers, 1985). Optimal theory "provide[s] a cultural and historical basis for breaking through the barriers of superficial differences to understand the more salient issues of values, attitudes,
emotions, and experiences" (Myers, 1991 p.60). All counseling is multicultural in nature. In this redefinition, there is no entity called “regular counseling.” Rather it encourages us to simultaneously look at our individual uniqueness and our commonalities and consider a harmony of differences.

Regardless of the definition of multicultural counseling one favors, the most important question now is whether institutions of higher learning have embraced it in counseling and made it an integral part of counselor training programs. The literature suggests that the only answer can be no, but universities are making an attempt. Unfortunately, the attempt is very small.

Bernal and Padilla (1982) were the first to challenge the true receptivity of counseling programs towards multiculturalism. Their study was prompted by the growing number of minorities in the United States and the critical need to prepare mental health professionals to provide quality services to ethnic minority populations. Questionnaires were sent to 106 accredited clinical psychology programs, of which 76 responded: 31 programs offered 57 minority-related courses. “Minority-related,” however, was not clearly defined. And as only 16 programs taught 74% of these courses, only a handful of programs seemed to have valued multiculturalism. Fifteen clinical psychology programs (20 percent) offered “minority” or cross-cultural clinical courses, and two of these programs also offered courses on the minority child. Not one of the responding programs required minority or cross-cultural clinical courses for the completion of the Ph.D., although one program required a course in cross-cultural clinical skills. Only 11 respondents actually submitted a syllabus or a bibliography for
the courses. Thus, there is the content of most of the courses could not be ascertained
nor the extent they deal with issues that pertain to persons of another culture.

In Bernal and Padilla’s study, two programs housed a set of courses and
experiences designed to provide a broad based cross-cultural experience as a critical
component of psychologist preparation. Programs that offered units on multicultural
issues tended not to offer full courses; which seemed like an attempt to make
multicultural education an integral part of each course as opposed to an isolated event.
Among courses that included multicultural units were assessment, social psychology,
personality, community psychology, abnormal psychology, contemporary professional
issues, program evaluation, group process and mental health consultation.(p. 785)

Bernal and Padilla (1982) also discussed the faculty’s role in prioritizing
multiculturalism and minority training resources on and off campus. Forty-three
percent of the programs had faculty coordinators who were interested in minority
issues, and at least one faculty member in 49% of the programs was engaged in
minority-related research.

Regarding training resources on and off campus, 24% of the programs indicated
that they had co-sponsored workshops on minority issues with various ethnic studies
departments, and 48% of respondents had sought the expertise of non-academic based
ethnic minority mental health professionals. Bernal and Padilla’s (1982) most
astounding revelation was the response of directors to the question “How important is
it to provide multicultural curriculum and training to future clinical psychologists.”
Only 11% said it was extremely important; 29% said it was very important; 46% said
it was somewhat important; 8% said it was not too important; and 1% said it said not important. These statistics speak to the very weak link between the critical need for solid multicultural education and the lack of serious commitment to its inclusion in the curriculum. Bernal and Padilla concluded, “This survey suggests that this comprehensive multicultural approach was poorly represented in coursework, clinical practice, research training, and language requirements for the Ph.D.” (p.786).

Basically, programs are attempting to bring multiculturalism into the classroom, but they are ushering it in quite slowly and ineffectively.

In reviewing the literature on the presence of multicultural education in counseling psychology programs, only one article was found that directly focused on multicultural training in APA-approved counseling psychology programs. Hills and Strozier (1992) modeled their study after the work done on the status of minority curricula and training in clinical psychology by Bernal and Padilla (1982). They looked at counseling psychology programs and the extent to which multicultural issues were given attention in coursework, practica, and research. They also examined the number of faculty in multicultural teaching, supervision, research and professional development; the pressures to develop multicultural curricula and research; and the numbers of ethnic minorities within programs. Forty-nine of the 61 APA-approved counseling psychology programs in the country responded to surveys, with 43 reporting at least one multicultural course; 31 having chapters or units in other courses; 29 having multicultural course requirements and 22 permitting students to create a sub-specialty. Overall, junior faculty were more involved in all areas of multicultural
training. "When senior faculty were involved, less pressure existed to increase multicultural coursework, more multicultural courses were required and a subspecialty was more available" (Hills & Strozier, 1992).

Quintana and Bernal, (1995) attempted to replicate the 1982 study conducted by Bernal and Padilla, by assessing the attention that both the fields of clinical and counseling psychology are giving to multicultural issues. Over the years, these two aspects of psychology seemed to have blended together even though the focus of clinical psychology is diagnosis and treatment of psychopathology and counseling psychology has paid more attention to identifying and working with the strengths of its clientele.

Quintana and Bernal began their investigation by casually surveying the professional journals of each discipline and found that counseling psychology journals tended to be more focused on ethnic and racial diversity than journals in clinical psychology. Over the past decade, 13.33% of articles in Counseling Psychologist were on racial or ethnic issues compared to a mere 4.1% in The Clinical Psychologist. The authors thus surmised that multiculturalism may become the strand that sets the two disciplines apart.

The followed their preliminary research by comparing multicultural training in counseling and clinical psychology in 1990-91, by surveying the training directors of all APA-approved counseling and clinical psychology doctoral programs. The survey questionnaire looked at seven areas: courses, faculty role in training, use of other training resources, practicum training, research, formalized training programs and
faculty view of training. With a response rate of 67% and 70% respectively, results showed that counseling psychology was only slightly more involved in multicultural training than clinical psychology. These results were surprising given the fact that counseling psychology had always given a generous amount of attention to issues of diversity as evidenced by official publications on the topic and conference themes. Quintana and Bernal’s (1995) failure to find significant differences between programs may be attributed to outside factors that are similarly affecting both programs. The authors suggest sociocultural bias and prejudice that is widespread in the United States is likely to affect both psychology specialties in similar ways. “Unfortunately sociocultural bias may lead some programs to underestimate the amount of feasibility and value of making more substantial changes. Consequently, the challenge to counseling psychology programs is to appreciate fully what control is available to them and channel these resources toward multicultural training.” (Quintana & Bernal, 1995) This research also showed a startlingly large portion of counseling programs that were resistant to and deficient in providing multicultural training. This research demonstrates that because of counseling psychology’s mission and visibility it has the ability to contribute a great deal to the multiculturalism movement, but important changes need to be made before culturally proficient counselors graduate from counseling psychology programs.

According to the results of the few studies that have looked specifically at the inclusion of multicultural counseling into the curriculum of counseling and clinical psychology programs (Hills & Strozier, 1992; Bernal & Padilla, 1982; Quintana &
Bernal, 1995), we see that the journey towards true multicultural education continues to be a challenge to the field.

Aside from the programs that have added a multicultural requirement (Toporek & Reza, 2001) to their curriculum, professional organizations have also contributed to the seeming receptivity of multiculturalism in counseling and counseling psychology programs. Professional organizations have also contributed to the seeming receptivity of multiculturalism in counseling and counseling psychology programs. "Most professional accrediting bodies such as the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and the American Psychological Association (APA) specify by standards, that counseling programs must educate faculty and students to guard the individual rights and dignity of their clients."

(Midgette & Meggert, 1991). What this means is that the helping professions have an ethical duty to be prepared for work with diverse populations. Ivey (1987) stated that only by placing multicultural counseling at the core of counseling curricula can counselors serve and be with those who need assistance. Unfortunately, this is not being implemented; it is only being entertained. McGoldrick et al., 1982, had a similar opinion. "There are still many psychotherapists in the United States who are trained with hardly a reference made to ethnicity.... in fact, most of us have gone through our entire professional education with hardly a word mentioned about ethnicity. It is not surprising that therapists have not appreciated the role of ethnicity in developing therapeutic models and interventions." (p.5)
Professional organizations had the right idea when they set forth guidelines and mandates for including multicultural education into counselor training programs, but they failed to strongly enforce their position. Multiculturalism has not been taken seriously as a fourth force in counseling (Pedersen, 1991). It is difficult to imagine a counseling curriculum that reserves one individual class to understanding and integrating the concepts of psychodynamic, behavioral and humanistic explanations of human behavior, that Pederson identifies as the first three forces in counseling (1991). The field of counseling psychology has significant challenges and strengths as it relates to educational pluralism, the grandmother of multicultural education. According to England, (1992), pluralism can be defined as a society in which members of diverse ethnic, racial, religious, and social groups maintain participation in and development of their traditions and special interest while cooperatively working toward the interdependence needed for a nation's unity. This definition is very idealistic and in an ideal world educational pluralism would exist. All cultures and groups would be made an equal part of the curriculum. Gone would be the days of adhering to theories that are products of middle-class European-American culture. Techniques based on these theories work best with clients who share the values and assumptions of the culture (Das, 1995). In a truly educationally pluralistic society the issue of multicultural education would not be an issue, but it would be a given. In order for multicultural education to truly be integrated into the curriculum, educational
pluralism must exist, or it could be said that if educational pluralism existed multiculturality would not be a separate issue—it would not be an issue at all.

Let us now examine some of the challenges and strengths in regards to educational pluralism in the discipline of counseling. One of the primary challenges is resistance to change. The research of Bernal and Padilla (1982) that there was a general reluctance on the part of the directors of training programs to perceive cross-cultural issues in therapy as important topics of study. The discipline has been taught in the same fashion for several decades and here comes these new age terms which attempt to turn history around. Historically speaking, pluralism has not existed in the field of counseling psychology or counselor education. As Pederson (1991) found, when challenged by the stress of radical social changes, it is not always possible to replace worn out habits with new alternatives. The challenge to bring an entire profession out of its comfort zone and embrace these concepts is a phenomenal task at best.

Another challenge facing training programs that offer the token multicultural class is to expand their curriculum to a more pluralistically inclusive format. Once counselor-trainees have taken this course, they may assume that they are competent, having a false sense of security that they are ready to deal with clients from diverse populations. Programs that handle multiculturalism in this fashion are doing a great disservice to their trainees. Lloyd (1987) postulates that the current trend of delivering generalized information about different cultural groups to counselors in training may not assist them in becoming more effective in counseling situations with those of
differing cultures. Lewis and Hayes, (1991) argue that “The concern is that students may use that information in a generalized way to form stereotypical judgments about the clients personal needs and issues rather than to respond to the client as an individual” (p.121). Students are being sent out ill-prepared to deal with their clients, which may cause negative repercussions not only for the client but also for the therapist and agency as well.

McGoldrick (1982) provides a very tactful disclaimer by stating that...“the authors have described ethnic patterns using simplified pictures of the cultures. There are disadvantages in this approach; the most obvious of which is stereotyping. We are keenly aware of the perniciousness of negative stereotyping and in no way wish to contribute to that tendency in our culture, although it can not be denied that our snapshots can be misused in that way.” (p. 5) Unfortunately, as convenient as this instructional method can be, it can also fosters racism, sexism, ageism, and all the other -isms that cause roadblocks to communication and true understanding.

“Although acknowledging and understanding value and attitudinal differences between cultures is obviously important to counselors, there can be some negative consequences of an overzealous concentration on cultural differences.” (Pedersen, 1983 p. 181). The cultural encapsulation approach must be eliminated. It is merely a reactive stance to a growing multicultural population. The compartmentalized approach to teaching multiculturalism does not allow for the individual differences within groups ... it makes the mistake of overemphasizing the culturally unique perspectives while neglecting those common-ground universals and within-group
differences that are shared across cultures (Pedersen, 1991). Multicultural counseling courses need to focus on assisting counselor trainees to become competent in a pluralistic society. The APA Division 17 position paper on cross-cultural counseling competencies (Sue, et al., 1982) outlines three areas of competency for the cross-cultural counselor: (a) beliefs/attitudes, (b) knowledge, and (c) skills. The APA believes that a competent cross-cultural counselor must be well trained in all three areas.

While the fields of psychology and counselor education must overcome several challenges before multiculturalism can take root as the fourth force in counseling, we cannot overlook the current strengths in regard to multiculturalism and educational pluralism.

One of the greatest strengths of the multicultural movement are the many psychologists and counselors (Myers, 1988; Speight et al., 1991; Leong, 1991; Ponterotto & Benesch, 1991; Bernal & Padilla, 1982; Parmer, 1994) who support the concept and write on issues that push multiculturalism to the forefront. The advocacy of the concept is critical to its stronghold in the profession. Without credible advocates, multiculturalism would have already been a forgotten concept. Someone has to be willing to fight for the cause, and several mental health professionals have accepted the challenge.

There are also training programs with very strong reputations for their commitment to multiculturalism. Multicultural programs can be found at the University of Maryland (College Park), Syracuse University, Boston University, and
the University of Hawaii, to name a few. One program in particular that has made notable strides is actually a school-counselor training program, but its efforts are exemplary. The school counselor program at Western Washington University (Bellingham) has as its main goal to train counselors whose approach to all clients is distinctly multicultural in nature, incorporating considerations of cultural background and experience, ethnicity, socioeconomic status, sex and age. We view multiculturalism as a thread that runs through our entire program, just as cultural and ethnic considerations are relevant to understanding the experience and problem situations of all clients. (Lewis & Hayes, 1991, p. 121)

Western Washington University has adopted a holistic approach to multiculturalism. Like most universities, the faculty comprises predominantly white Americans with cultural backgrounds that differ greatly from non-white Americans (Lewis & Hayes, 1991). In recruiting new faculty, a serious effort is made to recruit minorities or persons who have substantive experience working with persons from other cultures. Faculty members are also required to read the literature on cross-cultural counseling and multiculturalism. “Faculty members must also be willing to examine and challenge their own personal attitudes and beliefs about persons of other cultures and ethnic origins (Lewis & Hayes, 1991). The university also has a center for cross-cultural research housed within the psychology department. Students are encouraged to develop theses with cross-cultural or multicultural themes. In addition to the encouragement to contribute to the multicultural literature, students are also required to “engage in an ongoing counseling relationship with at least one client of a different ethnic or cultural background as part of the field placement and to conduct at least one classroom activity aimed at increasing sensitivity to multiculturalism” (Lewis

65
& Hayes, 1991). This article makes strides to move from theory to practice, demonstrating that placing multiculturalism into the whole of the curriculum is not an impossible task.

The university’s president summed it up nicely when he stated, “We must broaden our definition of an educated person to include one who has examined race, gender, and ethnicity in American culture. Our aim is to develop an atmosphere at Western where people glory in diversity rather than just tolerate it” (Lewis & Hayes, 1991, p. 121). If we look around, evidence does exist to indicate that positive strides are being made and that there are a faction of individuals who are truly dedicated to the cause of multiculturalism.

An additional strength of multiculturalism is the fact that various curriculum models exist (Ponterotto, 1988; Pederson, 1988). This demonstrates effort on behalf of the field. The majority of these models suggest that a multifaceted approach which includes experimental contact with persons from differing cultures, coupled with an opportunity for the student to examine their skills and beliefs is best (Mio, 1991). This experiential approach has been examined by several researchers in recent years (Manese, Wu, & Nepomuceno, 2001; Lazaro & Cohen, 2001; Sevig & Etzkorn, 2001). Manese, Wu, & Nepomuceno collected pre-test, post-test data on counseling and psychology interns over a ten year period in order to investigate the effect of training on multicultural counseling competencies. Interns were given the Multicultural Counseling Awareness Scale (Ponterotto, Sanchez & Magids, 1991) at the beginning and end of their internship year. During the internship year culture and individual
differences were integrated into all experiences. The results indicated that knowledge and skills increased as a result of the multicultural training.

Pederson (1973) created the triad training method, which consists of videotaped cross-cultural counseling role-play that involves three people. The third person plays either a supportive ally to the counselor or is anti-counselor who highlights relevant cultural values that have an impact on the counseling relationship (Pederson, 1978). After the role-play, participants view their taped interactions and share insights about their observations. Because the role of the pro-counselor or anti-counselor is played by someone from the same cultural background as the client, it promotes understanding of potential cultural, ethnic, or racial conflicts between counselor and client (McRae and Johnson, 1991). This model allows for a simulated connection to cultural others.

Johnson (1982) was the first to develop a multicultural training program that included the competency triad: awareness, knowledge, and skill. The Minnesota Multiethnic Counselor Education Curriculum (MMCEC) provided expertise from psychologists of various ethnic backgrounds, and ethnically focused interviews with clients from each ethnic group, and experimental exercises that allowed trainees to practice and apply the knowledge learned. Johnson (1982) developed a two-part graduate course that encompassed theory and current research, followed by a laboratory course that was entirely experimental. This model takes the counselor trainee out of the contrived classroom role-play environment and places the trainee with real people, but it does so gradually.
There are several ways to approach the issue of incorporating multiculturalism into the curriculum and the training of not simply culturally sensitive counselors, but culturally proficient counselors (Quintana & Bernal, 1995). The task of the profession is to recognize which techniques are more effective and adapt standards that the profession as a whole will adhere to.

In summary, the field of counseling has been engaged in a more than 30-year struggle to place multiculturalism at a position of importance within the discipline. Barriers and resistance to change still exist, but hope can be found in the dedication of the many rehabilitation counselors, mental health counselors and psychologists who have published in the area and developed training models despite opposition. “It is no longer possible for counselors to ignore their own culture or the culture of their clients. Until the multicultural perspective is understood as making a counselor’s job easier instead of harder and increasing rather that decreasing, the quality of a counselor’s life, however, little real change is likely to happen” (Pedersen, 1991).
CHAPTER 3

METHODOLOGY

The chapter's purpose is to describe the methodology used to conduct this study. Included are descriptions of the population, sample, instruments, data collection procedures, research design, and statistical analysis. This chapter is organized into six sections: The first section is the research design. The second provides a statement of the research questions. The third describes the instrumentation used in the study as well as descriptions of the variables. The fourth provides a description of the procedures used in data collection, including a description of the population from which the sample was drawn, the sampling procedure, and the actual data collection procedures. The fifth provides a description of the participants of this study. The final section presents a description of the data analyses employed in answering each research question.

Research Design

This study used a self-report, paper and pencil quantitative survey, which allowed the researcher to describe the characteristics of the rehabilitation service providers and how this population is distributed on the multicultural counseling
competencies and the selected demographic variables. Specifically, a cross-sectional survey method was utilized to collect information at one point in time from a sample of rehabilitation practitioners in the private sector. Ary, Jacob, and Razavich (1985) indicated that a major purpose of descriptive survey research is to inquire into the status quo and attempt to measure what exists without questioning why it exists. The statistical design component of this research design was used to explain the relationships among the variables and to predict the likely outcomes of the significantly correlated variables. The major purpose of correlation research is to clarify the understanding of important phenomena through the identification of relationships among the variables being studied, and to predict the likely outcomes of the variables. This design yields data that demonstrates the relationships between multicultural competencies and selected demographic characteristics of rehabilitation professionals in the private sector.

In this research design, self-report questionnaires were used because such instruments are the most extensively used form of data collection. Respondents can reply to sensitive questions privately, which is useful in securing a more reliable response, and survey questionnaires are less time-consuming and less expensive than either interview or observational methods (Dillman & Salant, 1978).
Research Questions

The purpose of this study, as specified in Chapter 1, was to investigate the current level of multicultural counseling competencies and the self-perceived adequacy of training of rehabilitation service professionals in the private sector nationwide. Toward this end, seven global research questions were formulated to provide focus and clarity for the study:

Research question one. What is the relationship between the selected demographic characteristics of rehabilitation service providers in the private sector and their multicultural counseling competencies? More specifically, is there a relationship between each of the demographic variables—sex, age, race, highest degree earned, major area of study, and geographic location of current practice—with the multicultural competencies of knowledge, awareness, counselor relationship, and skills, as well as overall multicultural competency as measured by the MCI?

Research question two. Do rehabilitation service providers in the private sector differ from those in the public sector with respect to multicultural counseling competency?

Research question three. Is the amount and type of training in multiculturalism related to multicultural competency?
1. Is the number of mandatory multicultural counseling courses related to multicultural competency as measured by the knowledge, awareness, counselor relationship, skills, and total scales of the MCI?

2. Is the number of workshops in multiculturalism related to multicultural competency as measured by the knowledge, awareness, counselor relationship, skills, and total scales of the MCI?

3. Is the number of training sessions in multiculturalism related to multicultural competency as measured by the knowledge, awareness, counselor relationship, skills, and total scales of the MCI?

Research question four: Is self-perceived adequacy of multicultural preparation related to multicultural competency as measured by the knowledge, awareness, counselor relationship, skills, and total scales of the MCI?

Research question five. Is satisfaction with training in multiculturalism related to multicultural competency?

1. Is satisfaction with mandatory multicultural counseling courses related to multicultural competency as measured by the knowledge, awareness, counselor relationship, skills, and total scales of the MCI?

2. Is satisfaction with workshops in multiculturalism related to multicultural competency as measured by the knowledge, awareness, counselor relationship, skills, and total scales of the MCI?
3. Is satisfaction with training sessions in multiculturalism related to multicultural competency as measured by the knowledge, awareness, counselor relationship, skills, and total scales of the MCI?

Research question six. Is the amount of experience in either private rehabilitation or rehabilitation in general related to multicultural competency?

1. Is the number of years of experience as a rehabilitation provider in general related to multicultural competency as measured by the knowledge, awareness, counselor relationship, skills, and total scales of the MCI?

2. Is the number of years of experience as a rehabilitation provider in the private sector related to multicultural competency as measured by the knowledge, awareness, counselor relationship, skills, and total scales of the MCI?

Research question seven. What combination of demographics, training, satisfaction with training, perceived adequacy of preparation, and experience variables best predicts multicultural counseling competency?

Instrumentation

The participants in this study were asked to complete an instrument comprised of three components: The Multicultural Counseling Inventory (MCI) (Sodowsky, et al., 1994), The Marlowe-Crowne Social Desirability Scale (MCSDS) (Crowne &
Marlowe 1964), and the Demographic Information Form (DIF). Each instrument is described below.

**Multicultural Counseling Inventory (MCI)**

Sodowsky, et al. (1994) created the Multicultural Counseling Inventory (MCI). The MCI is a self-report instrument consisting of 40 items scored on a 4-point Likert scale: 4 = very accurate to 1 = very inaccurate, and a fifth response (does not apply).

The Education and Training Committee of the American Psychological Association’s (APA) Division of Counseling Psychology (APA Division 17) conceptualized three dimensions of cross-cultural counseling competencies. This committee (Sue et al. 1982) proposed the following three competency areas: (a) skills which cover proficiencies in multicultural communications and in observing the multicultural counseling roles; (b) cultural self awareness and other awareness which covers the affective domain, encompasses therapists’ attitudes toward their own culture and toward differences in cultural values and biases, and; (c) knowledge which covers the cognitive domain, including knowing the theory, research, and cross paradigmatic approaches to multicultural counseling to understand cultural diversity (Sodowsky et al. 1994 p. 138). Relationship was a competency area added as a fourth dimension by Sodowsky et al. to assess the counselor’s interaction process with minority consumers.

The MCI is divided into the following subscales based on the work of APA Division 17:
Skills: The skills scale is composed of 11 items that measure both general counseling (6 items) and specific multicultural counseling skills (5 items).

Awareness: This scale has 10 items measuring multicultural sensitivity, interactions, and advocacy, both generally and professionally, in addition to enjoyment of multicultural activities, and multicultural increases in the caseload.

Relationship: This scale is composed of eight items that measure the counselor's interaction process with the minority client. Areas measured are counselor trustworthiness and recognition of the worldview of persons from different cultures, as well as comfort level with and possible stereotyping of the minority consumer.

Knowledge: The 11 items on the knowledge scale measure an understanding of multicultural treatment planning, culturally relevant treatment strategies, and multicultural research.

Results from several studies have supported using the MCI in assessing multicultural competencies. Past research (Sodowsky et al., 1994; Ottavi, Pope-Davis, & Dings, 1994; Pope-Davis & Dings, 1994) using this instrument demonstrates that it is a “psychometrically robust instrument, measuring distinct, yet interrelated dimensions.” (Sodowsky, 1996, p.318). Studies conducted by Pope-Davis and his colleagues (Pope-Davis & Nielson, 1996) found that subscale internal consistency (Cronbach's Alpha) reliabilities were generally high, ranging from .65 for relationship (Pope-Davis, et al., 1993) to .82 for skills (Pope-Davis et al., 1995). Pope-Davis and
Dings (1995) also concluded that construct-related validity appeared to be adequate and that content related validity “seems good for an instrument of this type, although not quite sufficient by the standards applied to standardized tests” (p. 299).

The Marlowe-Crowne Social Desirability Scale (MCSDS)

The MCSDS is a 33-item true-false questionnaire that is widely used to measure the degree to which a respondent may be answering in a socially desirable direction. When asked potentially sensitive attitude and behavior questions, few wish to be seen as responding in what might be seen as a biased or unfavorable manner. Thus, some persons have a tendency to answer such questions the way they believe the questions are “supposed to be answered.” High scores suggest that the person may be responding in a way that suggests a strong need for approval. Evidence has shown that compared to low scorers, high scorers on the MCSD respond more to social reinforcement, inhibit aggression, and are more amenable to social influence. High scorers also may tend to exaggerate their claims to good qualities (Crown & Marlowe, 1964). Therefore, a high correlation between the MCI and the Marlowe-Crowne raises suspicion about the veracity of the MCI responses (Wheaton & Granello, 1998).

Demographic Information Form (DIF)

This instrument is a modified version of the instrument Wheaton and Granello (1998) utilized in a similar study that investigated the multicultural competencies of rehabilitation counselors in a state vocational rehabilitation system. The instrument includes 15 items designed to gather socio-demographic, occupational, and training/
educational information. Additional items were developed for each characteristic of interest in this study.

The form contains socio-demographic information items: sex, age, race, major area of study, geographic location of practice and highest degree earned. The remaining items focus on occupational and training-related information; the amount of multicultural training (including the number of courses, workshops, and training sessions attended), perceived discrimination, satisfaction with multicultural training, interest in workplace training, percentage of minority caseload, adequacy of training to work with diverse cultures, years in the profession, and future training needs.

The DIF was given to a panel of four human service professionals (NARPPS members who were not included as participants in this study) to evaluate face validity before the survey was mailed to respondents. This panel included two doctoral students in rehabilitation counseling, a licensed professional counselor working in the area of job analysis, and a counseling psychologist working as a professor at a major research university and in private practice.

Data Collection

The Population

The population for this study was composed of rehabilitation professionals who were members of the National Association of Rehabilitation Professionals in the Private Sector (NARPPS). As an association, "NARPPS is dedicated to enhancing the competency of private sector rehabilitation professionals, advancing the professional
field, improving the effectiveness of state-level affiliates, and playing a leadership role in the resolution of public policy issues that affect private sector rehabilitation” (NARPPS, 1997, p.1).

The membership of NARPPS includes representatives of several disciplines that contain a rehabilitation focus. “The interdisciplinary nature of NARPPS membership brings the strength of diversity to an association which invites case managers, rehabilitation nurses, educators, occupational therapists, vocational counselors, rehabilitation managers/administrators, job placement specialists, vocational evaluators, and other professional disciplines united in providing rehabilitation services in the private sector.” (NARPPS, 1997, p.1.) Consequently, the rich diversity of disciplines within the organization offers an optimal setting for the examination of multicultural competencies in the field of private-sector rehabilitation.

**Sampling Procedure**

The researcher secured permission from NARPPS to select randomly a sample of rehabilitation professionals from the national membership population for the purpose of this study. The active membership consisted of 2800 members. From this, 500 subjects who met this study’s criteria were randomly selected to receive a mailing requesting participation in the study. In order to be selected, participants had to have the opportunity to be currently providing rehabilitation services. Thus, students, retirees, and emeritus members were excluded from this study.
The NARPPS comprehensive membership directory was used to randomly select the n=500 sample. The total number of those listed was determined and a file containing numbers representing each eligible person in the list was developed. The file was then imported into SPSS, and the SPSS random select feature was used to identify the cases. The NARPPS directory was then used to pull the cases that were identified through the SPSS random selection process.

**Data Collection Procedures**

Selected procedures were followed in this study to help control for representativeness, measurement error, and data accuracy. A conscientiously structured process for choosing a sample representative of the population was implemented by paying particular attention to selecting the population of interest and using a randomization method to select the sample from the population. The Total Design Method (TDM) of survey research (Dillman & Salant, 1978) provided this study with a systematic method of data collection. The TDM assists in maximizing response quality and quantity from the respondents by employing a precise mailing and follow-up procedure to maximize the return rate.

Each of the 500 subjects received the survey contents and specific instructions on completing the questionnaire by first-class mail. The mailing included a one-page cover letter, the MCI, the MCSDS, and the DIF. The questionnaire was printed on goldenrod paper and was compiled into a 5"x7" booklet. Dillman and Salant (1978) suggested creating an instrument that is attractive and would elicit the attention of
potential respondents. Respondents were also given the researcher's telephone number if needed for clarification or assistance.

Following the TDM method, the mailing included two other elements. First, a business reply mail envelope, professionally printed with the address of the university and the return address of the department, was included for the return of the completed questionnaires. The cover letter stressed that respondents not place their name or other identifying information on the return envelope or questionnaires so that they could return the packet anonymously (See Appendix B). Second, a pre-paid commemorative, professionally printed postcard was included for the respondent to return separately from the survey packet. Three weeks after the original mailing, a follow up mailing was sent out. Each mailing used a different commemorative stamp on the postcards. The commemorative postcards were used to encourage respondents to read the questionnaire and to increase the return rate (Dillman & Salant, 1978). They also indicated the mailing to which the respondent was replying.

The postcards provided in the first and second mailings allowed the respondent to check a box if they wanted to receive a written summary of the results. This procedure was designed to maintain the respondents' anonymity on the questionnaires while providing the researcher a means to follow up with participants who did not return their packets within two to three weeks (Dillman & Salant, 1978). Assuring the participants a high level of confidentiality was considered necessary to secure candid
responses from subjects. Coding was used on the questionnaires only to follow up non-respondents. The completed questionnaires were coded numerically and dated as they were received so that promptness of response could be analyzed. No information was used from the return envelopes, which were destroyed.

Three weeks after the initial mailing date, a follow-up packet was sent to all participants, via first class mail. The packet was the same as the original mailing. However the cover letter urged participants to please reply to this second mailing. To aid in increasing the response rate, the guidelines for the TDM follow-up procedures were used. Follow-up commemorative postcards were sent via first class mail to all participants. The mailing thanked those who had returned their completed questionnaires and served as a reminder to those who had not yet returned theirs (Dillman & Salant, 1978). Data were collected between February and May 1998.

Risk to Participants

A description of the study was submitted to The Ohio State University’s Human Subjects Review Committee, which granted a waiver from review based upon Category IV criteria. This waiver is presented in Appendix C. Information concerning identification of subjects was kept in strict confidence, and all identifying information was omitted from the questionnaires. Only group data were reported.
Statistical Analysis

This section presents the statistical analyses used to answer the research questions given previously in this chapter. For purposes of ease of reference, the research questions are restated here, followed by the statistical procedure(s) used. In addition, the variables used in each analysis are identified. Analysis of the research questions was conducted using SPSS/PC.

Research Question One

What is the relationship between the selected demographic characteristics of rehabilitation service providers in the private sector and their multicultural counseling competencies?

Dependent variables: The Scales of the Multicultural Counseling Inventory (MCI). The Multicultural Counseling Inventory (MCI) contains the criterion (dependent) variables used in this research question. The MCI has four subscales—awareness, knowledge, skills, and counseling relationship—as well as a total score. Each subscale is measured on a four-point Likert scale from “very inaccurate” to “very accurate.”

Independent variables. Selected demographic characteristics were the predictor (independent) variables used in this research question. All these demographic variables were obtained by self-report from the demographic questionnaire. Their definition and scaling follow.

1. Sex. A categorical variable with two levels: male and female.
2. **Race/Ethnicity.** A categorical variable with two levels: European and non-European.

3. **Age.** A continuous variable measured in years.

4. **Highest educational degree earned.** An ordinal variable with five levels:
   a. High school diploma or GED.
   b. Associates degree.
   c. Bachelors degree.
   d. Masters degree.
   e. Doctoral degree.

5. **Major area of study.** A nominal variable with four categories:
   rehabilitation, rehabilitation related, rehabilitation unrelated, and no major.

5. **Geographic location of current practice.** A nominal variable with five categories:
   a. Northeast,
   b. Northwest.
   c. Midwest.
   d. Southeast.
   e. Southwest.

*Statistical analysis for research question one. Pearson-product moment correlation coefficients were used to describe the relationships between each of the*
multicultural counseling competency (dependent) variables and the independent variables of age, race, and gender. One-way ANOVAs were used to determine the relationships for the independent variables of geographic location, major area of study and highest degree earned with each of the MCI scales.

**Research Question Two**

Do rehabilitation service providers in the private sector differ from those in the public sector with respect to multicultural counseling competency?

**Variables.** The subscales and total scale of the MCI was the criterion or dependent variable of the study. The independent variable was type of rehabilitation provider membership. It was a nominal variable with two levels: private rehabilitation provider or public rehabilitation provider.

**Statistical analysis of research question two.** The group mean MCI scores of the private rehabilitation service providers in this study were compared with the group mean MCI scores of those in the public sector as reported by Granello and Wheaton (1998). A series of one-sample t-tests were used for the comparison.

**Research Question Three**

Is the amount and type of training in multiculturalism related to multicultural competency?

**Variables.** The subscales and total of the MCI were the criterion or dependent variables for this research question. The separate independent variables were (a) the number of mandatory multicultural counseling courses, (b) the number of workshops,
and (c) the number of brief training sessions in multiculturalism, all of which were
categorical in nature.

Statistical analysis for research question three. A series of monotonic trend
analyses was used to answer this question. The dependent variables, which were
analyzed separately, were the four scales of the MCI as well as the total MCI. The
factor for each set of analyses consisted of the amount of training of a particular type
(courses, workshops, or training sessions).

In other words, the first set of analyses was performed for the number of
mandatory courses on each separate MCI scale. The second set involved the number of
workshops on each scale, and the third set consisted of the number of training sessions
on each scale.

Trend analyses were performed because of the nature of the scaling of the
independent variables. That is, the independent variables were ordinally scaled rather
than nominally scaled. Eta (\( \eta \)) was used as a measure of effect size (see Wheaton &
Granello, 1998).

The factors were not combined in the analysis design because of the lack of
independence among them. For example, the participants could have taken any
combination of courses, workshops, and/or sessions, and almost certainly not all
participants took the same combination. Thus, it was not possible to analyze the
number of courses, workshops, and training sessions in conjunction with each other. It was more appropriate to examine them separately.

Research Question Four

Is self-perceived adequacy of multicultural preparation related to multicultural competency?

Variables. The subscales and total of the MCI were the criterion or dependent variables for this research question. The independent variable was item 84 of the DIF, self-reported perceived adequacy of preparation to work with persons from other cultural groups.

Statistical analysis for research question four. A series of monotonic trend analyses for perceived adequacy of preparation was performed, one for each MCI scale. The three ordinal groups for adequacy of preparation: were adequately prepared, somewhat adequately prepared, and not adequately prepared.

Research Question Five

Is satisfaction with training in multiculturalism related to multicultural competency?

Variables. The subscales and total of the MCI were the criterion or dependent variables for this research question. The separate independent variables were (a) satisfaction with mandatory multicultural counseling courses, (b) number of workshops, and (c) number of brief training sessions in multiculturalism.
Statistical analysis for research question five. A series of monotonic trend analyses was used to answer this question. The dependent variables, which were analyzed separately, were the four scales of the MCI as well as the total MCI. The factor for each set of analyses consisted of the amount of satisfaction with training of a particular type (courses, workshops, or training sessions).

In other words, the first set of analyses was performed for satisfaction with mandatory courses on each separate MCI scale. The second set involved satisfaction with workshops on each scale, and the third set consisted of satisfaction with training sessions on each scale.

Trend analyses were performed because of the nature of the scaling of the independent variables. That is, the independent variables were ordinally scaled rather than nominally scaled. Eta ($\eta$) was used as a measure of effect size (see Wheaton & Granello, 1998).

Consistent with the statistical analyses for research question three which dealt with the amount of training of each type, the satisfaction factors were not combined in the analyses because of the lack of independence among them. For example, the participants could have taken any combination of courses, workshops, and/or sessions; and almost certainly not all participants took the same combination. Thus, it was not possible to analyze satisfaction with courses, workshops, and training sessions in conjunction with each other. It was more appropriate to examine these separately.
Furthermore, satisfaction with a specific type of training was not combined with amount of that training to produce two-way trend analyses because of practical reasons: Simply, there were not enough subjects per cell. In fact, at times, the cell size dropped as low as three participants, with the total number per analysis of 29. It was determined that this would not yield any meaningful or useful information. Since this is an exploratory study, it was decided to risk an inflated alpha (α) error and an infraction of parsimony for the sake of perhaps obtaining some useful results.

**Research Question Six**

Is the amount of experience in either private rehabilitation or rehabilitation in general related to multicultural competency?

**Variables.** The subscales and total of the MCI were the criterion or dependent variables. The independent variables were the number of years of experience in the field of private rehabilitation and in rehabilitation in general.

**Statistical analysis for research question six.** Two sets of Pearson correlations were performed. The criterion variables for each set were the subscales of the MCI. The single independent variable for the first set was the number of years the provider had worked in the field of private rehabilitation (question 93). The independent variable for the second set was the number of years the provider had worked in the field of rehabilitation in general (question 94).
Research Question Seven

What combination of demographics, training, satisfaction with training, perceived adequacy of preparation, and experience variables best predicts multicultural counseling competency?

The intent of this research question was to provide a model that could best predict multicultural competencies.

Variables. The scales of the MCI were the dependent variables.

Selected training and experience characteristics were the independent variables for this research question. All training and experience variables were obtained by self-report from the demographic questionnaire. These variables included the following:

1. The number of workshops
2. The number of training sessions
3. The number of mandatory multicultural counseling courses attended
4. Satisfaction with past multicultural training in workshops
5. Satisfaction with training sessions, satisfaction with mandatory courses
6. Self-perceived adequacy of multicultural preparation
7. The number of years of experience as a rehabilitation professional both in the private sector and in general.

Statistical analysis for research question seven. Stepwise multiple regressions were performed on each of the multicultural competency scales. The predictors for each regression were those independent variables found to be significantly related to
the particular dependent variable or MCI scale in a preliminary correlation analysis. In other words, zero-order correlations were obtained between each of the independent variables and each MCI scale. For a single multiple regression involving one particular MCI scale, only the independent variables that were found to have a significant zero-order correlation with that scale were included. This process was repeated for every MCI scale, so it was possible to include different predictor variables for the five multiple regressions. This technique was chosen as a means to reduce the number of predictor variables, eliminating those with no significant zero-order relationship with the MCI scale and thus probably not contributing to the overall accounting of variance.
CHAPTER 4

RESULTS

This chapter presents the results of the statistical analyses applied to the seven research questions described in Chapter 3. The reader is referred to that chapter for a description of sampling procedures, data collection, and detailed research questions. The implications of the findings presented in this chapter will be discussed in Chapter 5.

This chapter is organized into two major sections. The first presents descriptive statistics on the demographic and training variables. The second major section is organized around the specific research questions. In that section, the research questions are restated for reference purposes and then are followed by the results of the statistical analyses.

**Descriptive Statistics for Demographic and Training Variables**

This section presents descriptive statistics for the demographic and training variables used throughout this study. This information was obtained from the Demographic Information Form (DIF), and can be classified as socio-demographic information or occupational training related information.
There were 21 demographic and training items on the DIF, contained in Section III of the actual questionnaire. For ease of reference, Table 4.1 presents a synopsis of these questions and their item numbers as found in the DIF, with the specific response choices omitted. For the actual questions, the reader is referred to Appendix E.
### Demographic Items

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>74</td>
<td>Highest earned degree</td>
</tr>
<tr>
<td>75</td>
<td>Major area of study</td>
</tr>
<tr>
<td>85</td>
<td>Interested in taking course in multicultural competencies if offered in the workplace</td>
</tr>
<tr>
<td>86</td>
<td>Percentage of caseload that is minority consumers</td>
</tr>
<tr>
<td>87</td>
<td>Geographic service area in the United States</td>
</tr>
<tr>
<td>88</td>
<td>Consider racial discrimination a problem within private rehabilitation system</td>
</tr>
<tr>
<td>89</td>
<td>Thinks consumers denied opportunities by rehabilitation professionals based on race</td>
</tr>
<tr>
<td>90</td>
<td>Sex</td>
</tr>
<tr>
<td>91</td>
<td>Race</td>
</tr>
<tr>
<td>92</td>
<td>Age</td>
</tr>
<tr>
<td>93</td>
<td>Years worked in field of private rehabilitation</td>
</tr>
<tr>
<td>94</td>
<td>Years worked in field of rehabilitation in general</td>
</tr>
</tbody>
</table>

### Training Items

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>76</td>
<td>Number of mandatory courses on multiculturalism in degree program</td>
</tr>
<tr>
<td>77</td>
<td>Satisfaction with these multicultural courses</td>
</tr>
<tr>
<td>78</td>
<td>Number of workshops on multiculturalism lasting more than a day but less than a week</td>
</tr>
<tr>
<td>79</td>
<td>Satisfaction with these multicultural workshops</td>
</tr>
<tr>
<td>80</td>
<td>Number of training sessions or inservices on multiculturalism lasting one day or less</td>
</tr>
<tr>
<td>81</td>
<td>Satisfaction with training or inservices in multiculturalism.</td>
</tr>
<tr>
<td>82</td>
<td>Number of training experiences in multiculturalism focused on self-knowledge</td>
</tr>
<tr>
<td>83</td>
<td>Number of multicultural training experiences examining worldview of different cultural groups</td>
</tr>
<tr>
<td>84</td>
<td>Adequacy of training to work with persons from other cultural groups</td>
</tr>
</tbody>
</table>

Table 4.1. Synopsis of demographic and training variables given to participants, as found in the DIF.
Frequencies, percentages, and means and standard deviations (when appropriate) were obtained for these demographic and training variables and are presented here. This section is organized with the descriptive data presented first for the demographic variables and then for the training variables. For simplification, the data is presented in text rather than tabular form where feasible. This data is presented in paragraphs, with the name of the demographic variable preceding each paragraph.

Demographic Variables

Gender. \(N = 209\) Of the subjects who responded to this item in the study, 137 (65.6%) were female; 72 (34.4%) were male.

Age. \(N = 201\) The mean age of respondents was 46.4, with a standard deviation of 8.72. The majority of respondents (78.6%) were over 41 years of age. The youngest respondent was 26 years of age, and the oldest was 76. Ten participants did not report their age.

Race. \(N = 207\) The majority of respondents, 137, or 66.2%, were classified as European American, while 70 respondents (33.8%) were classified as non-European Americans. Four respondents did not report their race. Originally, there were four categories for ethnic groups (African American, Asian American, Hispanic American, and Native American) but because of low numbers, they were collapsed into a single category of non-European American. Although collapsing the groups does not consider the cultural nuances of ethnic minorities, it still offers insight into the differences in multicultural competencies of non-European Americans as a group.
Educational level. A high majority of the respondents (63%) had attained a graduate degree, 10% of which were doctoral degrees. Two respondents (1%) had no formal education beyond high school. Educational level was collapsed into two categories, a bachelor's or associate's degree, and a graduate degree (either a master's or doctorate). The two participants who had no degree beyond high school were eliminated from the study. Six participants failed to give educational information.

Years worked in private rehabilitation. The mean number of years worked in private rehabilitation was 13.4 (SD = 6.76). Table 4.1 presents the frequencies and percentages of years worked in private rehabilitation broken down by categories representing number of years. The majority of respondents (n = 161; 77.8%) had worked in private rehabilitation between 6 and 25 years. Twenty-three respondents (11.1%) had worked in the field of private rehabilitation five years or less, whereas seven respondents (3.4%) had worked in private rehabilitation for 26 or more years. Four respondents did not report this information.

Years worked in field of rehabilitation in general. The mean number of years that participants had worked in the field of rehabilitation in general was 16.60 (SD = 7.53). Table 4.2 also presents the frequencies and percentages of years worked in rehabilitation in general, broken down by categories representing number of years.
Again, the majority of these (84.6%) had worked between 6 and 25 years. Only 11 participants (5.3%) had worked in the general field of rehabilitation for 5 years or less, while 21 (10.1%) had worked for more than 25 years. Four participants did not report this data.

Major area of study. Major area of study comprised three categories: (a) the field of rehabilitation, such as rehabilitation counseling, rehabilitation administration, rehabilitation education; (b) fields related to rehabilitation, such as special education, psychology, social work, sociology, counseling, guidance and counseling, deaf education, nursing, speech, occupational therapy, physical therapy; and (c) fields unrelated to rehabilitation, such as education other than special education, art, English, business, and all others. Of the 207 respondents who gave this information, 82 (39.6%) of them had majored in rehabilitation, 96 (46.4%) had majored in rehabilitation related fields, and 29 (14.0%) had majored in fields unrelated to rehabilitation. Four respondents did not report this information.

Table 4.2. Frequencies and percentages for years worked in private and general rehabilitation.

| Years worked | Private | | |
|--------------|--------|--------|--------|--------|
|              | Frequency | Percent | Frequency | Percent |
| 5 years or less | 24 | 11.6 | 11 | 5.3 |
| 6 – 25 years | 177 | 85.5 | 175 | 84.5 |
| 26 or more | 6 | 2.9 | 21 | 10.1 |

96
Interest in workplace multicultural competency course. When asked if they would be interested in taking a course in multicultural competencies if it were offered at their workplace, an overwhelming majority of the 207 respondents answered in the affirmative (n = 166, 80.2%). Only 41 respondents (19.8%) were not interested.

Percentage of minority caseload. This item was categorized into four percentage groups. (The original response of “0” was grouped with the 1–15% category.) Table 4.2 presents the frequencies and percentages of those who responded in each category. Almost half the respondents (46.8%) had 15% or fewer minority consumers. Eight respondents did not report this information.

<table>
<thead>
<tr>
<th>Minority Consumers</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% - 15%</td>
<td>95</td>
<td>46.8</td>
</tr>
<tr>
<td>16% - 30%</td>
<td>45</td>
<td>22.2</td>
</tr>
<tr>
<td>31% - 45%</td>
<td>31</td>
<td>15.3</td>
</tr>
<tr>
<td>Over 45%</td>
<td>32</td>
<td>15.8</td>
</tr>
<tr>
<td>Total</td>
<td>203</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 4.3. Descriptive data for percentage of caseload that consisted of minorities.

Service area in the United States. When asked the location of their service area, 201 respondents replied. Their responses are presented in Table 4.4.
<table>
<thead>
<tr>
<th>Service Area</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast (New York, Massachusetts, etc.)</td>
<td>32</td>
<td>15.9</td>
</tr>
<tr>
<td>Northwest (Montana, Washington, etc.)</td>
<td>36</td>
<td>17.9</td>
</tr>
<tr>
<td>Midwest (Ohio, Michigan, etc.)</td>
<td>33</td>
<td>16.4</td>
</tr>
<tr>
<td>Southeast (Florida, Georgia, etc.)</td>
<td>55</td>
<td>27.4</td>
</tr>
<tr>
<td>Southwest (Texas, Arizona, etc.)</td>
<td>45</td>
<td>22.4</td>
</tr>
<tr>
<td>Total</td>
<td>201</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 4.4. Geographic service area of respondents.

*Racial discrimination. (N = 204)* When asked if they considered racial discrimination to be a problem within the private rehabilitation system, 143 (70.1%) respondents said no; 61 (29.9%) respondents said yes, they considered such racial discrimination to be a problem.

*Denied opportunities based on race. (N = 204)* When asked if they believe that consumers are denied opportunities by rehabilitation professionals based on race, 146 respondents (71.6%) said no; 58 respondents (28.4%) said yes. Seven respondents did not reply to this item.

*Training Variables*

*Number of mandatory courses. (N = 208)* More than half, 127, (61.1%), were not required to take a multicultural counseling course in their degree program; 40 respondents (19.2%) were required to take one course, and 41 respondents (19.7%) were required to take two or more multicultural courses. These categories were based on Wheaton and Granello (1998).
Satisfaction with multicultural courses. Of those 81 participants who had taken at least one required course in multicultural counseling, the majority of them were satisfied with them (n = 58; 71.6%). The remaining 23 participants (28.4%), were not satisfied with their mandatory course(s).

Number of multicultural workshops. (N = 209) A multicultural workshop was defined as lasting for more than a day but less than a week. The majority of respondents, 149 (71.3%) had not attended any such workshops; 43 respondents (20.6%) had attended between one and three workshops, and 17 respondents (8.1%) had attended four or more. Categories were grouped this way based on similar research conducted by Wheaton and Granello (1998). Two respondents did not provide this information.

Satisfaction with workshops. Of the 60 respondents who attended workshops, 52 were satisfied (71.2%). Only 21 respondents (28.8%) were unsatisfied with their multicultural workshops.

Number of multicultural training sessions or inservices. Multicultural training sessions and inservices were defined as lasting one day or less. Of the 207 subjects who responded to this item, 83 (40.1%) had not attended any, 93 (44.9%) had attended between one and three sessions, and 31 (15%) had attended four or more.

Satisfaction with training sessions or inservices. Of the 124 participants who had taken at least one training session or inservice, 89 (71.8%) were satisfied with them, whereas 35 (28.2%) were not satisfied.

Number of training experiences focusing on self-knowledge. Of the 204 subjects responding to this item, 95 (46.6%) reported that they had never taken a multicultural
counseling course that focused on self-knowledge; 87 respondents (42.6%) reported that they had between one and three training experiences that focused on self-knowledge; and 22 respondents (10.8%) reported having four or more training experiences that focused on self-knowledge.

Number of training experiences focused on worldview. Of the 202 subjects responding to this item, 80 (39.6%) had never taken a multicultural course that focused on the worldview of different cultural groups; 105 respondents (52.0%) reported that they had between one and three such training experiences; 17 respondents (8.4%) reported having four or more.

Adequacy of training to work with persons from other cultures. Of the 200 subjects responding to this item, only 37 (18.5%) felt they were adequately trained. On the other hand, 86 respondents (43.0%) reported feeling somewhat adequately trained, and 77 respondents (38.4%) reported not being adequately trained.

Multicultural Competency Inventory (MCI) Scales

Table 4.4 presents the means and standard deviations for the scales of the MCI. Mean scale scores were utilized, rather than a simple summing of items comprising a scale, in order to render the scores interpretable within the original units. Thus, a mean scale score could range from 1 to 4, with 4 representing the highest degree of that competency. The means presented in Table 4.5 represent the means of the scale mean scores across the entire sample.
Table 4.5. Means and standard deviations for the scales of the MCI.

<table>
<thead>
<tr>
<th>MCI Scale</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills</td>
<td>122</td>
<td>3.45</td>
<td>.38</td>
</tr>
<tr>
<td>Awareness</td>
<td>118</td>
<td>2.84</td>
<td>.55</td>
</tr>
<tr>
<td>Counselor relationship</td>
<td>167</td>
<td>3.20</td>
<td>.45</td>
</tr>
<tr>
<td>Knowledge</td>
<td>150</td>
<td>3.21</td>
<td>.42</td>
</tr>
<tr>
<td>MCI Total</td>
<td>75</td>
<td>3.17</td>
<td>.35</td>
</tr>
</tbody>
</table>

Results for Research Questions

This section of this chapter presents the results pertaining to the research questions. This section is organized by research question. The questions are restated for purposes of clarity, and the results follow.

Results for Research Question One

Research question one. What is the relationship between the selected demographic characteristics of rehabilitation service providers in the private sector—sex, age, race, highest degree earned, major area of study, and geographic location of current practice—and their multicultural counseling competencies?

The correlations between each of the MCI scales and the variables of age, race, gender, and highest degree earned can be found in Table 4.6. Because race, gender, and highest degree earned are all dichotomous variables, these correlations can be interpreted as point biserial correlations. Race was coded as a 1 for European and 2 for non-European. Gender was coded as a 1 for male and 2 for female. Highest degree earned was coded as a 1 for an associates or bachelors degree, and a 2 for a masters or
doctorate degree. Examination of Table 4.6 shows that, with the exception of knowledge and gender, there were no relationships between any of the MCI scales and the demographic variables of age, race, gender, and degree. The small correlation between gender and knowledge indicates that females scored somewhat higher on the knowledge scale than did males.

Geographic location and major area of study were the remaining demographic variables. Both of these were non-dichotomous categorical variables. Thus, to ascertain if either was related to any of the MCI scales, one-way analyses of variance were performed separately on each MCI scale.

The results of the one-way analyses of variance among geographic locations on each of the multicultural competency scales are presented in Table 4.6. The results show that there were no differences on any of the multicultural competencies according to geographic location of services.

<table>
<thead>
<tr>
<th>MCI Scale</th>
<th>Gendera</th>
<th>Age</th>
<th>Raceb</th>
<th>Degreec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills</td>
<td>.09</td>
<td>-.03</td>
<td>.04</td>
<td>.17</td>
</tr>
<tr>
<td>Awareness</td>
<td>.07</td>
<td>-.07</td>
<td>.09</td>
<td>-.03</td>
</tr>
<tr>
<td>Counselor relationship</td>
<td>.04</td>
<td>-.05</td>
<td>.05</td>
<td>-.04</td>
</tr>
<tr>
<td>Knowledge</td>
<td>.17*</td>
<td>-.08</td>
<td>.02</td>
<td>.06</td>
</tr>
<tr>
<td>MCI Total</td>
<td>.01</td>
<td>-.10</td>
<td>.01</td>
<td>.05</td>
</tr>
</tbody>
</table>

* p < .05

Gender: 1 = Male; 2 = Female
Race: 1 = European; 2 = Non-European
Degree: 1 = Associates/Bachelors; 2 = Masters/Doctorate

Table 4.6. Correlations between each of the MCI scales and the demographic variables of age, race, gender, and degree.
Table 4.7. Results of one-way ANOVAs among geographic locations on each MCI scale.

<table>
<thead>
<tr>
<th>MCI Scale</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between</td>
<td>4</td>
<td>.24</td>
<td>1.65</td>
</tr>
<tr>
<td>Within</td>
<td>112</td>
<td>.14</td>
<td></td>
</tr>
<tr>
<td>Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between</td>
<td>4</td>
<td>.46</td>
<td>1.53</td>
</tr>
<tr>
<td>Within</td>
<td>108</td>
<td>.30</td>
<td></td>
</tr>
<tr>
<td>Counselor relation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between</td>
<td>4</td>
<td>.02</td>
<td>.08</td>
</tr>
<tr>
<td>Within</td>
<td>155</td>
<td>.21</td>
<td></td>
</tr>
<tr>
<td>Knowledge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between</td>
<td>4</td>
<td>.07</td>
<td>.36</td>
</tr>
<tr>
<td>Within</td>
<td>138</td>
<td>.19</td>
<td></td>
</tr>
<tr>
<td>Total MCI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between</td>
<td>4</td>
<td>.10</td>
<td>.81</td>
</tr>
<tr>
<td>Within</td>
<td>67</td>
<td>.12</td>
<td></td>
</tr>
</tbody>
</table>

The results of the one-way analyses of variance among major areas of study an each of the multicultural competency scales are presented in Table 4.8. Again, the results indicate that there were no differences on any of the multicultural competencies according to major area of study.

In summary, there were virtually no relationships between the specified demographics (gender, age, race, highest degree earned, geographic, location, and major area of study) and any of the MCI scales.

*Results for Research Question Two*

*Research question two*: Do providers in the private sector differ from those in the public sector with respect to multicultural counseling competency?
The means and standard deviations of the MCI scales from providers in the public sector were obtained from Wheaton and Granello (1998). One-sample t-tests were performed comparing counselors in the private sector—the participants in the current study—to the published data for counselors in the public sector. The results of these one-sample t-tests can be found in Table 4.9. Examination of Table 4.9 shows that counselors in the private sector demonstrated higher multicultural competencies in the areas of skills and knowledge than did their counterparts in the public sector, but those in the public sector had slightly higher competencies in the area of counselor relationship. There were no differences between the two groups on awareness or the MCI total score.

<table>
<thead>
<tr>
<th>MCI Scale</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between</td>
<td>2</td>
<td>.08</td>
<td>.55</td>
</tr>
<tr>
<td>Within</td>
<td>119</td>
<td>.15</td>
<td></td>
</tr>
<tr>
<td>Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between</td>
<td>2</td>
<td>.32</td>
<td>1.06</td>
</tr>
<tr>
<td>Within</td>
<td>114</td>
<td>.30</td>
<td></td>
</tr>
<tr>
<td>Counselor relationship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between</td>
<td>2</td>
<td>.53</td>
<td>2.64</td>
</tr>
<tr>
<td>Within</td>
<td>162</td>
<td>.20</td>
<td></td>
</tr>
<tr>
<td>Knowledge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between</td>
<td>2</td>
<td>.38</td>
<td>2.14</td>
</tr>
<tr>
<td>Within</td>
<td>146</td>
<td>.18</td>
<td></td>
</tr>
<tr>
<td>Total MCI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between</td>
<td>2</td>
<td>.17</td>
<td>1.40</td>
</tr>
<tr>
<td>Within</td>
<td>72</td>
<td>.12</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.8. Results of one-way ANOVAs among major area of study on each MCI scale.
<table>
<thead>
<tr>
<th>MCI Scale</th>
<th>Private</th>
<th>Public</th>
<th>$t$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>3.45</td>
<td>3.36</td>
<td>2.72**</td>
</tr>
<tr>
<td>$SD$</td>
<td>.38</td>
<td>.42</td>
<td></td>
</tr>
<tr>
<td>$n$</td>
<td>122</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>2.84</td>
<td>2.76</td>
<td>1.66</td>
</tr>
<tr>
<td>$SD$</td>
<td>.55</td>
<td>.53</td>
<td></td>
</tr>
<tr>
<td>$n$</td>
<td>118</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>3.20</td>
<td>3.28</td>
<td>-2.36*</td>
</tr>
<tr>
<td>$SD$</td>
<td>.45</td>
<td>.43</td>
<td></td>
</tr>
<tr>
<td>$n$</td>
<td>167</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>3.21</td>
<td>3.13</td>
<td>2.25*</td>
</tr>
<tr>
<td>$SD$</td>
<td>.42</td>
<td>.43</td>
<td></td>
</tr>
<tr>
<td>$n$</td>
<td>150</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCI total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>3.17</td>
<td>3.13</td>
<td>.98</td>
</tr>
<tr>
<td>$SD$</td>
<td>.35</td>
<td>.34</td>
<td></td>
</tr>
<tr>
<td>$n$</td>
<td>75</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Table 4.9 Results of one-sample $t$-tests on the MCI scales comparing counselors in the private sector with those in the public sector.

Results for Research Question Three

Research question three. Is the amount and type of training in multiculturalism related to multicultural competency?

The amount of training was measured by three variables, each of which represents a different type of training: number of mandatory courses, number of workshops,
and number of training sessions. Categories were used within each type. Table 4.10 presents the means and standard deviations for the four subscales and total score of the MCI, broken down by the individual categories of each training variable.

Individual monotonic trend analyses were performed on each of the five MCI scales for amount of each of the three particular training variables, for a total of 15 such analyses. The results of these analyses are presented in Table 4.11. This table is organized so that the results for the three separate analyses performed on each MCI scale are presented together, i.e., clustered by the MCI scale. Each MCI scale is given, then the results of the analyses on that scale are presented below it.

Examination of Table 4.11 shows that for only counselor relationship were there no significant differences on amount of training. For skills, significant differences were found for both the number of training sessions and the number of workshops. Newman-Keuls post hoc tests revealed that those who had had four or more training sessions related to multicultural counseling had higher skill levels than those who had no such training sessions or even those who had one to three such sessions. The same pattern was found for the number of workshops pertaining to multicultural topics: Those with four or more such workshops had higher skill scores than those with no or fewer than three such workshops.
<table>
<thead>
<tr>
<th>Training</th>
<th>Skills</th>
<th>Awareness</th>
<th>Relationship</th>
<th>Knowledge</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>3.43</td>
<td>2.75</td>
<td>3.21</td>
<td>3.12</td>
<td>3.08</td>
</tr>
<tr>
<td></td>
<td>0.39</td>
<td>0.52</td>
<td>0.40</td>
<td>0.45</td>
<td>0.35</td>
</tr>
<tr>
<td></td>
<td>69</td>
<td>75</td>
<td>97</td>
<td>88</td>
<td>43</td>
</tr>
</tbody>
</table>

|          | 3.49   | 3.10      | 3.14         | 3.36      | 3.29  |
|          | 0.30   | 0.40      | 0.52         | 0.32      | 0.36  |
|          | 24     | 17        | 34           | 32        | 12    |

| Two or more | 3.48   | 2.96      | 3.19         | 3.29      | 3.28  |
|             | 0.38   | 0.63      | 0.52         | 0.37      | 0.33  |
|             | 29     | 26        | 35           | 30        | 20    |

<table>
<thead>
<tr>
<th>Number of workshops</th>
<th>Skills</th>
<th>Awareness</th>
<th>Relationship</th>
<th>Knowledge</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>3.46</td>
<td>2.75</td>
<td>3.22</td>
<td>3.16</td>
<td>3.15</td>
</tr>
<tr>
<td>M</td>
<td>0.40</td>
<td>0.55</td>
<td>0.47</td>
<td>0.43</td>
<td>0.36</td>
</tr>
<tr>
<td>n</td>
<td>84</td>
<td>51</td>
<td>115</td>
<td>104</td>
<td>46</td>
</tr>
</tbody>
</table>

| One to three       | 3.33   | 2.96      | 3.17         | 3.23      | 3.13  |
| M                   | 0.34   | 0.51      | 0.38         | 0.39      | 0.32  |
| n                   | 27     | 29        | 38           | 33        | 22    |

| Four or more       | 3.72   | 3.28      | 3.13         | 3.52      | 3.43  |
| M                   | 0.26   | 0.23      | 0.51         | 0.29      | 0.23  |
| n                   | 11     | 10        | 14           | 13        | 7     |

<table>
<thead>
<tr>
<th>Number of training sessions</th>
<th>Skills</th>
<th>Awareness</th>
<th>Relationship</th>
<th>Knowledge</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>3.43</td>
<td>2.67</td>
<td>3.20</td>
<td>3.11</td>
<td>3.21</td>
</tr>
<tr>
<td>M</td>
<td>0.44</td>
<td>0.58</td>
<td>0.52</td>
<td>0.50</td>
<td>0.37</td>
</tr>
<tr>
<td>n</td>
<td>46</td>
<td>42</td>
<td>60</td>
<td>52</td>
<td>26</td>
</tr>
</tbody>
</table>

| One to three              | 3.40   | 2.92      | 3.17         | 3.23      | 3.15  |
| M                          | 0.34   | 0.51      | 0.41         | 0.35      | 0.34  |
| n                          | 57     | 58        | 80           | 75        | 38    |

| Four or more              | 3.68   | 3.02      | 3.25         | 3.35      | 3.36  |
| M                          | 0.29   | 0.50      | 0.42         | 0.41      | 0.29  |
| n                          | 19     | 18        | 26           | 23        | 11    |

Table 4.10. Means and standard deviations for the MCI scales by training variables.
<table>
<thead>
<tr>
<th>MCI Scale</th>
<th>F</th>
<th>$\eta$</th>
<th>$\eta^2$</th>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skills</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of mandatory courses</td>
<td>0.24</td>
<td>0.06</td>
<td>0.004</td>
<td>0.09</td>
</tr>
<tr>
<td>Number of training sessions</td>
<td>4.14*</td>
<td>0.26</td>
<td>0.07</td>
<td>0.72</td>
</tr>
<tr>
<td>Number of workshops</td>
<td>4.26*</td>
<td>0.26</td>
<td>0.07</td>
<td>0.74</td>
</tr>
<tr>
<td><strong>Awareness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of mandatory courses</td>
<td>3.84*</td>
<td>0.24</td>
<td>0.06</td>
<td>0.69</td>
</tr>
<tr>
<td>Number of training sessions</td>
<td>3.73*</td>
<td>0.24</td>
<td>0.06</td>
<td>0.67</td>
</tr>
<tr>
<td>Number of workshops</td>
<td>5.52*</td>
<td>0.30</td>
<td>0.09</td>
<td>0.84</td>
</tr>
<tr>
<td><strong>Relationship</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of mandatory courses</td>
<td>0.15</td>
<td>0.04</td>
<td>0.002</td>
<td>0.07</td>
</tr>
<tr>
<td>Number of training sessions</td>
<td>0.32</td>
<td>0.06</td>
<td>0.004</td>
<td>0.10</td>
</tr>
<tr>
<td>Number of workshops</td>
<td>0.31</td>
<td>0.06</td>
<td>0.004</td>
<td>0.10</td>
</tr>
<tr>
<td><strong>Knowledge</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of mandatory courses</td>
<td>4.80*</td>
<td>0.24</td>
<td>0.06</td>
<td>0.79</td>
</tr>
<tr>
<td>Number of training sessions</td>
<td>2.85</td>
<td>0.20</td>
<td>0.04</td>
<td>0.55</td>
</tr>
<tr>
<td>Number of workshops</td>
<td>4.36*</td>
<td>0.24</td>
<td>0.06</td>
<td>0.75</td>
</tr>
<tr>
<td><strong>MCI total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of mandatory courses</td>
<td>3.24*</td>
<td>0.28</td>
<td>0.08</td>
<td>0.60</td>
</tr>
<tr>
<td>Number of training sessions</td>
<td>2.05</td>
<td>0.22</td>
<td>0.05</td>
<td>0.41</td>
</tr>
<tr>
<td>Number of workshops</td>
<td>2.25</td>
<td>0.24</td>
<td>0.06</td>
<td>0.44</td>
</tr>
</tbody>
</table>

* $p < .05$

Table 4.11. Monotonic trends for the MCI scales by training experience variables.
For awareness, it was found that there were significant differences for all three training variables. Those who had one mandatory course on multiculturalism had higher awareness than either those who had no such mandatory courses or those who had two or more such courses. Those who had four or more training sessions had higher awareness scores than those who had no such training sessions. In addition, those who had four or more workshops had higher awareness scores than those who had no or less than three such workshops.

For knowledge, significant differences were found for the number of mandatory courses, and for the number of workshops. Those who had taken one mandatory course scored higher on knowledge than either those who had taken no such courses or those who had taken two or more. For workshops, those who had attended four or more had higher knowledge scores than either those who attended no such workshops or those who attended one to three such workshops.

Finally, for the MCI total, significant results were obtained for number of mandatory courses. However, the Newman-Keuls post hoc test failed to reveal any paired differences.

**Results for Research Question Four**

*Research question four:* Is self-perceived adequacy of multicultural preparation related to multicultural competency?

Table 4.12 presents the means and standard deviations for the MCI subscales broken down by perceived adequacy of preparation to work effectively across cultures.
<table>
<thead>
<tr>
<th>Adequacy of Preparation</th>
<th>MCI Scales</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Skills</td>
</tr>
<tr>
<td>Adequate</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>3.60</td>
</tr>
<tr>
<td>SD</td>
<td>.30</td>
</tr>
<tr>
<td>n</td>
<td>27</td>
</tr>
<tr>
<td>Somewhat adequate</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>3.46</td>
</tr>
<tr>
<td>SD</td>
<td>.36</td>
</tr>
<tr>
<td>n</td>
<td>50</td>
</tr>
<tr>
<td>Not adequate</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>3.41</td>
</tr>
<tr>
<td>SD</td>
<td>.40</td>
</tr>
<tr>
<td>n</td>
<td>42</td>
</tr>
</tbody>
</table>

* p < .05

Table 4.12. Means and standard deviations for the MCI scales by perceived adequacy of preparation.

Table 4.13 presents the monotonic trend analyses among the three groups of those adequately prepared, somewhat adequately prepared, and not adequately prepared on each MCI scale.

A significant difference among the three groups was found for every MCI scale except skills. Newman-Keuls post hoc tests revealed that those who felt they were adequately prepared had higher scores on awareness, counselor relationship, knowledge, and MCI total than those who felt they were not adequately prepared. Moreover, those who felt they were adequately prepared had higher counselor relationship scores than those who felt they were somewhat prepared. In addition, those who felt they
were somewhat prepared had higher knowledge scores than those who felt they were inadequately prepared.

Thus, the more counselors felt they were adequately prepared to work with persons from other cultural groups, the greater were their multicultural counseling competencies. This was especially true for those who felt they were adequately prepared compared to those who felt they were inadequately prepared. This was also true for some specific competencies when comparing those who were somewhat adequately prepared to both those who were adequately prepared and those who were not adequately prepared.

Results for Research Question Five

Research question five: Is satisfaction with training in multiculturalism related to multicultural competency?

<table>
<thead>
<tr>
<th>MCI Scale</th>
<th>F</th>
<th>η</th>
<th>η²</th>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills</td>
<td>2.45</td>
<td>.20</td>
<td>.04</td>
<td>.48</td>
</tr>
<tr>
<td>Awareness</td>
<td>4.83*</td>
<td>.28</td>
<td>.08</td>
<td>.79</td>
</tr>
<tr>
<td>Relationship</td>
<td>4.49*</td>
<td>.22</td>
<td>.05</td>
<td>.76</td>
</tr>
<tr>
<td>Knowledge</td>
<td>3.15*</td>
<td>.20</td>
<td>.04</td>
<td>.60</td>
</tr>
<tr>
<td>MCI Total</td>
<td>4.05</td>
<td>.32</td>
<td>.10</td>
<td>.70</td>
</tr>
</tbody>
</table>

* p < .05

Table 4.13. Monotonic trends for MCI scales by perceived adequacy of training.

Satisfaction with training was measured by three separate variables, each of which represented satisfaction with a different type of training: satisfaction with man-
datory courses, with workshops, and with training sessions. Although originally measured on a 4-point Likert scale from very unsatisfied to very satisfied, responses were collapsed into two categories: unsatisfied and satisfied. This was done primarily because of the number and distribution of responses to these items. Table 4.14 presents the means and standard deviations for the MCI scales and total broken down by satisfaction with the three types of training.

Individual independent t-tests were performed on each scale for each satisfaction with training variable, for a total of 15 t-tests. The results of these are presented in Table 4.14. Similar to the presentation of results for the training variables in Table 4.10, Table 4.14 is organized so that the results for the three t-tests for each MCI scale are clustered and presented together. Thus, each competency is presented, followed by the results first for satisfaction with courses, then satisfaction with workshops, and finally satisfaction with training.

Examination of Table 4.14 shows that there were only three differences found between the unsatisfied and satisfied groups. For satisfaction with workshops, it was found that, ironically, those who were not satisfied with their workshops demonstrated slightly higher multicultural counseling skills than did those who were satisfied. The other two significant t-tests were found for the competency of counselor relationship. Again, satisfaction with workshops was found to be significant, but in this case, those who were satisfied with workshops scored higher on counselor relationship than those who were not satisfied with their workshops. Similarly, those who were satisfied with
training sessions on multiculturalism scored higher on counselor relationship than those who were not satisfied with their training sessions.

<table>
<thead>
<tr>
<th>Satisfaction</th>
<th>MCI Scales</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Skills</td>
</tr>
<tr>
<td>Courses</td>
<td></td>
</tr>
<tr>
<td>Unsatisfied</td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>3.51</td>
</tr>
<tr>
<td>$SD$</td>
<td>.40</td>
</tr>
<tr>
<td>$n$</td>
<td>15</td>
</tr>
<tr>
<td>Satisfied</td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>3.48</td>
</tr>
<tr>
<td>$SD$</td>
<td>.38</td>
</tr>
<tr>
<td>$n$</td>
<td>37</td>
</tr>
<tr>
<td>Workshops</td>
<td></td>
</tr>
<tr>
<td>Unsatisfied</td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>3.64</td>
</tr>
<tr>
<td>$SD$</td>
<td>.30</td>
</tr>
<tr>
<td>$n$</td>
<td>11</td>
</tr>
<tr>
<td>Satisfied</td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>3.36</td>
</tr>
<tr>
<td>$SD$</td>
<td>.36</td>
</tr>
<tr>
<td>$n$</td>
<td>27</td>
</tr>
<tr>
<td>Training</td>
<td></td>
</tr>
<tr>
<td>Unsatisfied</td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>3.52</td>
</tr>
<tr>
<td>$SD$</td>
<td>.32</td>
</tr>
<tr>
<td>$n$</td>
<td>23</td>
</tr>
<tr>
<td>Satisfied</td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>3.45</td>
</tr>
<tr>
<td>$SD$</td>
<td>.36</td>
</tr>
<tr>
<td>$n$</td>
<td>53</td>
</tr>
</tbody>
</table>

Table 4.14. Means and standard deviations for MCI by satisfaction with training items.
<table>
<thead>
<tr>
<th>MCI Scale</th>
<th>Group means</th>
<th>Results of t-tests</th>
<th>df</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unsatisfied</td>
<td>Satisfied</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Courses</td>
<td>3.51</td>
<td>3.48</td>
<td>50</td>
<td>27</td>
</tr>
<tr>
<td>Workshops</td>
<td>3.64</td>
<td>3.36</td>
<td>36</td>
<td>2.32*</td>
</tr>
<tr>
<td>Training</td>
<td>3.52</td>
<td>3.45</td>
<td>74</td>
<td>.84</td>
</tr>
<tr>
<td>Awareness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Courses</td>
<td>3.03</td>
<td>3.00</td>
<td>40</td>
<td>.14</td>
</tr>
<tr>
<td>Workshops</td>
<td>3.22</td>
<td>2.99</td>
<td>37</td>
<td>1.32</td>
</tr>
<tr>
<td>Training</td>
<td>2.97</td>
<td>2.93</td>
<td>74</td>
<td>34</td>
</tr>
<tr>
<td>Relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Courses</td>
<td>3.08</td>
<td>3.22</td>
<td>67</td>
<td>-.98</td>
</tr>
<tr>
<td>Workshops</td>
<td>2.90</td>
<td>3.24</td>
<td>50</td>
<td>-2.72**</td>
</tr>
<tr>
<td>Training</td>
<td>3.07</td>
<td>3.24</td>
<td>1.04</td>
<td>-2.03*</td>
</tr>
<tr>
<td>Knowledge</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Courses</td>
<td>3.36</td>
<td>3.32</td>
<td>59</td>
<td>.42</td>
</tr>
<tr>
<td>Workshops</td>
<td>3.47</td>
<td>3.25</td>
<td>44</td>
<td>1.72</td>
</tr>
<tr>
<td>Training</td>
<td>3.23</td>
<td>3.27</td>
<td>96</td>
<td>-.41</td>
</tr>
<tr>
<td>MCI Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Courses</td>
<td>3.32</td>
<td>3.27</td>
<td>29</td>
<td>34</td>
</tr>
<tr>
<td>Workshops</td>
<td>3.30</td>
<td>3.16</td>
<td>27</td>
<td>1.01</td>
</tr>
<tr>
<td>Training</td>
<td>3.23</td>
<td>3.19</td>
<td>47</td>
<td>.38</td>
</tr>
</tbody>
</table>

* p < .05

** p < .01

Table 4.15. Results of t-tests between satisfaction with type of training groups on MCI scales.
These results should be interpreted with caution. First of all, three significant t-tests from a total of 15 could reflect spurious findings. Also, the majority of respondents fell into the “satisfied” category for every type of training. At least twice as many were satisfied than not. In addition, both groups demonstrated relatively high skills in every area, with mean scores of 3.00 or greater.

*Results for Research Question Six*

*Research question six*. Is the amount of experience in either private rehabilitation or rehabilitation in general related to multicultural competency?

Table 4.15 presents the correlations between each of the two experience variables, years of experience in private rehabilitation and years of experience in rehabilitation in general, with the scales of the MCI. Examination of table 4.15 shows that there were no significant correlations between either experience variable with any MCI scale. It therefore appears that there is no relationship between years of experience in the field of rehabilitation in the private sector or in general and competency in multicultural counseling.
often more than one, other training and/or satisfaction variable was related to every MCI scale. Satisfaction with courses was the only variable not related to any MCI scale. Satisfaction with workshops was the only other variable related to skills. The three training variables were all related to both awareness and knowledge, with number of mandatory courses also being related to the MCI Total, with no satisfaction variables demonstrating significant correlations with these scales. On the other hand, no training variables were related to the scale of counselor relationship, but both satisfaction with workshops and satisfaction with training were.
Table 4.16. Correlations between years of experience in rehabilitation in the private sector and in general and the MCI scales.

<table>
<thead>
<tr>
<th>MCI Scale</th>
<th>Private</th>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skills</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correlation</td>
<td>.02</td>
<td>.11</td>
</tr>
<tr>
<td>n</td>
<td>122</td>
<td>121</td>
</tr>
<tr>
<td><strong>Awareness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correlation</td>
<td>-.09</td>
<td>-.03</td>
</tr>
<tr>
<td>n</td>
<td>118</td>
<td>117</td>
</tr>
<tr>
<td><strong>Counselor relationship</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correlation</td>
<td>-.09</td>
<td>-.01</td>
</tr>
<tr>
<td>n</td>
<td>166</td>
<td>166</td>
</tr>
<tr>
<td><strong>Knowledge</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correlation</td>
<td>-.08</td>
<td>-.06</td>
</tr>
<tr>
<td>n</td>
<td>149</td>
<td>149</td>
</tr>
<tr>
<td><strong>MCI Total</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correlation</td>
<td>-.20</td>
<td>-.08</td>
</tr>
<tr>
<td>n</td>
<td>75</td>
<td>74</td>
</tr>
</tbody>
</table>

**Results for Research Question Seven**

*Research question seven.* What combination of demographics, training, satisfaction with training, perceived adequacy of preparation, and experience variables best predicts multicultural counseling competency?

The zero-order correlations of the training and satisfaction variables with each MCI scale are presented in Table 4.16. Examination of this table shows that perceived adequacy of preparation was significantly related to all four scales of the MCI as well as the MCI total scale. In addition to perceived adequacy of training, at least one, and
Table 4.17. Correlations between the training variables and MCI scales.

In other words, the training variables, dealing with number of courses, workshops, and training sessions, were related to the MCI scales of awareness and knowledge. Number of courses was related to the MCI total. Conversely, the satisfaction
variables of satisfaction with workshops and satisfaction with training were related to
the MCI scale of counselor relationship, and satisfaction with workshops was related
to the MCI scale of skills. Perceived adequacy of preparation was related to all the
MCI scales.

It can be recalled that the only demographic variable related to any of the MCI
scales was gender, which was slightly related to knowledge (See Table 4.5), with fe­
males having slightly higher knowledge scores. Furthermore, it can be recalled that
neither of the experience variables were related to any MCI scale (See Table 4.15).

Only those demographic, training, satisfaction, and experience variables with
significant zero-order correlations with an MCI scale were included in the second
phase of the data analysis for this research question, which included a series of multi­
ple regressions. The predictor variables with the significant zero-order correlations
with each MCI scale were entered into separate multiple regression analyses predict­
ing each MCI scale. Table 4.17 presents the results of the multiple regressions. Only
predictors with significant beta weights are presented in this table.

Perceived adequacy of preparation, which had significant zero-order correlations
with all the MCI scales, was found in the multiple regressions to be a significant pre­
dictor for three of the five MCI scales: awareness, knowledge, and total MCI, for
which it was the only significant predictor.

For skills, satisfaction with multicultural workshops was the only significant
predictor, and this was in a negative direction (β = -.36). This indicates that those who
were less satisfied with their multicultural workshops had higher multicultural counseling skills as measured by their MCI scores.

For awareness, number of workshops attended was the largest predictor, with a Beta (β) of .28. Adequacy of preparation was only a slightly smaller predictor, with a Beta (β) weight of .27. The two predictors together accounted for 16% of the variance. Thus, it can be said that awareness of multicultural counseling issues can be somewhat predicted fairly evenly by the number of workshops a counselor attended and the perceived adequacy of preparation in multicultural areas.

A similar pattern was found for knowledge of multicultural issues. Number of workshops, while entering the step-wise multiple regression first, ended up with a slightly smaller beta weight (β = .20) than did perceived adequacy of preparation (β = .21). In addition to number of workshops and perceived adequacy of preparation, the demographic variable of gender was also a significant predictor (β = .17), indicating that females had slightly higher knowledge than did males. Knowledge was the only MCI scale that could be predicted, albeit only slightly, by any demographic variable. The three predictors accounted for 12% of the variance in the knowledge scores.
### Table 4.18. Results of five multiple regressions using significant training variables to predict multicultural competency.

<table>
<thead>
<tr>
<th>MCI Scale</th>
<th>Stepwise Statistics</th>
<th>Final-Order β</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$R$</td>
<td>$F$</td>
<td>$df$</td>
</tr>
<tr>
<td><strong>Skills</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with workshops</td>
<td>-.36</td>
<td>5.40*</td>
<td>1,36</td>
</tr>
<tr>
<td><strong>Awareness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of workshops</td>
<td>.29</td>
<td>10.47*</td>
<td>1,111</td>
</tr>
<tr>
<td>Adequacy of preparation</td>
<td>.40</td>
<td>10.33*</td>
<td>2,110</td>
</tr>
<tr>
<td><strong>Relationship</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with workshops</td>
<td>.36</td>
<td>7.41**</td>
<td>1,50</td>
</tr>
<tr>
<td><strong>Knowledge</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of workshops</td>
<td>.22</td>
<td>7.15**</td>
<td>1,145</td>
</tr>
<tr>
<td>Adequacy of preparation</td>
<td>.29</td>
<td>6.62**</td>
<td>2,144</td>
</tr>
<tr>
<td>Gender</td>
<td>.34</td>
<td>6.12*</td>
<td>3,143</td>
</tr>
<tr>
<td><strong>Total MCI</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequacy of preparation</td>
<td>.32</td>
<td>8.20**</td>
<td>1,72</td>
</tr>
</tbody>
</table>

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

A completely different pattern of prediction was found for counselor relationship. In this case, the only significant predictor was satisfaction with workshops, accounting for about 13% of the variance.
Throughout this study, the MCI scales, including the total, which is a composite of the other four scales, have been treated as separate constructs. For the sake of completion, Table 4.18 presents the intercorrelations among the MCI scales. It can be seen that with the exception of counseling relationship with knowledge, all the MCI scales were moderately related to each other. The correlations of the individual scales with the total MCI were, as expected, somewhat higher. The implications of this involve an interpretation issue. That is, when interpreting the results, it must be kept in mind that the competencies represented by the MCI scales are not entirely independent of each other.

<table>
<thead>
<tr>
<th></th>
<th>Skills</th>
<th>Awareness</th>
<th>Relationship</th>
<th>Knowledge</th>
<th>MCI Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness</td>
<td>.55**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship</td>
<td>.31**</td>
<td>.29**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge</td>
<td>.53**</td>
<td>.59**</td>
<td>.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCI Total</td>
<td>.81**</td>
<td>.87**</td>
<td>.44**</td>
<td>.81**</td>
<td></td>
</tr>
</tbody>
</table>

** p<.01

Table 4.19. Correlations among the MCI scales.
CHAPTER 5

DISCUSSION

Previous research on multicultural competencies of rehabilitation service professionals has been limited. Havranek & Stewart (1997) investigated the inclusion of individuals of multicultural backgrounds into public and private sector rehabilitation agencies. He found that in general, private sector rehabilitation professionals were not fully addressing multicultural issues in their practice. His research stated that public-sector rehabilitation professionals were more responsive to the overall issues of multiculturalism.

Wheaton and Granello (1998) conducted groundbreaking research on the multicultural counseling competency levels of rehabilitation service providers in the public sector. They found that on the multicultural subscales of skills, knowledge, relationship and awareness, the lowest scores were in the areas of relationship and awareness respectively. Distinguished from Wheaton and Granello, the current investigation studied the multicultural competency levels of rehabilitation service providers in the private sector. This current investigation, varying from Wheaton &
Granello (1998), also measured whether individuals felt prepared to work effectively across cultures upon graduation.

This study attempted to determine what relationships existed between training variables, demographic variables and multicultural competencies of rehabilitation counselors in the private sector. Toward that end, several specific research questions were generated and a series of exploratory inferential statistical analyses were performed.

The purpose of this chapter is to summarize and discuss the results of the statistical analyses found in Chapter 4 and to consider the application of these findings in the field of rehabilitation counselor education, practice and research. This chapter is divided into six sections. The first section presents a summary and discussion of the major findings of this study and compares the present findings and past research. The second section discusses implications for rehabilitation counselors. The third section presents recommendations for future training. The fourth section presents the limitations of the present study. The fifth section discusses recommendations for future research, and finally in the sixth section, conclusions are discussed.

Summary and Discussion of Findings

This section presents a summary and discussion of the most important findings. Comparisons between the present findings and past research are also given. This section is organized around the research questions. For ease of reference, the research
questions are restated, followed by the summary of the findings and pertinent discussion.

Research Question One

Is there a relationship between selected demographic characteristics and the multicultural counseling competency level of rehabilitation service providers in the private sector?

To summarize the findings for this research question, it can be said that there were virtually no relationships between the specified demographics (gender, age, race, highest degree earned, geographic location, and major area of study) and any of the MCI scales.

Of particular interest in the area of multicultural competencies was the issue of race. While there were no differences between European American and Non-European American counselors in their responses, in general, those whose caseloads included over 45% minorities had higher multicultural competencies in awareness, counseling relationship and MCI total. This might indicate that those who have more contact and professional interaction with minorities in all likelihood have more opportunity to become aware and knowledgeable and sensitive to multicultural issues.

The only demographic variable predicting competency was gender, with females having slightly higher knowledge scores. It is interesting to note that no other demographic variable was related to multicultural competence, including minority membership, which might seem counterintuitive. What this may indicate, however, is
that there appear to be other factors related to multicultural competency than those traditionally considered (i.e., race).

Other researchers were better able to differentiate racial and ethnic competency levels because of larger sample sizes within the groups. In these past studies, racial and ethnic minorities tended to have higher overall competency scores (Wheaton & Granello, 1998; Ottavi, Pope-Davis, & Dings, 1994). The current findings do not support those found in past research. Pope-Davis and Ottavi (1994) reported significant differences in some MCI subscales based on the race and ethnic affiliations of the subjects. Their research suggested that Asian Americans and Hispanic counselors scored significantly higher on the knowledge subscale than did European American counselors. African American, Asian American and Hispanic counselors scored significantly higher on awareness and relationship subscales than did European American counselors.

Research Question Two

Do rehabilitation service providers in the private sector differ from those in the public sector with respect to multicultural counseling competency?

The results of this question indicate that counselors in the private sector demonstrated higher multicultural competencies in the areas of skills and knowledge than did their counterparts in the public sector, but those in the public sector had slightly higher competencies in the area of counselor relationship. There were no differences between the two groups on awareness or the MCI total.
These results could be due to knowledge and skills being easily attained through a book, and not being contingent on experiential processes or contact with culturally different individuals. Individuals in private practice may have the time to process the multicultural material while lacking the diversity in caseload; hence the higher scores in the areas of knowledge and skills. Public sector rehabilitation counselors may have scored higher in counselor relationship because of the diversity in their caseloads and their greater opportunities to interact with individuals of varied backgrounds.

Research Question Three

Is the amount and type of training in multiculturalism related to multicultural competency?

When the actual number of courses, workshops, or training sessions the participants had taken were examined, it was found that in general, those who had more training experiences scored higher on awareness and knowledge but not necessarily on skills and relationship. Wheaton and Granello (1998) found that training tended to increase overall multicultural competency levels in general.

In regard to mandatory courses in multiculturalism and multicultural competency in counseling, the following general conclusions can be made based upon the findings. Not surprisingly, rehabilitation counselors who had taken at least one mandatory course in multiculturalism as part of their degree programs scored higher on the multicultural competencies of awareness and knowledge than those who had taken no such required courses. This indicates that required coursework increases knowledge of
the subject matter, as it should. More importantly, awareness of other cultures, which includes sensitivity toward others, advocacy, and understanding one's own cultural heritage, might also be increased by formal coursework. Counseling skills and relationship, however, were unaffected.

Examining the findings for the other training variables which dealt with workshops of various lengths (more than a day, less than a day) and those that dealt with specific multicultural training issues (such as self-knowledge and worldview), it was generally found that a difference in multicultural competency scores was not attained until the participants had attended four or more such workshops or training sessions. Again, multicultural awareness and knowledge were the two areas of competency seemingly most affected by workshops, although counseling skills was affected by the number of workshops taken in general, whether they lasted less or more than a day.

This indicates that the process of attaining sufficient multicultural competencies is not one that can be met rapidly. It involves multiple encounters and experiences. This is especially true when one considers the difficulty of affecting any attitude change. Therefore, when designing a training program, consideration should be made toward making it in-depth and comprehensive, covering enough material to span several days. This also allows time for assimilation and accommodation of concepts.
It is reasonable and expected that knowledge would be effected by training. The fact that awareness is also affected by participation in workshops is heartening. Indeed, the workshop format may be ideal for training in such challenging areas as multicultural awareness due to the experiential nature of workshops. Workshops often consist of interactive experiences, including more discussion, more expression of ideas and personal values.

Research Question Four

Is self-perceived adequacy of multicultural preparation related to multicultural competency as measured by the knowledge, awareness, counselor relationship, skills, and total scales of the MCI?

The more counselors felt they were adequately prepared to work with persons from other cultural groups, the greater were their multicultural counseling competencies. This was especially true for those who felt they were adequately prepared compared to those who felt they were inadequately prepared. This was also true for some specific competencies when those who were somewhat adequately prepared were compared to both those who were adequately prepared and those who were not adequately prepared.

Thus it can be said that, in general, the more that counselors felt they were adequately prepared to work with persons from other cultural groups, the greater were their multicultural counseling competencies.
Research Question Five

Is satisfaction with various types of training in multiculturalism related to multicultural competency?

Perceived satisfaction of workshops and training sessions on multiculturalism was related to three multicultural competencies: awareness, counseling relationship, and knowledge, as well as total multicultural competency. It would appear, then, that these counselors reliably assessed the impact the training experiences had on their own competencies, being satisfied that taking the training enhanced their professional development in multicultural competence.

Research Question Six

Is the number of years of different types of experience in rehabilitation related to multicultural competency?

There were no significant correlations between either experience variable with any MCI scale. It therefore appears that there is no relationship between years of experience in the field of rehabilitation in the private sector or in general and competency in multicultural counseling.

Research Question Seven

What combination of demographics, training, satisfaction with training, perceived adequacy of preparation, and experience variables best predicts multicultural counseling competency?
Perceived adequacy of preparation was significantly related to all four scales of the MCI as well as to the MCI total scale. In addition to perceived adequacy of training, at least one, and often more than one, other training and/or satisfaction variable was related to every MCI scale. Satisfaction with courses was the only variable not related to any MCI scale. Satisfaction with workshops was the only other variable related to skills. The three training variables were all related to both awareness and knowledge, with the number of mandatory courses also related to the MCI total, with no satisfaction variables demonstrating significant correlations with these scales. On the other hand, no training variables were related to the scale of counselor relationship, but both satisfaction with workshops and satisfaction with training were.

In other words, the training variables, dealing with number of courses, workshops, and training sessions, were related to the MCI scales of awareness and knowledge. The number of courses was related to the MCI total. Conversely, the satisfaction variables of satisfaction with workshops and satisfaction with training were related to the MCI scale of counselor relationship, and satisfaction with workshops was related to the MCI scale of skills. Perceived adequacy of preparation was related to all the MCI scales.

It can be recalled that the only demographic variable related to any of the MCI scales was gender, which was slightly related to knowledge, with females having
slightly higher knowledge scores. Furthermore, it can be recalled that neither of the experience variables were related to any MCI scale.

Perceived adequacy of preparation was found to be a significant predictor for three of the five MCI scales: awareness, knowledge, and total MCI, for which it was the only significant predictor.

For skills, satisfaction with multicultural workshops was the only significant predictor, and this was in a negative direction. This indicates that those who were less satisfied with their multicultural workshops had higher multicultural counseling skills as measured by their MCI scores.

For awareness, the number of workshops attended was the largest predictor. Thus, awareness of multicultural counseling issues can be predicted fairly evenly by the number of workshops a counselor attended and the perceived adequacy of preparation in multicultural areas.

In addition to the number of workshops and perceived adequacy of preparation, the demographic variable of gender was also a significant predictor, indicating that females had slightly higher knowledge than did males. Knowledge was the only MCI scale that could be predicted, albeit only slightly, by any demographic variable.

A completely different pattern of prediction was found for counselor relationship. In this case, the only significant predictor was satisfaction with workshops, accounting for about 13% of the variance.
Throughout this study, the MCI scales, including the total, which is a composite of the other four scales, have been treated as separate constructs. The implications of this involve an interpretation issue. That is, when interpreting the results, it must be kept in mind that the competencies represented by the MCI scales are not entirely independent of each other.

The scales of the MCI were mildly to moderately related to each other and, of course, to the total MCI. While it can be concluded that there is, therefore, some overlap among the various multicultural competencies, the relationship scale was not so high that they couldn’t be considered distinct concepts. These results are congruent with past findings that suggest the MCI subscales are measuring different, but related, constructs. As noted in Wheaton and Granello (1998) “The intercorrelations are higher between Sue’s original three subscales than the intercorrelations with the relationship subscale added by Sodowsky and her colleagues (1994). This suggests that the relationship scale can be measuring a different construct” (p. 9).

It is not unexpected that there would be some overlap among the scales of the MCI. These concepts do not, after all, exist in a vacuum. Knowledge is related to skills, and to some extent, any attitudinal variable, such as awareness, is related to knowledge. The important issue in this study, however, is that the measurement of these concepts is sufficiently independent to consider them separate. It can be concluded that this is the case in this particular instance.
At least one training variable predicted every multicultural competency except counseling relationship, with two predicting awareness. What is interesting is that when examined together, it was the attendance at some type of workshop rather than mandatory coursework that demonstrated the highest level of multicultural competencies. This distinction could possibly exist because workshop participation for rehabilitation providers in the private sector is optional. Participation in workshops may indicate a genuine interest in issues of multiculturalism, as opposed to mandatory courses being attended out of obligation.

Both knowledge and awareness were predicted by the number of workshops attended that were longer in duration. This supports a previous finding (Diaz-Lazaro & Cohen, 2001) and also makes sense. Because the longer the exposure to ideas, the greater the likelihood that they will be assimilated and accommodated. The number of training sessions focused on self-knowledge also predicted awareness, as well as overall competency. This is a logical finding because, again, the longer the exposure to thoughts, the greater the likelihood they will be adopted into one's own system.

According to Myers (1991), self-knowledge is the foundation of all knowledge and leads to the ability to better connect with others because of the greater cognizance of one's own worldview.
Implications for Rehabilitation Counselors

Primarily, this research could serve as a baseline for an increase in the number of workshops for training in the area of multicultural competency. The results demonstrate that training programs of four or more sessions had a greater impact on competency level than did mandatory required multicultural courses in a degree program, and one training session was better than no training at all. One could venture to say that multicultural competencies are based on the particular life experiences one has encountered. This implies that one may need to move beyond what has traditionally been perceived as obvious.

This research could also impact the design of more appropriate multicultural training programs that would more effectively meet the needs of rehabilitation counselors. Despite the constant debate over the importance of multiculturalism, to some degree the possession of multicultural competencies is still seen as an altruistic, politically correct endeavor. Multiculturalism can no longer be viewed as an act of tolerance and kindness; it is more appropriately related to being prepared for the ever-changing demographic needs of the country. Being prepared for imminent change is a challenge, yet it lends itself to better business practices and the ability to meet the needs of those being served.

Statistics from the U.S. Department of Education indicate that vocational rehabilitation caseloads will soon consist of at least one in three clients being ethnic
minority individuals. Given that clients of minority status comprise a large, significant, and growing population within the rehabilitation counseling setting (Wilson, 1996; Ehiobuche, 1995) and that research indicates that the racial or ethnic status of a rehabilitation client can have an impact on the quality of provision (Ehiobuche, 1995; Feist, 1995), it is important to examine the potential influence that cultural biases can have on the rehabilitation process. In the words of Growick (1999) “expectation equals actualization.” If we develop treatment plans for individuals based on the biases in our own minds rather than their culture’s worldview, we are doing a disservice to our clients. We are then working with a collective stereotype, not an individual.

Rehabilitation counselors are responsible for determining their clients’ eligibility for services, assessing their rehabilitation needs, and developing service plans to meet those needs. The bias, either conscious or unconscious of the rehabilitation service provider could hinder the valid assessment of a client’s assets and limitations. Underestimates of client potential, inappropriate vocational objectives and/or ineffective service plans could result.

Research has shown that inequitable patterns of rehabilitation service delivery to ethnic minorities exist. African American clients are less likely to be accepted for rehabilitation services than European American counterparts. If African Americans are accepted for services, their cases are more likely to be closed without achieving successful employment. Successful employment outcomes with African American
clients have been found to result in lower earnings for them compared to European Americans in similar situations. Wilson (1997) and Atkinson, et al. (1993) researched similar conclusion about Latino and Native American populations.

Rasch et al (1977) found that rehabilitation counselors in training tend to judge vocational rehabilitation services for older clients as less feasible, and they perceived both individuals with physical disabilities and non-disabled individuals as being significantly better able to cope with life stressors than elderly individuals. These biases (and others) in client perception must be explored if effective services are to be provided.

Recommendations for Future Training

Training sessions should be aimed at increasing levels of counselor awareness and relationship. Service providers may benefit greatly from experiential workshops, which allow them the opportunity to see themselves as multicultural entities. These workshops should focus on offering participants the opportunity to explore personal bias in a non-threatening environment. A training that spans at least four days may allow counselors adequate time to begin the processes of self-exploration and discovering their own cultural background.

1. Training should be didactic in nature, offering the occasion for both lecture and experiential opportunities.
2. New technology should be explored for multicultural training, such as a four-part series using distance learning followed by an experiential workshop component.

3. Creation of an on-line multicultural competency training resource guide on a website that would inform interested parties of various multicultural training opportunities worldwide.

4. Training sessions that teach providers how to seek out cultural experts who could serve as both a referral source and a sounding board for multicultural issues.

5. Training sessions should be conducted by individuals representing various cultural groups, not solely ethnic minority or numeric majority group members.

6. University curriculums need to be more responsive to the changing demographics and social composition of the United States, a goal that can be achieved with an integrated approach to multiculturalism. The issues of diversity should be incorporated into the overall curriculum and not simply into isolated elective courses.

Limitations of the Study

As with any study, certainly there are limitations of the present study that need to be addressed. These can be divided into two broad categories: methodological and
conceptual. Regarding methodological limitations, there are those that pertain to the sampling and those that are statistical in nature.

Limitations of this study are similar to those found in any descriptive study utilizing a self-report instrument mailed out to participants (Heppner et al., 1992). There is always a chance of a self-reporting bias and social desirability in the respondents’ answers. An example of this could have been that rehabilitation practitioners answering that they would participate in a multicultural training if it were offered at their place of employment could have responded in this manner as a way of saving face at a time when multicultural topics are seen as important by the ethical and accreditation boards of the profession. In addition, it could be that only rehabilitation professionals who feel strongly about multicultural topics chose to participate in the study, which may have skewed these findings.

The fact that the study was predominantly quantitative in nature makes it difficult to study the multiple complexities of the issue at hand. For example, in responding to the category of race, if you are Puerto Rican and of African descent, do you respond that you are Hispanic or African American? Utilizing simple discreet categories may serve as a convenient manner of categorizing for the sake of statistical analysis, but richness of the actual data may be compromised.

The most important limitation in studies of a statistical nature deals with the large number of analyses performed. The danger of performing extensive analyses on a
single sample lies with an inflated alpha. Although the stated probability of making an alpha error in a single analysis is .05, the actual probability of making an alpha error when multiple analyses are performed is much higher. Therefore, all conclusions must be made with this in mind. While this was an exploratory study that attempted to ascertain trends and differences in multicultural competencies wherever they might have existed, caution must be exerted in making generalizations based upon these findings. Refinement in future research is needed.

Related to this problem is the issue of interrelatedness. The dependent variables (e.g., the scales of the MCI) are interrelated, leading perhaps to redundant findings. A multivariate analysis of variance on the set of MCI scales for example, could help ameliorate this issue. This was not done in the present study because of the exploratory nature of the research and the desire to be liberal in finding relationships.

**Recommendations for Future Research**

A study utilizing a pre-test, post-test training design would shed light on specific competencies that might be enhanced by specific types of training. The MCI could be given before training is offered, perhaps to different groups receiving various types of training or training dealing with different issues. Following training, the groups could be compared. This would require the participation of professionals adept at teaching various multicultural topics, as well as the time and space required for such a design (Manese, Wu & Nepomuceno, 2001).
Although this study found no differences between European American and non-European Americans on their competencies or other characteristics, a study could be designed that specifically attempted to determine any differences among counselors of different cultures. It is possible that differences exist relative to the number of multicultural clients they serve as well as the particular culture to which they belong. This study found that regardless of the race/ethnic culture of the counselor, multicultural competencies increased with the number of minority clients they served. This could be expanded in future research by specifying particular races and/or cultures of both counselors and the clients and examining different combinations.

One of the training needs expressed by several counselors in the present study concerned issues related to the difference between race and culture. This, too, would be an interesting topic for future research. Related to this are concerns of a psychometric nature: Are participants responding to the items on the MCI as truly multicultural or as specific to a given minority population? Have training experiences dealt with issues that transcend culture or have they been culturally specific? Certainly there is a need for training in the cultural nuances of specific cultures, but how is this different from training that deals with general multicultural concepts such as cultural relativity? These issues could be further explored.

To confirm or disconfirm the results of this study, qualitative methodologies using in-depth, open-ended face-to-face interviews would be welcomed. Additional
qualitative studies that delve into the particular types of multicultural training that are being recommended would be useful for the development of appropriate multicultural training tools and techniques.

Other suggestions for future research include the following:

• Focus groups to discuss how past multicultural learning has occurred.

• Case studies on how multicultural competence has assisted or hindered the rehabilitation process.

• Focus groups with ethnic minority consumers to gain insight into why ethnic minorities tend to terminate services prematurely.

• Focus groups with ethnic minority consumers to gain insight into why ethnic minorities utilize rehabilitation services less often than their European American counterparts.

Conclusions

As Wheaton and Granello (1998) found, overall training tended to have a positive effect on the MCI subscales of skills, awareness, and knowledge, as well as on the MCI total. Experience had a positive effect on the relationship subscale score.

Respondents took the liberty to communicate openly with the researcher via, phone calls and letters. These communications became a sounding board for the overall opinion of the research, the personal view of self-perceived competency and a place to
let the researcher know that they were competent or that the researcher was racist for even bringing up the very topic of multiculturalism.

It was also very interesting that several respondents said that they focused on the individual, not on the individual's culture. Others responded that they don't work in a multicultural practice and, therefore, this research does not apply to them. Others simply said that they don't want any training. One respondent replied, “I counsel at present in a very one-dimensional world setting. White, mostly male, mostly blue-collar injured workers. It is thus very difficult to respond to your questions as they do not apply to my present work setting.” This response assumes that blue-collar white males don’t have a culture. The working definition of multiculturalism used in this investigation states that all individuals have multiple cultures and subcultures to which they belong. Culture cannot be separated from the experience. We are all a collection of our life journeys. Our racial, ethnic, sociopolitical, and historical underpinnings come with us to all experiences. It is naïve to say that our interactions are not multicultural. Deducting culture from the equation fragments the client. Some of the responses were very poignant. One stated the equation that multiculturalism equals racism, which supports a similar assertion by Thomas and Weinrach, (1998).

This research called forth many late night and early morning discussions on various topics. The course of this investigation has been very emotional. This research has been called both necessary and racist in nature. The effort was praised by some,
and others expressed disdain for “bringing up old racist issues of the ’60s” The fact that it elicited such strong responses sent a message that the investigation was a necessary step forward in the profession, a time for introspection on the behalf of the service provider.

The discourse was fascinating. Several respondents said they did not have a need for training while others said any and all training would be helpful. There were also those individuals who stated they were a member of a particular ethnic group and did not need of training—they were fully competent. This statement never fails to amuse me because it is in direct contrast to the results of this investigation, which demonstrated that there is not a significant correlation between race and increased multicultural competencies. Being of a particular ethnic origin did not increase the multicultural competency scores of the respondents, as individuals expected it would. Often there is a misconception that multicultural initiatives are only directed towards European American/white people, this could not be further from the truth. All people should be students of multiculturalism because in this society we are all exposed to historical distortions, media generalizations and rampant perpetuation of stereotypes that subconsciously dictate how we perceive and interact with certain minority or ethnic groups.

As with the variable of race, age and gender (slightly significant) were not strong indicators of multicultural competence. The strongest indicators were related to
training and perceived adequacy to work effectively across cultures. It seems that multicultural competencies transcend the very salient demographic variables of race, age and gender. It would be very easy to relegate the issue of multiculturalism to a posture of racism, for then we could eradicate the very premise of multiculturalism based on separatist doctrine. When multiculturalism is put into the context of all persons being multicultural entities, the burden of greater accountability is upon us. It forces us to the uncomfortable position of taking an honest look at ourselves, delving into our own knowledge base and examining our own worldview. Multiculturalism is really a personal odyssey into the very core of our being. In the words of (1991) "Self knowledge is the basis of all knowledge." Do not begin the quest for multiculturalism in someone else's back yard—begin in your own. Begin with yourself and the multitude of issues that you bring to the counseling relationship.

The challenge of multiculturalism is not a fixed destination; it is a life long journey, a constant evaluation of where our biases reside, knowing ourselves in order to honestly interact with a client as opposed to interfacing with stereotypes in the course of our interactions.
LIST OF REFERENCES


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Appendix A. Multicultural Counseling Inventory: A survey of rehabilitation practitioners in the
private sector MCI

Multicultural counseling competencies: A survey of rehabilitation practitioners in the
private sector MCI

Kelley Kirksey, M.A., CRC

The Ohio State University
Multicultural Counseling Inventory (MCI)®
by Sodowsky, Taffe, Gutein, and Wise

The following statements cover counselor practices in multicultural counseling. Indicate how accurately each statement describes you when working in a multicultural counseling situation. Give ratings that you actually believe to be true rather than those that you wish were true.

The scale ranges from 1 (Very Inaccurate) to 4 (Very Accurate). Not Applicable is indicated by 5. The scale indicates the following:

1 - Very Inaccurate (VI)
2 - Somewhat Inaccurate (I)
3 - Somewhat Accurate (SA)
4 - Very Accurate (VA)
5 - Not Applicable (NA)

For the following questions, please circle the answer that best corresponds with your experiences.

1. I perceive that my race causes the consumers to mistrust me.
2. I have feelings of overcompensation, oversolicitation, and guilt that I do not have when working with majority consumers.
3. I am confident that my conceptualization of consumer problems does not consist of stereotypes and value-oriented biases.
4. I find that differences between my world views and those of the consumers impede the counseling process.
5. I have difficulties communicating with consumers who use a perceptual, reasoning, or decision-making style that is different from mine.
6. I include the facts of age, gender roles, and socioeconomic status in my understanding of different minority cultures.
7. I use innovative concepts and treatment methods.
8. I manifest an outlook on life that is best described as "world-minded" or pluralistic.
9. I examine my own cultural biases.
10. I tend to compare consumer behaviors with those of majority group members.
11. I keep in mind research findings about minority consumers' preferences in counseling.
12. I know what are the changing practices, views, and interests of people at the present time.
13. I consider the range of behaviors, values, and individual differences within a minority group.
14. I make referrals or seek consultations based on the consumers' minority identity development.
15. I feel my confidence is shaken by the self-examination of my personal limitations.
16. I monitor and correct my defensiveness (e.g., anxiety, denial, anger, fear, minimizing, overconfidence).
<table>
<thead>
<tr>
<th></th>
<th>Very Inaccurate (VI)</th>
<th>Somewhat Inaccurate (SI)</th>
<th>Somewhat Accurate (SA)</th>
<th>Very Accurate (VA)</th>
<th>Not Applicable (NA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.</td>
<td>I apply the sociopolitical history of the consumers' respective minority groups to understand them better.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>I am successful at seeing 50% of the consumers more than once, not including intake.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>I experience discomfort because of the consumers' different physical appearance, color, dress, or socioeconomic status.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>I am able to quickly recognize and recover from misunderstandings or cultural mistakes.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>I use several methods of assessment (including free response questions, observations, and varied sources of information and standardized tests).</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>I have experience at solving problems in unfamiliar settings.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>I learn about consumers' different ways of acculturation to the dominant society to understand the consumers better.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>I understand my own philosophical preferences.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>I have a working understanding of certain cultures (including African American, Native American, Hispanic, Asian American, new Third World immigrants, and international students).</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

26. I am able to distinguish between those who need brief, problem-solving, structured therapy and those who need long-term, process-oriented, unstructured therapy. 1 2 3 4 5

27. When working with international students or immigrants, I understand the importance of the legalities of visa, passport, green card, and naturalization. 1 2 3 4 5

Evaluate the degree to which the following multicultural statements can be applied to you. 1 2 3 4 5

28. My professional or collegial interactions with minority individuals are extensive. 1 2 3 4 5

29. In the past year, I have had a 50% increase in my multicultural case load. 1 2 3 4 5

30. I enjoy multicultural interactions as much as interactions with people of my own culture. 1 2 3 4 5

31. I am involved in advocacy efforts against institutional barriers in mental health services for minority consumers (e.g., lack of bilingual staff, multiculturally skilled counselors, racial and ethnic minority counselors, minority professional leadership, and outpatient counseling facilities). 1 2 3 4 5

32. I am familiar with nonstandard English. 1 2 3 4 5

33. My life experiences with minority individuals are extensive (via ethnically integrated neighborhoods, marriage, and friendship). 1 2 3 4 5
34. In order to be able to work with minority consumers I frequently seek consultation with multicultural experts and attend multicultural workshops or training sessions. 1 2 3 4 5

35. I am effective at crisis interventions (e.g., suicide attempt, tragedy, broken relationship). 1 2 3 4 5

36. I use varied counseling techniques and skills. 1 2 3 4 5

37. I am able to be concise and to the point when reflecting, clarifying, and probing. 1 2 3 4 5

38. I am comfortable with exploring sexual issues. 1 2 3 4 5

39. I am skilled at getting a consumer to be specific in defining and clarifying problems. 1 2 3 4 5

40. I make my nonverbal and verbal responses congruent. 1 2 3 4 5

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is True or False as it pertains to you personally. 1 = True 2 = False

41. Before voting, I thoroughly investigate the qualifications of all the candidates. 1 2

42. I never hesitate to go out of my way to help someone in trouble. 1 2

43. It is sometimes hard for me to go on with my work when I am not encouraged. 1 2

44. I have never intensely disliked anyone. 1 2

45. On occasion I have had doubts about my ability to succeed in life. 1 2

46. I sometimes feel resentful when I don't get my way. 1 2

47. I am always careful about my manner of dress. 1 2

48. My table manners at home are as good as when I eat out in a restaurant. 1 2

49. If I could get into a movie without paying and be sure I was not seen, I would probably do it. 1 2

50. On a few occasions, I have given up doing something because I thought too little of my ability. 1 2

51. I like to gossip at times. 1 2

52. There have been times when I felt like rebelling against people in authority even though I knew they were right. 1 2

53. No matter who I'm talking to, I'm always a good listener. 1 2
54. I can remember "playing sick" to get out of something.  
   T  F  1  2

55. There have been occasions when I took advantage of someone.  
   T  F  1  2

56. I'm always willing to admit it when I make a mistake.  
   T  F  1  2

57. I always try to practice what I preach.  
   T  F  1  2

58. I don't find it particularly difficult to get along with loud mouthed, obnoxious people.  
   T  F  1  2

59. I sometimes try to get even, rather than forgive and forget.  
   T  F  1  2

60. When I don't know something, I don't at all mind admitting it.  
   T  F  1  2

61. I am always courteous, even to people who are disagreeable.  
   T  F  1  2

62. At times I have really insisted on having things my own way.  
   T  F  1  2

63. There have been occasions when I felt like smashing things.  
   T  F  1  2

64. I would never think of letting someone else be punished for my wrong doings.  
   T  F  1  2

65. I never resent being asked to return a favor.  
   T  F  1  2

66. I have never been irked when people expressed ideas very different from my own.  
   T  F  1  2

67. I never make a long car trip without checking the safety of my car.  
   T  F  1  2

68. There have been times when I was quite jealous of the good fortune others have.  
   T  F  1  2

69. I have almost never felt the urge to tell someone off.  
   T  F  1  2

70. I am sometimes irritated by people who ask favors of me.  
   T  F  1  2

71. I have never felt that I was punished without cause.  
   T  F  1  2

72. I sometimes think when people have a misfortune they get what they deserved.  
   T  F  1  2

73. I have never deliberately said something that hurt someone's feelings.  
   T  F  1  2

For the following demographic questions, read each item and decide which statement pertains to you and mark the corresponding number.

74. My highest earned degree is:
   1) High School Degree or GED
   2) Associates Degree
   3) Bachelors Degree
   4) Masters Degree
   5) Doctoral Degree
75. My major area of study was:
1. Rehabilitation (such as Rehab Counseling, Rehab Admin, Rehab Ed)
2. Rehabilitation related (such as Special Ed, Psychology, Social Work, Sociology, Counseling, Guidance & Counseling, Deaf Ed, Nursing, Speech, OT, PT)
3. Unrelated to Rehabilitation (such as Education, Art, History, English, Business, and All Others)
4. No major, high school diploma only

76. How many mandatory courses on multiculturalism did you have in your degree program? (Course refers to any quarter or semester long class in a University or College setting)
1. It was not required
2. 1
3. 2 - 4
4. 4 - 6
5. More than 7

77. How satisfied were you with these multicultural courses?
1. Very Unsatisfied
2. Somewhat Unsatisfied
3. Somewhat Satisfied
4. Very Satisfied
5. Not Applicable

78. How many workshops on multiculturalism have you had that lasted for more than a day, but less than a week?
1. None
2. 1 to 3
3. 4 to 6
4. 7 to 9
5. More than 10

79. How satisfied were you with these multicultural workshops?
1. Very Unsatisfied
2. Somewhat Unsatisfied
3. Somewhat Satisfied
4. Very Satisfied
5. Not Applicable

80. How many training sessions/inservices on multiculturalism have you had that lasted one day or less?
1. None
2. 1 to 3
3. 4 to 6
4. 7 to 9
5. More than 10

81. How satisfied are you with your previous training/inservices in multiculturalism?
1. Very Unsatisfied
2. Somewhat Unsatisfied
3. Somewhat Satisfied
4. Very Satisfied
5. Not Applicable

82. How many of your training experiences in multiculturalism have been focused on self-knowledge?
1. None
2. 1 to 3
3. 4 to 6
4. 7 to 9
5. 10 or more

83. How many of your multicultural training experiences examined the world view of different cultural groups?
1. None
2. 1 to 3
3. 4 to 6
4. 7 to 9
5. 10 or more

84. Do you feel that you were adequately trained to work with persons from other cultural groups?
1. Adequately Trained
2. Somewhat Adequately Trained
3. Not Adequately Trained
85. Would you be interested in taking a course in multicultural competencies if it were offered at your workplace?
   1. Yes
   2. No

86. What Percentage of your caseload is minority consumers?
   1. 0%
   2. 1% to 15%
   3. 16% to 30%
   4. 31% to 45%
   5. Over 45%

87. My service area in the United States:
   1. Northeast
   2. Northwest
   3. Midwest
   4. Southeast
   5. Southwest

88. Do you consider racial discrimination to be a problem within the private rehabilitation system?
   1. Yes
   2. No

89. Do you think consumers are denied opportunities by rehabilitation professionals based on race?
   1. Yes
   2. No

90. My gender is:
   1. Male
   2. Female

91. My race is:
   1. African American
   2. Asian American
   3. European American
   4. Hispanic American
   5. Native American
   6. Other

For the following questions, please write your answers in the spaces provided.

92. What is your age? ________

93. How many years have you worked in the field of private rehabilitation? ________

94. How many years have you worked in the field of rehabilitation in general? ________

For the following questions, please write your answers in the spaces provided. Feel free to use the back of the pages, if necessary.

95. What training would be beneficial to you in regards to multicultural counseling?

96. What training do you believe would be beneficial to other counselors regarding multicultural counseling?

Please return this booklet in the provided self-addressed, stamped envelope.

Thank you for your participation in this research!
Thank you for your purchase of the Multicultural Counseling Inventory (MCI). I have enclosed the instrument for your use as outlined in the Agreement for Procedural Use.

For scoring purposes, I employed a Likert scale with values of 1 through 4, with 4 indicating high multicultural competence, and 1 indicating poor multicultural competence. Item numbers 1, 2, 4, 5, 10, 15, and 19 are to be reversed. Listed below are the specific subscales and the items included in each:

Subscale one, Multicultural Counseling Skills, consists of 11 items: 18, 20, 21, 24, 26, 35, 36, 37, 38, 39, and 40.

Subscale two, Multicultural Awareness, consists of 10 items: 22, 25, 27, 28, 29, 30, 31, 32, 33, and 34.

Subscale three, Multicultural Counseling Relationship, consists of 8 items: 1, 2, 3, 4, 5, 10, 15, and 19.

Subscale four, Multicultural Counseling Knowledge, consists of 11 items: 6, 7, 8, 9, 11, 12, 13, 14, 16, 17, and 23.

Good luck on your research. Please contact me at (402) 489-2017 if you have any further questions.

Sincerely,

Gargi Royshcar Sodowsky
Multicultural Consultation
1231 Eldon Drive
Lincoln NE 68510

enclosure
January 13, 1998

Dear Rehabilitation Provider:

Because of the demographic shift over the last few years, rehabilitation providers will be serving more diverse/multicultural clients. I am conducting a study to ascertain the current level of multicultural competence among rehabilitation providers in the private sector.

Since the 1997 NARPPS (National Association of Rehabilitation Professionals in the Private Sector) directory has identified you as a member in good standing, you have been selected to participate in this study. The study will hopefully have implications for future training and continuing education in our field. I have discussed this study with my advisor/principal investigator, Dr. Bruce Growick, who is an associate professor at The Ohio State University and past NARPPS President. Current NARPPS Director, Robert Teplansky has also endorsed and offered support of this project.

Your cooperation and prompt reply are much appreciated. Please complete and return this questionnaire by February 20, 1998. It will take approximately 20 minutes of your time. Return the enclosed stamped postcard addressed directly to NARPPS headquarters if you want to be one of two lucky respondents to win our drawing for complimentary conference registrations at the NARPPS 1998 National Convention. By completing and returning this survey, you are consenting to participate. All the responses will remain strictly confidential and only group data will be reported. A stamped, self-addressed envelope has been enclosed for your convenience.

Thank you for your assistance,

Kellie Kirksey  
Doctoral Candidate

Bruce Growick, Ph.D.  
Dissertation Chairperson

Appendix B. Letter sent to members of the National Association of Rehabilitation Professionals in the Private Sector asking for their participation.
Just a Reminder...

It's not too late to respond!! You were recently sent a packet from Kellie Kirksey of The Ohio State University asking for your help with an important research project. If you have not already done so, please complete and return your booklet within the week if possible. If you have already mailed your booklet back, thank you very much for your time and help!!

Kellie Kirksey (614) 292-8174
E-mail: kirksey.1@osu.edu
APPLICATION FOR EXEMPTION FROM HUMAN SUBJECTS INSTITUTIONAL REVIEW BOARD REVIEW

All research activities that will involve human beings as research subjects must be reviewed and approved by the appropriate human subjects Institutional Review Board, or receive exemption status, prior to implementation of the research.

Grovick, Bruce
Principal Investigator:
(Must be OSU Faculty)
(Typed name) Last First Initial

Academic Title: Associate Professor
Phone No.: 292-8463 Fax No.: 292-4255

Department: Physical Activities & Educational Services
Department No.: 292-8174

Campus Address: 356 Arps Hall
1945 N. High Srr. (4 digit no.)

Co-investigator(s):
(Must be OSU Faculty)
( Typed name) Last First Initial

Kirksey, Kellie

PROTOCOL TITLE: A Nationwide Assessment of Multicultural Counseling Competencies of Rehabilitation Practitioners in the Private Sector.

THE ONLY INVOLVEMENT OF HUMAN SUBJECTS IN THE PROPOSED RESEARCH ACTIVITY WILL BE IN ONE OR MORE OF THE EXEMPTION CATEGORIES LISTED ON THE BACK OF THIS APPLICATION.

CATEGORIE (Check one or more) 1 2 3 4 5

SOURCE OF FUNDING FOR PROPOSED RESEARCH: (Check A or B)

A. OSURF: Sponsor RF Proposal/Project No.
Currently seeking funds through the Graduate School

EXEMPTION STATUS:  ✓ APPROVED  DISAPPROVED**

Office Use:

OCT 17 1997

Date

** Principal Investigator must submit a protocol to the appropriate Human Subjects IRB.

IMPORTANT NOTICE TO INVESTIGATORS: Exempting an activity from review DOES NOT absolve the investigators of the activity from ensuring that the welfare of human subjects in the activity is protected and that methods used, and information provided, to gain subject consent are appropriate to the activity.

Appendix D. Approved application for Exemption from Human Subjects Institutional Review Board review

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