COUNSELORS’ KNOWLEDGE, SKILLS, AND ATTITUDES REGARDING INDIVIDUALS WITH DISABILITIES: EXAMINING CONTACT AND ATTITUDES AS PREDICTORS OF KNOWLEDGE AND SKILLS

By

ALFRED GRANT MCDougall

A DISSERTATION PRESENTED TO THE GRADUATE SCHOOL OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

UNIVERSITY OF FLORIDA

2008
To my mother, Eloise Adams McDougall,  
my greatest teacher
ACKNOWLEDGMENTS

I would like to thank the members of my committee, Dr. Peter A.D. Sherrard, Dr. Mary Ellen Young, and Dr. John C. Rosenbek. Prior to beginning my doctoral studies, I was advised by many to place extreme importance on the selection of committee members. I was frequently told that this choice would be a primary factor as to how, or if, I made it through the dissertation process. My committee members’ guidance and input were invaluable, and their professionalism and motivation were consistent from beginning to end.

I would also like to thank my committee chair, Dr. Linda R. Shaw. Truthfully, more than once I questioned my decision to pursue this degree. She served not only as a teacher, colleague, and motivator, but also as a role model for myself and many others. Without her guidance, navigating through such academic terrain would have seemed impossible.

Space does not permit me to name the numerous friends and colleagues that helped along the way. However, I would be remiss without acknowledging Dr. Robert P. Hosford, Dr. Paula S. Lovett, and Dr. Theodore R. DeRoache. Dr. Hosford and Dr. Lovett were perhaps most instrumental in igniting the spark of my academic pursuits. And throughout the years, each has embodied the role of mentor. Dr. DeRoache was, more than anything else, a sounding board for my frequent complaints and struggles. His good humor and insight were medicinal.

I would also like to thank my two sons, Sam and Drew. Although their age sometimes prevented them from understanding my absence, their tolerance was remarkable. Their presence throughout this process never let me lose perspective on what’s really important. Finally, and certainly most of all, I thank my wife, Michele. Her patience, support, encouragement, and love never faltered. She was, without question, the single most influential factor in the completion of this study.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>4</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>7</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>8</td>
</tr>
<tr>
<td>CHAPTER</td>
<td>10</td>
</tr>
<tr>
<td>1 INTRODUCTION</td>
<td>10</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>10</td>
</tr>
<tr>
<td>Rationale for the Study</td>
<td>11</td>
</tr>
<tr>
<td>Significance of the Study</td>
<td>17</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>17</td>
</tr>
<tr>
<td>Disability</td>
<td>17</td>
</tr>
<tr>
<td>Licensed Mental Health Counselor</td>
<td>19</td>
</tr>
<tr>
<td>Contact</td>
<td>20</td>
</tr>
<tr>
<td>Research Questions and Hypotheses</td>
<td>20</td>
</tr>
<tr>
<td>Research Question #1</td>
<td>20</td>
</tr>
<tr>
<td>Hypothesis #1</td>
<td>20</td>
</tr>
<tr>
<td>Research Question #2</td>
<td>21</td>
</tr>
<tr>
<td>Hypothesis #2</td>
<td>21</td>
</tr>
<tr>
<td>Research Question #3</td>
<td>21</td>
</tr>
<tr>
<td>Hypothesis #3</td>
<td>21</td>
</tr>
<tr>
<td>2 LITERATURE REVIEW</td>
<td>22</td>
</tr>
<tr>
<td>Demographics of Disability</td>
<td>22</td>
</tr>
<tr>
<td>History of Mental Health Counseling</td>
<td>25</td>
</tr>
<tr>
<td>Counselor Preparation, Training, and Continuing Education</td>
<td>27</td>
</tr>
<tr>
<td>Counseling Needs Among Persons with Disabilities</td>
<td>29</td>
</tr>
<tr>
<td>Models of Disability</td>
<td>32</td>
</tr>
<tr>
<td>Psychosocial Adjustment to Disability</td>
<td>38</td>
</tr>
<tr>
<td>Practical Issues of Disability</td>
<td>45</td>
</tr>
<tr>
<td>Health Maintenance Issues</td>
<td>48</td>
</tr>
<tr>
<td>Social Reactions</td>
<td>50</td>
</tr>
<tr>
<td>Countertransference</td>
<td>52</td>
</tr>
<tr>
<td>Legal and Ethical Issues</td>
<td>54</td>
</tr>
<tr>
<td>Self Awareness/Beliefs/Attitudes Towards Individuals with Disabilities</td>
<td>57</td>
</tr>
<tr>
<td>LMHC’s Level of Knowledge Regarding Disability</td>
<td>63</td>
</tr>
<tr>
<td>LMHC’s Level of Skill Regarding Disability</td>
<td>64</td>
</tr>
<tr>
<td>Summary</td>
<td>65</td>
</tr>
</tbody>
</table>
## LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-1</td>
<td>Demographic Variables</td>
<td>79</td>
</tr>
<tr>
<td>4-2</td>
<td>Paired Samples T-Tests for Knowledge, Skills, and Self-Awareness Subscales</td>
<td>80</td>
</tr>
<tr>
<td>4-3</td>
<td>Measurement Reliabilities for the CCDS and CDP</td>
<td>80</td>
</tr>
<tr>
<td>4-4</td>
<td>Pearson Product Moment Correlations Matrix</td>
<td>80</td>
</tr>
</tbody>
</table>
The purpose of this study was to examine the amount of contact licensed mental health counselors (LMHCs) in Florida have with individuals with physical disabilities utilizing the Contact with Disabled Person Scale (CDP). LMHCs also completed the Counseling Clients with Disabilities Survey (CCDS) in which they described their Self-Awareness/Beliefs/Attitudes, perceived Knowledge, and perceived Skills when treating individuals with physical disabilities. Furthermore, this study investigated the amount of contact LMHCs have with individuals with physical disabilities as a predictor of their perceived Knowledge and perceived Skills. Lastly, the study examined LMHCs’ Self-Awareness/Beliefs/Attitudes toward disability as predictors of their perceived Knowledge and perceived Skills.

One hundred, ninety-nine LMHCs participated in the study. LMHCs reported moderate amounts of contact with individuals with physical disabilities, suggesting the possibility that clinicians are interacting with this population on a regular basis. LMHCs reported higher levels of perceived Knowledge about disability than perceived Skills. Self-Awareness/Beliefs/Attitudes regarding physical disabilities had the lowest average score of the three scales. Counselors with higher levels of Self-Awareness/Beliefs/Attitudes, as well as
higher levels of reported contact with individuals with physical disabilities, had higher levels of perceived Knowledge and perceived Skills.

Results from this study support the assumption that LMHCs are treating individuals with physical disabilities. Findings also support the possibility that additional training and education may be needed to improve LMHCs’ Self-Awareness/Beliefs/Attitudes, Knowledge, and Skills regarding the treatment of individuals with physical disabilities.
CHAPTER 1
INTRODUCTION

Individuals with disabilities and physical impairments are woven into the fabric of our general population and have become one of the largest minority groups in the United States (Hunt & Hunt, 2004). Based largely on the aging of the population, demographic data indicate this minority population will continue to grow and place increasing demands on healthcare providers (Waldrop & Stern, 2003). Licensed Mental Health Counselors (LMHCs) provide counseling and psychotherapeutic services to every segment of the population. Because of the diversity of individuals they treat, LMHCs are required to participate in educational and training programs that provide exposure to and experience in multicultural, minority, and special populations. However, the literature reflects concerns regarding a lack of specialized training that mental health providers receive in preparation for providing services to individuals with disabilities. (Allison, Echemendia, Crawford & Robinson, 1996, Huitt & Elston, 1991, Olkin, 1999, Strike, 2002).

Statement of the Problem

To date, there have been few studies and little research regarding mental health counseling for persons with disabilities. The majority of the existing research has focused on the impact or influence of the disability itself as the presenting problem in counseling (Linton, 1998). Further, the mental health professionals studied in the literature pertaining to individuals with disabilities have typically been psychologists, psychiatrists, or rehabilitation counselors (Atkinson & Hackett, 1998; Brodwin, Orange, & Brodwin, 1994; Hayes, Potter, & Hardin, 1995). A review of literature for this study found no research that specifically examined LMHCs' contact with, or treatment of, individuals with disabilities.
The number of LMHCs that provide services to people with disabilities is unknown. The unique treatment needs for this minority population have been well documented in both medical and psychological literature (Coulehan, Schulberg, & Block, 1990; Diamond, 1998; Keitner, Ryan & Miller, 1991; Olkin, 1999; Turner & McLean, 1989; White, Marans, & Krengel, 1998). Yet, research has also shown that generalist behavioral healthcare workers have limited training and education pertaining to this minority population (Brems, 2001; Brodwin et al., 1994; Strike, 2001; Renard, 2001; Rosenau, 2000). From professional, legal, and ethical standpoints, it is imperative that greater knowledge and understanding be obtained regarding LMHCs’ contact with and treatment of clients with disabilities. Without such data, it is unknown whether additional LMHC training addressing clients with disabilities is warranted.

**Rationale for the Study**

The traditional types of services provided to individuals with disabilities include special education, medical intervention, vocational assistance, or counseling related to acute psychological adjustment to the disability (Linton, 1998). Most often, the focus of mental health interventions has been constricted to the acute adjustment and initial acceptance of disability (Olkin, 1999). “It is as if persons with disabilities were viewed as only having disability-focused problems” (Renard, 2001, p. 66). However, due to changes in healthcare, political and social sectors, and the movement towards inclusion, LMHCs may be called upon to assist individuals with disabilities with a broader array of mental health concerns. These concerns may include personal growth and enhancement, depression, marital or familial issues and other presenting problems that may not be associated with the disability itself. Individuals with disabilities may have special needs or cultural issues but should also be expected to have needs and issues consistent with the general population. People with disabilities are likely to request psychotherapy for issues that parallel those prompting non-disabled persons to seek professional
help (Leigh, Powers, Vash, & Nettles, 2004). Insufficient training or education pertaining to the provision of services to individuals with disabilities might result in the LMHC being unprepared to provide appropriate interventions.

Specialists in rehabilitation such as rehabilitation psychologists and rehabilitation counselors have traditionally provided mental health services to individuals with disabilities (Olkin & Pledger, 2003). Yet, with the growing trend toward service provision in integrated settings, it is incorrect to assume that only rehabilitation counselors or rehabilitation psychologists will treat this population. It has also been shown that many rehabilitation providers employed in case manager roles refer out for mental health counseling services (Leahy, Chan, & Saunders, 2003; Leahy, Szymanski, & Linkowski, 1993).

In this study, individuals with disabilities are considered to be a separate and distinct minority group. The theoretical framework of multicultural counseling has expanded well beyond racial and ethnic minority groups to encompass dimensions such as age, gender, religion, sexual orientation, and disability (Strike, 2001). “Multiculturalism and diversity, by whatever name, are currently ‘hot’ and important topics for mental health professionals” (Pistole, 2004, p. 39). However, there is a surprising lack of research and data regarding mental health counselors and their exposure to one of the largest of all minority groups - individuals with disabilities.

It may be appropriate to question why LMHCs should need to be prepared to treat individuals with disabilities when there are other specializations within the counseling arena that may be better equipped to serve this population (i.e. rehabilitation counselors or rehabilitation psychologists). There are both ethical and practical reasons that LMHCs should not rely on others to address the mental health needs of individuals with disabilities. Since the 1960’s, there has been a general trend in our society towards inclusion and integration of individuals with
disabilities into the general population (Shapiro, 1994). Movements such as civil rights, consumerism, and de-institutionalization have contributed to greater independence, empowerment, and mainstreaming of individuals with disabilities.

Beginning in the late 1960s and early 1970s, individuals with disabilities joined together to protest their exclusion from society's mainstream and to demand more humane, non-medical attention from service delivery systems (Shapiro, 1994). Much of this movement modeled or was concurrent with the civil rights movement led by African-Americans that began in the early 1960s. African-Americans fought the injustice of being told where they could sit on a bus. The individual with a disability fought the reality of not being able to use the bus at all.

Consumerism added a new dimension to the disability rights movement. Individuals with disabilities argued that they were consumers first and patients last. They began a fight for the right of autonomy, including deciding for themselves what services, products, or treatment they wished to purchase or receive. Legislation like the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 (ADA), and the Workforce Investment Act of 1998 emphasized inclusion of individuals with disabilities and created environments where mainstreaming and consumer choice were commonplace (Gilbride, 2000; Linton, 1998; Shapiro, 1994).

The ADA, which will be discussed in greater detail in the following chapter, set the stage for widespread, mandatory integration. The purpose of the Act is to ensure that individuals with disabilities have access to public facilities and services and to facilitate equality between such individuals and the general public. The results have been evident in academic settings, public transportation, media, corporate policy, and virtually every aspect of public life in the United States. Our current environment does not require that an individual with a disability go to a “special” movie theater, restaurant, bank, or doctor. It therefore would seem inappropriate to
assume that an individual with a disability would need to go to a “special” mental health counselor. However, the counselor that treats the individual with a disability should possess adequate knowledge and understanding of this sector of our population.

The importance of competence when working with individuals with disabilities is evident when approaching the issue from a theoretical perspective. The current theoretical model of disability adopted by the World Health Organization incorporates the concept of disability from a social context (World Health Organization, 2001). That is, disability involves the interaction between individuals with disabilities and their environments. Therefore, disability may actually be caused or perpetuated by society’s inability or unwillingness to accommodate people with impairments. The condition itself may not be as debilitating as the social environment within which the individual lives. It is imperative that LMHCs possess the competence to set LMHCs apart from the general population so that they are not guilty of perpetuating or creating an environment of disempowerment or disability.

Changes in the healthcare environment will continue to provide additional opportunities for LMHCs to treat a growing diversity of clients. Managed care organizations (MCO) now dominate the landscape of health insurance. MCOs typically offer packages or plans to consumers that include some form of mental health treatment (Davis & Freeman, 1996). “MCOs have become the primary driving force in today's mental health delivery system” (Palmo, 1999, p. 217). Because of reduced fees compared to those of many doctorate level mental health professionals, MCOs may view LMHCs as viable, cost saving alternatives (Palmo, 1999). Increasingly, LMHCs are becoming providers on MCO plans, which will increase exposure to a greater diversity of clients. As the provision of care moves to a more integrated model of service, LMHCs will also be working in more diverse settings in the future. Typical
employment settings for LMHCs will include a wide range of practice settings and populations (Messina, 1999).

As changes in public policy and perceptions occur, individuals with disabilities will be afforded greater opportunities to obtain behavioral healthcare, including the services of LMHCs. Gaining knowledge regarding aspects of LMHCs exposure to people with disabilities will assist the profession in understanding the strengths and possible shortcomings of treatments provided to this population.

The rationale for this study is also supported from a legal perspective. During the past fifty years, there has been a considerable amount of state and federal legislation passed that has attempted to address discrimination against minority populations (Shapiro, 1994). As mentioned earlier, the ADA was created to prevent the discrimination of individuals with disabilities. Because LMHCs provide a public service, they are required by the ADA to do so in a manner that is both accessible and non-discriminatory. It is important to understand the extent to which services are provided to persons with disabilities, as well as the level of competence of the LMHC providing those services. Without such data, the profession may be operating “in the dark” and unaware of possible legal implications.

Finally, reasons for this study may be derived from an ethical standpoint. All LMHCs adhere to some code of professional ethics, and in states without licensure, professional codes of ethics are used exclusively to govern counselor’s actions. Within these codes, there are specific rules governing multicultural issues and associated appropriate counseling practices. Some people may view multicultural issues as limited to racial and ethnic categories. However, disability should be viewed as a social construct (Olkin, 1999; Renard, 2001; Shapiro, 1994).

This view or theory of disability, which will be examined in greater detail in forthcoming
pages, is known as the social/minority group model. “The social/minority group model asserts that the problems lie not within the person with disabilities, but in the environment that fails to accommodate persons with disabilities and in the negative attitudes of people without disabilities” (Renard, 2001, p. 80). Although changes in federal laws and increased protection against disability discrimination have occurred in recent decades, individuals with disabilities remain a minority population that is insufficiently represented and too often misunderstood (Shapiro, 1994). “Persons with disabilities are seen as a minority group—in the same way that persons of color are a minority group—that has been denied its civil rights, equal access, and protection” (Olkin, 1999, p. 26).

LMHCs are ethically bound to provide unbiased, competent treatment to all clients with whom they enter a counseling relationship. In the 2005 American Counseling Association (ACA) Code of Ethics, there are several specific references regarding the treatment of individuals with disabilities. When describing appropriate counseling environments, the code requires that counselors “strive to provide a site that is accessible to persons with disabilities” (American Counseling Association, 2005, p. 7). In the section of the code that deals with nondiscrimination, the code indicates “counselors do not condone or engage in discrimination based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital status/partnership, language preference, socioeconomic status, or any basis prescribed by law” (American Counseling Association, 2005, p. 10). Currently, no data exist detailing the treatment of individuals with disabilities by LMHCs. Nor is it clear what the level of competence and professionalism of LMHCs for this population might be. As a profession, mental health counselors are ethically bound to explore and investigate the provision of services to all the populations they serve.
Significance of the Study

Individuals with disabilities should be afforded the same rights and privileges as the general population. Federal laws such as the ADA were constructed and passed to ensure these rights. While multiculturalism and diversity gain more attention and popularity in the research and practice of mental health providers, a significant population of individuals with disabilities may continue to be left on the outside, looking in. “Training relevant to the provision of psychological services to members of ethnic-minority groups is far from adequate, and even less emphasis has been given to understanding and serving the diverse needs of Lesbian, Gay, and Bisexual clients and individuals with sensory or motor impairments” (Allison et al., 1996, p. 386). This becomes a critically important issue if individuals with disabilities are increasingly seeking behavioral health interventions, including services from LMHCs. If data from this study indicates that LMHCs are indeed serving clients with disabilities, then it would also be important to determine the level of perceived competence LMHCs have specific to this client population.

Definition of Terms

Disability

The ADA defines disability as any type of mental or physical impairment that produces substantial limitations in one or more major life activity, or a history of such an impairment, or being regarded as having such an impairment (ADA, 1990). In 2001, the World Health Organization released the International Classification of Functioning, Disability and Health (ICF) with the intent of providing a common and consistent language and definitions pertaining to health conditions and related issues. The ICF defines disability as “…an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors)” (World Health Organization, 2001, p. 213). The
ICF views disability as a multidimensional phenomenon that exists due to an interaction between people and their environment. “Disability is a complex phenomena that is both a problem at the level of a person’s body, and a complex and primarily social phenomena. Disability is always an interaction between features of the person and features of the overall context in which the person lives, but some aspects of disability are almost entirely internal to the person, while another aspect is almost entirely external” (World Health Organization, 2001, p. 34).

Although generally accepted as benchmark definitions, for the purposes of this study, the ADA and the World Health Organization definitions are modified. Both organizations include mental impairments and dysfunctions as part of their definitions of disability. However, previous researchers have shown that counselors may have a tendency for responding in an over-inclusive manner when referring to their client’s disability status (Leigh et al., 2004; Renard, 2001). Counselors may respond as if their clients, by virtue of seeking their services, are exhibiting a psychological dysfunction equal to a disability (Renard, 2001). That is, a client with a diagnosis of adjustment disorder may, in the counselor's opinion, be viewed as having a type of disability. Therefore, for the purposes of this study, the scope of the definition of disability will exclude psychological conditions and be narrowed to sensory, motor, and/or physical health conditions.

Sensory disabilities include vision, hearing and speech. Motor disabilities include muscle dysfunction or impairment, paralysis, neurological disorders or conditions, and loss or impairment of functional abilities of the body. Physical health conditions include chronic pain, recurring headaches or migraines, orthopedic disorders, cancer, heart disease, and other medical conditions that have a significant negative influence on an individuals’ life. This study will
utilize a definition of disability that is exclusive to sensory, motor, and/or physical health dysfunctions or impairments.

**Licensed Mental Health Counselor**

For the purposes of this study, the broad term of counselor has been narrowed to licensed mental health counselor. This definition would preclude other types of behavioral healthcare specialists or counselors such as marriage and family therapists, social workers, psychologists, psychiatrists, as well as substance abuse and addictions, vocational, rehabilitation, and school counselors. In the interests of professionalism and identity, only mental health counselors who have obtained their respective state licensure are considered. For logistical purposes, the population of LMHC's was limited to those within the state of Florida.

There is no single definition of a LMHC that is accepted or endorsed by all states, agencies, or associations. There are however common themes and concepts found in most all definitions that are central to the role. The LMHC utilizes scientific and behavior theories, methods, and techniques to prevent and treat undesirable behavior and enhance mental health and human development (Florida Department of Juvenile Justice, 1998). The U.S. Department of Labor (2006) defines the role of mental health counselors as one that emphasizes prevention and promotes optimum mental health. “They are trained in a variety of therapeutic techniques used to address a wide range of issues, including depression, addiction and substance abuse, suicidal impulses, stress management, problems with self-esteem, issues associated with aging, job and career concerns, educational decisions, issues related to mental and emotional health, and family, parenting, and marital or other relationship problems.” (U.S. Department of Labor, 2006, para. 7). It is worthy to note the broadness of the definitions and the wide scope of practice of LMHCs. Diversity in the client population is likely, given the wide parameters of practice. For
the purposes of this study, LMHC's were defined as licensed mental health counselors currently possessing licensure within the state of Florida.

**Contact**

This term describes the professional or personal interactions between LMHC's and individuals with disabilities. This term is not meant to specify whether or not the individual is a client or has received ongoing services from the LMHC. It is hypothesized that some LMHCs will have an initial interaction or an intake session or sessions with an individual with disabilities and will then refer the client or refrain from providing services. However, these LMHCs would have been exposed to such clients and the result of that exposure is of interest in the current study. The term *contact* is used in this study to describe professional and/or personal interactions or exchanges between LMHCs and individuals with disabilities who may be clients.

**Research Questions and Hypotheses**

The purpose of this study is to examine the amount of contact LMHCs have with individuals with disabilities, and to describe LMHC’s Self-Awareness/Beliefs/Attitudes, perceived Knowledge, and perceived Skills when treating individuals with disabilities. Furthermore, this study will investigate the amount of contact LMHCs have with individuals with disabilities as a predictor of their perceived Knowledge and Skills. Lastly, the study will look at LMHC’s Self-Awareness/Beliefs/Attitudes toward disability as a predictor of their perceived Knowledge and Skills.

**Research Question #1**

What is the amount of contact with individuals with disabilities reported by LMHCs?

**Hypothesis #1**

LMHCs will report between minimum and moderate amounts of contact with individuals with disabilities.
Research Question #2

Do LMHCs rate their levels of Self-Awareness/Beliefs/Attitudes, perceived Knowledge and perceived Skills in different ways?

Hypothesis #2

LMHCs will describe themselves as having higher levels of Self-Awareness/Beliefs/Attitudes toward disability-related issues than perceived Knowledge and perceived Skills, and will describe their levels of perceived Knowledge of disability and disability-related issues to be higher than their perceived Skills, with perceived Skills rated the lowest of the three variables.

Research Question #3

Does the amount of contact LMHCs’ have with individuals with disabilities and their Self-Awareness/Beliefs/Attitudes toward disability predict their perceived Knowledge and Skills when working with individuals with disabilities?

Hypothesis #3

LMHCs’ who report more frequent contact with individuals with disabilities and have high Self-Awareness/Beliefs/Attitudes scores will report higher levels of perceived Knowledge and Skills when working with individuals with disabilities. Thus, both amount of contact and Self-Awareness/Beliefs/Attitudes will be predictors of LMHC’s perceived Knowledge and Skills when working with individuals with disabilities.
CHAPTER 2
LITERATURE REVIEW

The following literature review contains 14 sections that will provide a greater understanding of various aspects LMHCs and their interactions with clients with disabilities. These sections include: 1) demographics of disability; 2) a historical look at the field of mental health counseling; 3) LMHC preparation, training, and continuing education; 4) counseling needs among individuals with disabilities; 5) models of disability; 6) psychosocial adjustment to disability; 7) practical issues of disability; 8) health maintenance issues; 9) social reactions; 10) countertransference; 11) legal and ethical issues; 12) self-awareness/beliefs/attitudes towards individuals with disabilities; 13) LMHCs’ level of knowledge regarding disability, and; 14) LMHCs’ level of skill utilized in treating individuals with disabilities.

Demographics of Disability

Approximately one in five citizens in the United States, or approximately 49.7 million people, has some type of disability (U.S. Bureau of Census, 2000). A conservative estimate of approximately 36 million or 15% of Americans has activities that are limited by some form of disability (LaPlante, 1996). The National Organization on Disability reported that approximately 20% of adults with disabilities reported the onset of disability between birth and adolescence. About 25% reported an onset in early adulthood and the remaining 53% reported onset after age 40 (National Organization on Disability and Harris Survey of Americans With Disabilities, 2000). Based upon the aging of the population and the prevalence of disability in older segments of the population, demographic forecasts indicate that an increasing proportion of the population will be persons with disabilities (Renard, 2001). Kaye et al. (1996) noted two trends that contributed to a probable increase in the prevalence of disability in the United States; a gradual
demographic change toward an aging population and an increase in disabilities reported among young adults.

The prevalence of disability has been found to vary among factors that include gender, age, ethnicity, and location or place of residence (LaPlante & Carlson, 1996). Among children and youth, a larger number of boys than girls have disabilities. This may in part be due to boys being more frequently diagnosed with learning disabilities, mental retardation, and attention deficit hyperactivity disorder (Strike, 2001). The adult and elderly population of individuals with disabilities is quite the opposite. A greater number of women than men have disabilities due to the greater average life expectancy of women (Harsh, 1993). Approximately 8% of the age group 5 through 20, or approximately 5.2 million, has some form of disability. Approximately 42% or 14 million individuals age 21 through 64 has some form of disability (U.S. Census Bureau, 2000).

An examination of the vocational aspects of the demographics of disability reveals disturbing information about this minority population. In 2000, the unemployment rate in the United States was less than 5% (U.S. Department of Labor, 2000). At about that same time, approximately 75% of individuals with disabilities were unemployed while roughly 11% of those with disabilities were considered unable to work or substantially limited in their ability to work (Kraus, Stoddard, & Gilmartin, 1996). Within the age group of 21 to 64, only 57%, or approximately 30.6 million individuals with disabilities ages were employed. Those individuals with disabilities that do work can expect to earn, on average, 57% less than non-disabled workers (Stoddard et al., 1998). Another survey noted that only 35% of people with disabilities, ages 18-64, worked full or part-time compared to 78% of non-disabled individuals in that same age range (National Organization on Disability and Harris Survey of Americans With Disabilities, 2004).
“These facts and figures point to the persistence of an uneven playing field of opportunity for persons with disabilities, and they underscore the importance of ongoing efforts toward vocational development and integration for persons who have disabilities” (Renard, 2001, p. 61). More recent studies have shown that employment discrepancies between individuals with disabilities and the non-disabled population have improved, albeit far too modestly. “Looking back four years, or ten years, to our earlier N.O.D./Harris surveys, we see Americans with disabilities heading in the right direction. But people with disabilities remain pervasively disadvantaged” (National Organization on Disability, 2004, p. 1, para3).

Because this author’s study utilizes a sample population from the state of Florida, it is important to examine disability statistics specific to that state. According to the 2000 U.S. Census, Florida is in the middle of the spectrum in most disability categories of the survey. The highest percentage of individuals with disabilities, ages five and over, reside in Arkansas, Kentucky, Mississippi, and West Virginia. The lowest rates of disability, ages five and older, belong to Alaska, Minnesota, and Utah.

There are approximately 3.3 million non-institutionalized individuals with disabilities, ages five years and older, living in the state of Florida (U.S. Census Bureau, 2000). This constitutes 22.2% of the population, ages 5 and over. In certain areas of Florida, the percentage is even higher. For example, the 2000 U.S. Census noted that Miami, Florida had the second highest percentage of individuals with disabilities (29.4%) among U.S. metropolitan areas with populations greater than 100,000. In Florida, approximate 8.7% of the population between the age of 5 to 20 years old has a disability. Within the state, 21.9% of individuals ages 21 to 64 have a disability. Approximately 40% of individuals ages 65 and older, living in Florida, have a
disability. According to 2000 census data, approximately 58% of individuals with disabilities, ages 21 to 64, are employed in the state of Florida.

As indicated previously, Florida falls in the middle of the range for most categories of disability in the United States. The number and percentage of non-institutionalized individuals with disabilities in the state represents a considerable presence. This number is expected to increase in the 2010 census (Waldrop & Stern, 2003). As this population grows, the likelihood of these individuals seeking mental health services is also expected to increase (Oliveira, Milliner, & Page, 2004). Along with psychology, marriage and family therapy, social work, psychiatry, and rehabilitation counseling, mental health counseling is one of the specialty fields which individuals with disabilities (not unlike the general population) may utilize.

**History of Mental Health Counseling**

Mental health counseling is one of the youngest behavioral health provider professions (Pistole, 2001). In the United States, the roots of the profession can be traced to what is now known as the American Counseling Association (ACA). Several groups of counseling specialties formed this organization in 1952 and it has become the world’s largest association devoted exclusively to representing professional counselors. In 2000, the U.S. Department of Labor reported there were approximately 67,000 mental health counselors in the United States (U.S. Department of Labor, 2006). Currently, the ACA represents approximately 52,000 counselors in the United States.

In 1963, the Community Mental Health Centers Act was passed which provided funding for community-based, mental health facilities staffed by practitioners at the masters level. The majority of these professionals were without specific training in the fields of psychology, psychiatry, or social work. As with the growth and development of any human service profession, traditional foundations needed to be established. First, a professional organization
was needed to promote the representation and further the cause of this group of professionals. Secondly, a uniform code of ethics outlining appropriate practice parameters was needed. Third, the development of licensure and credentialing for the individuals of the profession must be established. Without such representation and organization, these counselors were operating in an environment of professional disenfranchisement and invisibility (Pistole, 2001). By the late 1970’s, this group of counselors organized their pursuit of visibility, recognition, and identity. As a result, in July of 1978, the American Mental Health Counselors Association (AMHCA) was founded to establish and promote recognition, standards and accountability, and professional status for practice-oriented counselors (Beck, 1999). In 1983, AMHCA joined the ACA as one of its 18 divisions that provide specific professional identities and are organized around specific practice areas.

The creation of AMCHA helped provide an identity for mental health counselors. The organization then set its sights on providing the opportunity for licensure, a credential previously established in the fields of social work and psychology. This issue became increasingly important as the trend toward third party payments for counseling services grew in popularity. Counselors found it difficult, if not impossible, to obtain reimbursement for their services without some form of licensure. As a result, one of AMCHA’s primary goals became the licensure of mental health counselors in all 50 states (Pennington, 2003). By 2007, only one state had not obtained some form of counseling licensure law.

As mental health counseling grew as a profession, the population served by these counselors and the settings in which the services were provided also evolved. As a result of the changes in the funding of mental health services, the parameter and scope of services offered by LMHC’s expanded (Kelly, 1996). Employment settings for LMHC’s now include health
maintenance organizations or managed mental health care centers, large multi-disciplinary group practices, senior care and elderly housing and service centers, psychiatric hospitals’ inpatient or outpatient service, court systems, correctional systems, public and private schools, universities and colleges, and in-house mental health counseling services contracted by large corporations or governmental agencies (Messina, 1999). Indeed, the growth of mental health counseling as a profession has increased the exposure and access that practitioners have to the public. It has also brought about an increased diversity in the individuals served by these counselors.

Counselor Preparation, Training, and Continuing Education

To prepare for the provision of counseling services, students training to become LMHCs must earn a masters degree from an accredited counseling program. The main accrediting body for such academic programs is the Council for Accreditation of Counseling and Related Educational Programs (CACREP). Since its incorporation in 1981, CACREP has established academic training and experience standards for future mental health counselors. “CACREP Standards are written to ensure that students develop a professional counselor identity and also master the knowledge and skills to practice effectively” (CACREP, 2001, Introduction section, para. 2). Social and cultural diversities are part of the eight core curricula training areas required by CACREP. Educational institutions that adhere to CACREP standards require all counseling students to learn “advocacy processes needed to address institutional and social barriers that impede access, equity, and success for clients” (CACREP, 2001, Section 2, Unit K, 1-g). In addition to the common core requirements of all counselors, CACREP standards require mental health counseling students to obtain knowledge and skills pertaining to “the role of racial, ethnic and cultural heritage, nationality, socioeconomic status, family structure, age, gender, sexual orientation, religious and spiritual beliefs, occupation, and physical and mental status, and equity
issues in mental health counseling” (CACREP, 2001, Standards for mental health counseling section, # 6).

Curricula and academic training in the areas of minorities, diversity, and multiculturalism are addressed in and required by CACREP programs. However, recent research has shown that training in CACREP programs in the areas of disability has been sparse, lacks coverage, or has been biased (Rosenau, 2000). “Although nowadays disability is often mentioned among the types of diversity for which counselors should routinely receive training and continuing educational opportunities, disability is the least covered diversity issue in terms of course content and opportunities for supervised practice experience” (Renard, 2001, p. 72). Smart and Smart (2006) noted that “the disability experience, despite the large number of individuals with disabilities, remains invisible in most university curricula” (p. 36).

Another accrediting body for educational programs preparing future counselors is the Council on Rehabilitation Education (CORE). CORE accredits graduate programs in rehabilitation counselor education. In many states, including Florida, such programs may provide training and coursework that fulfills the academic qualifications necessary to earn licensure in mental health counseling. Because of the overall focus on rehabilitation and disability issues in CORE programs, individuals qualifying for mental health counseling licensure through these programs may have a greater understanding or level of competence in providing psychotherapeutic services to clients with disabilities.

However, the majority of LMHCs do not fulfill their academic qualifications for mental health counseling licensure within CORE accredited programs. Most students in counselor training programs, with the exception of specialties such as rehabilitation counseling or rehabilitation psychology, are not required to learn about individuals with disabilities (Smart &
Smart, 2006). This standpoint was supported by Rosenau (2000), who conducted a content analysis of the most frequently used textbooks in counselor education programs. The study indicated that these texts rarely address disability issues. Further, if disability concerns are addressed, they provide biased presentations of persons with disabilities (Rosenau, 2000).

**Counseling Needs Among Persons with Disabilities**

When examining the demographics of disability, it is suggested that mental health professionals across disciplines will encounter clients with disabilities in the community, in vocational settings, and in higher education (Strike, Skovholt, & Hummel, 2004). This is in part due to the combined effects of civil rights movements, medical advances, and assistive technologies (Barnes et al., 1999; Mackelprang & Salsgiver, 1999; Oliver, 1996). Individuals with disabilities are engaging in a broader range of social and vocational roles and activities than ever before. As this minority group grows, it is inevitable that its exposure and involvement in everyday life among non-disabled individuals will continue to grow as well. Although there are great strides to be made for equality to exist between disabled and non-disabled populations, it is evident that the two populations share more experiences and environments as time marches on.

“Thus, the composition of ‘the general public’ increasingly includes rather than excludes persons with disabilities, and counseling professionals who work as generalists must be prepared to work effectively with the public in all its diversity” (Renard, 2001, p. 65).

Literature suggests that mental health professionals are becoming more aware of the presence of individuals with disabilities and the large percentage of the population they represent (Henderson & Bryan, 1997, Kemp & Mallinckrodt, 1996, Renard, 2001, Strike et al., 2004). “Psychologists are increasingly recognizing persons with disabilities as the largest minority group in the United States and acknowledging disability as an inevitable part of human experience, thereby reshaping psychological research and practice” (Strike et al., 2004, p. 321).
However, data also exist that indicates an alarming lack of preparedness or adequate awareness of disability issues by mental health professionals (Rosenau, 2000). Yet, since census data indicates a growing percentage of the population is individuals with disabilities, and this population is becoming more and more “mainstreamed”, it seems reasonable to assume that individuals with disabilities would encounter problems similar to those in the general population. This is not to say that there are no significant differences between the disabled and non-disabled populations. However, it may not be the disability itself that creates these differences and divisions. Research has shown that prejudicial attitudes exhibited by non-disabled persons can create and maintain social distance from persons with disabilities (Abrams, Jackson, & St. Claire, 1990, Olkin & Howson, 1994; Westbrook, Legge, & Pennay, 1993). This social distance, along with discrimination and medical, vocational, and environmental issues can create credible needs for counseling and guidance. Individuals with disabilities are less likely to be married or coupled, less socially active than desired, and report significantly lower levels of life satisfaction (Jans & Stoddard, 1999). Because LMHC’s often assist clients in coping with and resolving these types of personal development problems, it seems likely that individuals with disabilities would seek their services.

In a 2004 follow-up article to the 2004 National Organization on Disability/Harris Survey of Americans with Disabilities, the organization summarized the findings regarding overall life satisfaction of individuals with disabilities (National Organization on Disability, 2004). A disturbing trend was noted when comparing disabled and non-disabled individuals. Between 1986 and 2004, there is evidence of slow and modest progress in regards to overall life satisfaction for individuals with disabilities. Yet, there are persistent gaps between the advantages experienced by non-disabled people and disadvantages encountered by individuals
with disabilities. The percentage of non-disabled individuals who are very satisfied with life was reported to be 61%. Only 34% of individuals with disabilities reported being very satisfied with life. Three times as many individuals with disabilities versus non-disabled individuals live in poverty (26% versus 9%). Individuals with disabilities are twice as likely to drop out of high school (21% versus 10%). They are almost three times as likely to go without adequate healthcare (18% versus 7%). It is important to remember that these data were gathered during a time when legal changes occurred designed to create an environment for improved life quality among individuals with disabilities.

The 2004 National Organization on Disability/Harris Survey of Americans with Disabilities also examined the outlooks or expectations that individuals with disabilities held about the future. Approximately 41% of individuals with disabilities expected their overall quality of life to improve in the coming four years. Yet, most likely due to age and increased impairments, 35% expected their lives to get worse. The study noted that, by contrast, 76% of non-disabled persons expected their quality of life to improve. Only 8% of non-disabled persons believed that their lives would get worse (National Organization on Disability/Harris Survey of Americans with Disabilities, 2004).

Data such as this is not meant to associate disability with poor quality of life, depression, victim roles, or pity. Nor should it be assumed that disabilities are the sole determining factor or even a major contributing factor in the overall quality of life of any person. It is also important to note that not all individuals with disabilities seek mental health counseling for strictly disability-related problems. Kemp and Mallinckrodt (1996) conducted a study that found mental health clinicians falsely assumed that certain disability-related issues were important to the client when, in actuality, they were not.
This focus on the disability or issues related to the disability resulted in the absence of focus on the presenting problem. There is clear evidence to support the mental health counseling needs of individuals with disabilities in the areas of social, relationship, vocational, and overall life satisfaction (Jans & Stoddard, 1999; Kemp & Mallinckrodt, 1996; National Organization on Disability, 2000; Olkin & Howson, 1994). “As people with disabilities enjoy greater involvement in the community, they are likely to seek mental health services independent of their disabilities” (Hayes & Potter, 1995, p. 25). While it is not imperative that LMHCs be experts on the specific dynamics of each type of disability, it is important the clinician have an awareness of disability issues and be able to differentiate between problems related to or caused by a disability and presenting problems unrelated to the individual's disability.

Models of Disability

To best understand the dynamics of disability and this minority population, the LMHC should have an understanding of the historical models of disability and how they may influence attitudes, environment, and the individual. Current literature reflects the numerous models of disability that have develop in recent years (Harris, 2000; Pledger, 2003; Smart, 2001; Smart & Smart, 2006; Tate & Pledger, 2003). However, it is generally accepted that all models have origins in one of three primary models: moral, medical, and social. A fourth group of more contemporary models will also be discussed.

The moral model of disability is perhaps the oldest model and is clearly the least prevalent in current literature. It is arguably derived from religious doctrine and associates disability with sin and shame (Kaplan, 2006). The moral model explains disability as an act of God in reaction to a sin of an individual or a family (Gill, Blanck, Schartz, Klein, & Searcy, 2003). Even in modern times, there are cultures that still view disability as shameful and individuals with disabilities are ostracized. “This model has been associated with shame on the entire family with
a member with a disability. Families have hidden away the disabled family member, keeping them out of school and excluded from any chance at having a meaningful role in society” (Kaplan, 2006, para5). Although this model is not prevalent in most modern cultures, it serves as a powerful reminder of a possible origin of discriminatory, negative and biased views of disability.

The medical model of disability became popular in the 19th century as physicians gained prominence in society. The medical model is derived from scientific origins, specifically the medical arena. It is the most familiar model to the general population and is supported by the power and prestige of the medical and scientific communities. The strength of this model is in its strong explanatory power, which far exceeds other models (Kahn, 1984). According to this model, issues associated with the disabling condition are considered to be “within” the individual. Social factors play little to no role at all in the disabling condition. The individual with the disability assumes a “sick” or patient role within this model. This can be problematic for the individual with the disability, especially those who do not view their impairment as a primary problem. “While professionals may view people with disabilities as patients, people with disabilities often accept their disabilities and move away from the patient role to resume life roles of worker, student and parent within the community” (Seelman, 2004, The Medical Model, Professional Training sect., para. 3). Nagi (1969) described this model as placing individuals with disabilities into stigmatizing categories that promoted non-disabled individuals to label them as their disability. For example, the individual with a visual impairment would be labeled as “the blind guy”.

Smart and Smart (2006) examined four aspects (pathologizing, objectification, categorization, & individualization) of the medical model that exemplify the shortcomings of this
view. Pathologizing refers to the underlying assumption that there is a pathology present within the individual with the disability. This can lead to the belief that individuals with disabilities have something wrong with them. Disability therefore is considered a flaw or deficit. Undoubtedly, this premise could be at the root of biased and discriminatory viewpoints. Objectification, which is intertwined with pathologizing, refers to the premise that disabilities are objective conditions that exist in and of themselves. Objectification makes it possible to lose focus on the person because attention is focused on the supposed pathology. It also can be interpreted as unbiased or fair because of the assumed objectivity under which the disability is being viewed or treated. Categorization, as discussed in the previous paragraph, refers to the labeling of individuals with disabilities. Although this behavior is apparent in the general population, it is also prevalent in medical settings (i.e. the quadriplegic in exam room two, or the bi-polar client). “This categorization according to disability type has had many pervasive, institutional, and systematic consequences, some of which have resulted in inferior services or a lack of services from the counseling professions” (Smart & Smart, 2006, p. 31). The fourth aspect, individualization, is a central theme in the medical model and places the disability within the individual, with little or no consideration of societal or environmental influences. This view relieves society of any responsibilities.

The lack of consideration of environmental or societal influences within the medical model is an important factor when dealing with mental and psychiatric disabilities. Stefan (2001) notes that the medical model’s lack of environmental consideration and its focus exclusively on the individual can make it inappropriate for treatment of individuals with mental health conditions, which are very responsive to context and environment.
The social model of disability is based upon the premise that individuals are not disabled because of their impairment. Rather, they are disabled due to societal or environmental factors (Given, 2005). Therefore, this model views disability as a social construct. “This disability paradigm maintains that disability is a product of the intersection of individual characteristics (e.g. conditions or impairments, functional status, or personal and socioeconomic qualities) and characteristics of the natural, built, cultural, and social environments” (U.S. Department of Education, Office of Special Education and Rehabilitative Services, NIDRR, 2000, p. 2). This model makes a clear distinction between an impairment and a disability. The social model supports the notion that an individual with an impairment does not equal an individual with a disability. The latter is determined by social and environmental factors.

Researchers have expanded upon barriers defined in the social model to include not only environmental, societal and structural limitations but also political and attitudinal barriers (Brandt & Pope, 1997; Tate & Pledger, 2003). Barriers in education, healthcare, transportation, housing, employment, communication, and public facilities as well as negative images and representations of disability in the media are the driving force behind the existence of disability. The social model supports the premise that if you remove the barriers, you eliminate the disability.

The World Health Organization's publication of the ICF - International Classification of Functioning, Disability, and Health (2000) furthered the argument for a model of disability with an emphasis on social factors. “A person's functioning and disability is conceived as a dynamic interaction between health conditions (diseases, disorders, injuries, traumas, etc.) and contextual factors” (World Health Organization, 2001, p. 8). The ICF defines contextual factors as both personal and environmental. Environmental factors interact with all the components of disability
and pertain to the impact of the physical, social and attitudinal world (World Health Organization, 2001).

The ICF explains the social model of disability as one where the makeup of disability is within society, not the person. “Disability is not an attribute of an individual, but rather a complex collection of conditions, many of which are created by the social environment. Hence the management of the problem requires social action, and it is the collective responsibility of society at large to make the environmental modifications necessary for the full participation of people with disabilities in all areas of social life” (World Health Organization, 2001, p. 20).

The basic premise of the social model is more closely related to the theoretical assumption and practice orientations of most LMHCs (Smart & Smart, 2006). By following this line of thought, the LMHC is more capable of viewing a client with a disability as a complete person within the context of his/her environment. It allows the LMHC to see beyond the disability which may or may not be the presenting problem. This is not to say that the social model has no limitations and should be unquestionably adopted by all LMHCs. It should be noted that many researchers and individuals with disabilities see the social model as just redefining the problem (Smart, 2001; Swain & French, 2000; Tate & Pledger, 2003). It is argued that the social model still frames the impairment and/or disability as something negative. “The non-tragic view of disability, however, is not about ‘the problem’, but about disability as a positive personal and collective identity, and disabled people leading fulfilled and satisfying lives” (Swain & French, 2001, p. 571).

It should also be noted that the ICF proposes a hybrid model of disability that combines the social model with the medical model. As mentioned, the medical model views disability as an individual phenomenon, within the person, caused by some disabling condition or trauma. The
combined social and medical approach, referred to by the ICF as a biopsychosocial model, attempts to integrate two different models to create a new model that considers medical, individual, and social perspectives.

Like the ICF model, new hybrid or modified models are emerging and gaining acceptance by researchers and individuals with disabilities. The sociopolitical model, also referred to as the minority model, attempts to explain and describe more of the day-to-day life of individuals with disabilities (Hahn, 1988; Smart & Smart, 2006). This model focuses more on the damaging effects of prejudice and discrimination rather than medical impairments or functional limitations. This model rejects the inferior and dependant definition of disability. This model also resists medical categorization by diagnosis and explains that such an occurrence actually may be the source of discrimination and prejudice. It is an interactional model that views disability not as a personal tragedy but as a public concern.

Similar to the sociopolitical or minority model is the affirmative model of disability. “It is essentially a non-tragic view of disability and impairment which encompasses positive social identities, both individual and collective, for disabled people grounded in the benefits and lifestyle and life experience of being impaired and disabled” (Swain & French, 2000, p. 569). The affirmative model does not focus so much on the problem of disability or impairment but instead on the positive experiences and identity of individuals with disabilities from being impaired and disabled. And although the affirmative model in some respects builds upon or extends the social or minority models, it also addresses some shortcomings of those paradigms. For example, issues such as pain and chronic illness may not be applicable to the social model. Crow (1996) explains that conditions such as chronic pain or chronic illness may be so debilitating that restrictions in the environment or outside world become irrelevant and that the impairment may
remain even when social or environmental barriers no longer exist. Other researchers extend this debate. “Pain and chronic illness are neither impairments nor restricted to the experiences of disabled people. Non-disabled people experience both pain and chronic illness. Indeed, in the pursuit of physical fitness, pain can be actively pursued by non-disabled people: no gain without pain” (Swain & French, 2000, p. 572).

The new models and paradigms clearly view disability and impairments in a different light; one focused less on dysfunction and tragedy. Understanding the conceptualization of disability is an important element within the LMHCs understanding of this minority population. Smart and Smart (2006) summarize this premise:

Typically, the disability is not the single defining characteristic of the individual; rather the disability is one of several important parts of the individual’s self-identity. When counselors dismiss or ignore the disability, a critical part of the client’s self-identity must remain unexplored. On the other hand, counselors may tend to overemphasize the salience of the disability and automatically assume that the disability is the ‘presenting problem’ or the cause and source of all the client’s concerns. Indeed, the ‘roadblocks’… may be due to a lack of understanding, training, and experience with disability issues. Many individuals with disabilities view their disability as a valued part of their self-identity, see positive aspects in the disability, and would not choose to eliminate the disability if they had this option. In contrast, few counselors conceptualize the client’s disability as a source for self-actualization. (pp. 29-30)

Knowledge of the various models, paradigms and conceptualizations of disability can further the LMHC’s ability to build empathy and rapport, effectively diagnose and treat, and create trust and understanding within the counseling relationship.

**Psychosocial Adjustment to Disability**

An understanding of how individuals adjust to disability can be another powerful tool within the LMHC’s repertoire. Early clinical theories pointed to the severity of the disability as the primary factor in adjustment (Shontz, 1989). More contemporary research has refuted this idea. “Rather, the relationship between psychological adjustment and physical disability is complex, multidimensional, and moderated by other variables, such as gender, socioeconomic
status, and availability of social supports” (Cook, 2004, p. 332). The importance of understanding psychosocial adjustment to disability is paramount. Psychosocial adjustment problems have been associated with extensive costs in terms of long-term community welfare and health service utilization (Kendall & Buys, 1998).

Vash (1981) explained that, because the adjustment to disability is an individualized experience, people with similar disabilities or circumstances may deal with the adjustment in different ways. There are also numerous factors that may influence the process of psychosocial adjustment for each individual (Atkins, Lynch, & Pullo, 1982). These factors include (but are not limited to) the severity of the disability, the age or stage of life at which the disability is acquired, the visibility of the disability, the gender of the individual, the individual’s spiritual/cultural beliefs, and the physical pain involved in the disability.

There are many theories in existence that attempt to explain psychosocial adaptation to disability. Perhaps the most popular methods for describing psychosocial adaptation to disability are based on stage theories. Typically, these models portray adjustment evolving through a sequential series of stages and culminating when an individual has achieved a working acceptance or adjustment (Garske & Turpin, 1998). Livneh (1991, 2001) developed a variation of the stage theory that placed the individual with a disability in an active role. Referred to as the “unified” model of psychosocial adaptation to disability, Livneh described this model as a process through which the individual slowly approaches an optimal state of person/environment congruence (Livneh, 1991).

Stage 1 of the unified model is initial impact. This is described as the individual’s response to the onset of a sudden disability or psychological trauma. This stage consists of two components: shock and anger. During the shock phase, the individual may be confused,
disoriented, or emotionally withdrawn. As the shock wears off and awareness increases, anxiety may set in. This anxiety occurs when one realizes the magnitude of the event. The anxiety may cause the individual to overreact, become irritable, or feel helpless.

The second stage is known as defense mobilization. This stage also has two phases: bargaining and denial. Both bargaining and denial are considered defense mechanisms, and in most instances are an appropriate part of overall adjustment (Marshak & Seligman, 1993). Bargaining involves “deals” that are offered up to God or any other entity or person that might be able to take away or reduce the impact of the disability. While bargaining is usually short-lived, denial can last much longer. Once no “bargains” are found, the individual may try to forget or erase the disability and everything related to it. The individual may seem upbeat or optimistic. While this mentality may seem unrealistic, it serves a valuable purpose in that it can insulate or protect the individual from his/her painful reality.

Stage three is known as initial realization. Common themes of this stage include mourning, reactive depression, and internalized anger. The individual may become withdrawn, detached, and may try to avoid social interactions. “The defense mechanisms of withdrawal and avoidance are necessary in order for the person to concentrate on the disability and its consequences without becoming distracted by the social and physical environments surrounding him/her” (Garske & Turpin, 1998, p. 35) It is important to note that while there is value in withdrawal and avoidance, internalized anger does not have a useful purpose and in no way insulates the individual from the painful adjustment he or she must make. This internalized anger may lead to long-term depression (Marshak & Seligman, 1993). In turn, this depression may lead to the individual seeking the services of an LMHC.
The fourth stage is known as retaliation or rebellion. This stage consists of anger and hostility that has an external focus. The direction or target of this hostility may be towards people, objects, or environmental aspects associated with the individual's functional limitations. Defense mechanisms such as projection, externalization, and regression may be used to fight and overcome anything in the external environment that may be perceived as threatening or as an obstacle in the individual’s way (Garske & Turpin, 1998).

The fifth and final stage in Livneh’s unified model is reintegration. This stage is characterized by acknowledgement, acceptance, and final adjustment. It is described as the “…gradual integration of the functional limitations associated with one’s condition into one’s self-concept” (Antonak & Livneh, 1997, p. 10). Acknowledgement occurs when the individual comes to terms with the permanent nature of his/her condition. Acceptance and final adjustment occur when the individual finds satisfaction and contentment in living with the disability. The individual no longer utilizes defense mechanisms to cope with his/her situation. This phase is constructed of the individual's emotional acceptance of his/her functional limitations, his/her behavioral adaptation to the disability, and a social integration as part of a newly perceived life situation (Antonak & Livneh, 1999).

Although stage models like Livneh’s unified approach are popular among researchers and practitioners, they are not without criticism and possible limitations. While stage models may adequately represent the general progression towards adjustment, they do not sufficiently address the recurrent nature of the psychosocial adaptation process (Kendall & Buys, 1998). Researchers have argued that linear models do not allow counselors to appreciate or anticipate the disorder, unpredictability, and complexity of the issues associated with psychosocial adaptation to disability (Rosenthal, 1996). Others criticize the implicit passivity of the individual with a
disability within the stage model (Stewart, 1996). The individual is subjected to waiting for unavoidable stages to occur and may be less like to be an active participant in the rehabilitation process. This may also cause counselors or health care providers to wait unnecessarily until one stage is completed before progressing on to the next. Stage models also normalize responses such as denial and distress, which may lead counselors or health care providers to expect, or even encourage, these types of responses (Kendall & Buys, 1998). Some researchers have even opined that stage models of psychosocial adjustment represent a form of social oppression. Dovey and Graffam (1987) indicated that these models encourage individuals with disabilities to accept fewer alternatives and less personal control than individuals in the non-disabled population.

Other researchers have noted that social and environmental factors play as much of a role as internal factors in determining an individual's response to disability (Charmaz, 1995 & Shontz, 1991). Hahn (1988) explained that adjustment to disability is not only an internal process, but also involves social reactions to disability. He argued that social attitudes, political climates, and physical environments could be as important as the individual's internal process of adjustment. “An alternate theoretical construct must better take into account the social impacts and implications of being labeled disabled. In order to provide an accurate model, it must go beyond the individual's immediate experience to encompass the various cultural and personal meanings of disability” (Olney, Brockelman, Kennedy, & Newsom, 2004, p. 7). Similar to the social model of disability, this social view of adaptation to disability considers disability as a product of the environment rather than an aspect of the individual. Olney et al. (2004, p. 8) discusses the following interrelated phenomena that have ties to the social model of adaptation to disability:
(1) An evolving disability policy which increasingly recognizes the pejorative treatment of individuals with disabilities as a human rights issue rather than as a result of individual failings (Rehabilitation Act Amendments of 1992);

(2) A gradual shift from a medical model of disability with its focus on ameliorating the limitations of the individual, to a minority group model that views the disenfranchisement of individuals with disabilities as evidence of discrimination (Hahn, 1985); and


Theories of adjustment are primarily derived from an event marking the onset of a disability or impairment. They do not typically address life long developmental, physical, cognitive, or learning disabilities. Individuals who are born with disabilities may have experiences quite different than people who acquire disabilities later in life. Also, adjustment for one disability group may be very different than another type of disability group (Mackelprang & Salsgiver, 1999, Olney et al., 2004). These issues are especially important for the LMHC who is treating an individual with a disability. Adjustments to disability can take place at any time or period of an individual's life. The majority of literature pertaining to the adjustment to disability ignores the on-going, long-term adjustments that are necessary as one goes through life after disability (Olkin, 1999).

In response to the shortcomings of stage models, Kendall and Buys (1998) proposed an alternative approach to conceptualizing adjustment to disability known as the recurrent model. This model views adjustment as an ongoing cycle. In articulating the recurrent model, the authors explain that cognitive theories of psychosocial well-being are based upon schemas, which are fundamental beliefs and assumptions about the self, others, and how the environment works (Kendall & Buys, 1998). “The recurrent nature of adjustment originates from the fact that new schemas will be developed incrementally and will be revised, modified or completely
restructured as the individual consolidates his or her new position in life and has opportunities to explore the environment” (Kendall & Buys, 1998, p. 18).

This modification of schemas is typically guided by three separate themes: (1) the search for meaning in the disability and in post-disability life; (2) the need for a sense of control over the environment, the disability, and one’s future; and (3) the effort to protect and enhance one’s post-disability life (Kendall & Buys, 1998). The recurrent process of adjustment may reflect the turbulence and confusion that occurs while individuals with disabilities try to find a balance between two extremes. For example, Barnard (1990) discusses how, in the search for identity, individuals oscillate between schemas dominated by either self-rejection or self-acceptance. Individuals who are able to move through this phase are likely to continue moving through a series of decreasing pendulum swings while they establish their new schemas (Kendall & Buys, 1998). These schemas may become more positive or negative, largely influenced by the individual’s environment and surroundings. The speed and quality with which individuals move through the adjustment process is heavily influenced by the individual’s available resources (Kendall & Terry, 1996). Thus, sufficient resources result in more positive schemas, more appropriate coping efforts, and greater psychosocial well-being (Lazarus, 1993). “A systemic, ecological model would focus counselors towards the identification of environmental as well as personal coping resources which are crucial to adjustment” (Kendall & Buys, 1998, p. 21).

While it may not be imperative that LMHC’s have a thorough and detailed understand of adjustment models, it is important that the practitioner have a basic understanding of the psychosocial adaptation process and the various approaches to this understanding. A lack of awareness of the strengths and limitations of the various models, or strict adherence to only one method, may negatively impact the quality of care provided to individuals with disabilities.
As part of adjustment to disability, as well as living with a disability, individuals must face everyday, recurring issues that can impact their overall quality of life. These issues are numerous and vary widely but, for the purposes of this study, they will be categorized into three general areas; practical issues, health maintenance issues, and social reactions.

**Practical Issues of Disability**

As indicated previously, it is inappropriate to assume that the reason for treatment or presenting problem of an individual with a disability arises out of the disability itself, or is even related to the disability. However, the LMHC should be aware of everyday issues related to the disability that may contribute to, or exacerbate, the presenting problem. Within the realm of multicultural counseling, therapists are challenged to understand the complexity of issues that different cultures face and the context within which problems present themselves. It is only reasonable to expect the LMHC treating the individual with a disability to have the same understanding. It is unlikely that a competent, ethical therapist would provide marriage counseling without having a working knowledge of the dynamics of marriage, family systems, or intimate relationships. Similarly, an LMHC may be ill advised to work with an individual with a disability without understanding the practical, everyday issues that comprise the world of the client.

Because individuals with disabilities are as varied and unique as non-disabled individuals, it is difficult to identify specific issues that all of them face. However, many individuals with disabilities encounter daily dilemmas and struggles that may seem unfamiliar or foreign to non-disabled persons. Research reflects evidence of barriers to full social participation and the slow rate of progression to an equal opportunity status for individuals with disabilities, even following the implementation of laws such as the ADA (Stoddard, Jans, Ripple, & Kraus, 1998). Such evidence points to the persistence of an uneven playing field of opportunity for persons with
disabilities (Renard, 2001). One example would be the increased percentage of individuals with disabilities categorized in a low socioeconomic status (SES) compared to the general population (Olkin, 1999 & Shapiro, 1994). Persons with low SES are at greater risk for personal adjustment problems and for diminished quality of life and sense of well-being (Adler, Boyce, Chesney, Cohen, Folkman, Kahn, & Syme, 1994). Counseling professionals need to be aware of the nature and personal consequences of the vocational, social, and economic arenas in which individuals with disabilities are situated.

Personal and/or intimate relationships are another important part of everyday life in which individuals with disabilities experience unique situations and circumstances. It has been shown that prejudicial attitudes by non-disabled persons create or maintain social distance from persons with disabilities (Abrams, Jackson, & St. Claire, 1990; Olkin & Howson, 1994; Westbrook, Legge, & Pennay, 1993). “Compared with non-disabled adults, adults who have disabilities are less likely to be married or coupled, are less socially active than they would desire, and report significantly lower levels of life satisfaction” (Renard, 2001, p. 62). Such issues are often the reasons why individuals, disabled or not, seek treatment with an LMHC. Understanding the source of these issues and the environment within which they exist is crucial in assisting clients in effectively improving their lives.

LMHC’s should also be aware of the discrimination and prejudice that many individuals with disabilities must face on a daily basis (Barnes, Mercer, & Shakespeare, 1999; Koch, 2001). The type of disability cannot only determine the environmental barriers but may also be a major factor in determining other people’s attitudes about the disabled person. Gething (1992) found that a visible disability functioned as a central and organizing characteristic around which global impressions were formed. Disabilities, especially those that are visible, are often the impetus
behind the *spread effect* (Wright, 1983, 1988). The spread effect is a phenomenon that occurs when multiple assumptions about a person are made on the basis of a single trait. Spread effects tend to be negative and they can lead to a lessening of the whole person (Wright, 1983, 1988). This phenomenon underlies stereotyping.

Another daily form of discrimination that is relatively consistent throughout disability types is the misuse of language (Olkin, 1999; Shapiro, 1994). This is especially important because it is an area where LMHC’s can easily portray understanding and competence regarding sensitivity and empathy. Yet, they can also easily distance, offend or anger a client by unintentionally using inappropriate language. Many people in the general population “label” individuals with disabilities based upon the disability itself. A person may be known as “the deaf man” or “the blind lady”. It is essential to put the focus on the individual, not the particular functional limitation.

It is also common to label successful individuals with disabilities as extraordinary or heroic (Shapiro, 1994). Even though the general population may appreciate overachievers, portraying people with disabilities as superstars raises false expectations that all people with disabilities should achieve this level (Westbrook, Legge, & Pennay, 1993). Disabilities, like individuals, should be dealt with on a case-by-case basis. The disability itself should be dealt with openly and straightforwardly without condescending euphemisms (Oliver, 1996). Terms such as handicap, mental, and physically challenged are considered condescending. They also reinforce the idea that disabilities cannot be dealt with up front.

Some practical issues of disability may be obvious to the general public or to LMHCs. However, in addition to accessibility issues and certain forms of discrimination, there are numerous issues that lie below the surface of awareness and are powerful forces that can shape
the lives of the individual with a disability. The previous paragraphs have touched on only a few. Yet, even if the practical issues are managed effectively, the individuals with disabilities must still face numerous issues that can affect the maintenance and quality of their health and well-being.

**Health Maintenance Issues**

Individuals with disabilities may be no different than persons in the general population when considering the need for ongoing health maintenance and medical care. Having a disability does not necessarily constitute the need for frequent medical interventions. However, individuals with disabilities may require specialized care or more frequent medical interventions as a result of a condition or functional limitation. Research has shown that there is a lack of understanding by health care providers regarding the difficulties faced by individuals with disabilities seeking health services (Leigh et al. 2004; Lishner, Richardson, Levine & Patrick, 1996; Livneh & Antonak, 1999). Scheer et al. (2003) noted a lack of disability literacy or understanding by health care providers that could dramatically impact the quality of care given to individuals with disabilities. “Disability literacy refers to the specific knowledge and skill set that enables health-care providers and administrators to respond more appropriately to the needs of individuals with disabilities. It encompasses a range of general skills, such as the ability to listen to, understand, acknowledge, and respond to the variable needs of individuals with disabilities” (Scheer et al., 2003, p. 229).

A possible myriad of barriers and dilemmas may be encountered, from maintaining personal hygiene to obtaining transportation to medical appointments. LMHCs should be aware of the impact that disability can have upon basic activities of daily living (ADLs) such as dressing, attending to personal appearance, and managing household chores. The individual with a disability may need to utilize a personal care assistant to help with ADLs. The LMHC should
maintain awareness of the psychological implications of depending upon others to complete ADLs. Even if the individual with a disability is completely independent, issues pertaining to sexuality, body temperature regulation, body image, and verbal communication may influence the counseling process (Hayes & Potter, 1995). The dynamics of disability have been shown to have considerable impact in the areas of sexual and body esteem (McCabe & Taleporos, 2003), family life (Rogers & Hogan, 2003), and marriage (Copel, 2006). Although it may be impossible for LMHCs to know and understand all the dynamics of so many potential issues, it would seem important that a general knowledge be established and maintained if they are treating members of this population.

A common barrier related to healthcare for individuals with disabilities is transportation. It has been frequently reported that access to healthcare services for individuals with disabilities is not equal to the general population (DeJong, Beatty, Neri, & Hagglund, 2001; Lishner, Richardson, Levine, & Patrick, 1996; Weissman, Stern, Fielding, & Epstein, 1991). Even when public transportation is available it can be insufficient. Clinics or medical providers may not have offices close to public transportation routes. Hours of operation for transportation may not be congruent with available appointment times of healthcare providers. Individuals that use wheeled mobility devices, have fatigue and energy limitations, or chronic physical pain may find it difficult to utilize public transportation, even if that transportation vehicle is designated for individuals with disabilities.

Scheer and colleagues (2003) performed a qualitative study that examined the issue of transportation and medical care for individuals with disabilities more closely. “Persons who used publicly funded door-to-door para-transit van or taxi services said that appointments often needed to be scheduled a week in advance, a system that is not responsive to more immediate
medical needs. Even with advance scheduling, participants frequently found the publicly funded services to be undependable, often picking them up too late or not coming at all. Another frustration was that when the transportation service did come, the drivers did not have the proper equipment to either load or securely attach wheelchairs or scooters to the floor” (Scheer et al., 2003, p. 224). Even if the individual is able to obtain transportation or travel independently, their struggles may not be over once they reach their destination.

Office accessibility is another problem encountered by individuals with disabilities seeking health care. Scheer and colleagues (2003) noted that inaccessible medical offices often proved to be an environment barrier. Specific elements of such a barrier included examination and diagnostic equipment, office parking (location, condition, topography and curb cuts), office and doorway entries, and restrooms. “In fact, some participants found the experience of trying to get into an inaccessible health-care setting too stressful and physically draining and put their health at risk by delaying or avoiding care” (Scheer et al., 2003, p. 224).

Not all health maintenance issues create problems or difficulties for individuals with disabilities. Yet, there is sufficient evidence of frequent struggles encountered by individuals with disabilities seeking health care to question the source underlying these struggles (Shapiro, 1993). The problem, like the disability itself, may be traced to the society or social environment within which the problem exists. This line of thought is consistent with the aforementioned social model of disability. As LMHCs, it is important to understand the wide variety of reactions and variables that are contained in the social life of individuals with disabilities.

**Social Reactions**

History has shown that social reactions to individuals with disabilities have been negative, aversive, and possibly damaging (Mackelprang & Salsgiver, 1999). Wolfensberger (1972) found that individuals with disabilities were often viewed as deviant and were assigned social role
expectations based upon such stereotypes. It has also been shown that individuals with disabilities are objects of pity (Shapiro, 1993). This pity is not only revealed on a person-to-person basis, but on a grander public scale as well. “Promoting public pity has been consistently used as an effective fund raiser for human services organizations serving people with disabilities” (Mackelprang & Salsgiver, 1999, p. 5). Although pity may be used as an effective fund raising tool or manipulated in other seemingly beneficial ways, the long-term results can be detrimental. Shapiro (1993) reported the words of Evan Kemp, Jr., a then advisor to President George Bush and a key figure in the disability rights movement. As an individual with a disability, he spoke out regarding displays of public pity and the possibly damaging effects. He explained that by “arousing the public’s fears of the handicap itself, the telethon makes viewers more afraid of handicapped people” and emphasized that “playing to pity may raise money, but it raises walls of fear between the public and us” (Shapiro, 1993, p. 22).

Individuals with disabilities continue to experience social discrimination and face significant challenges on many fronts (Kraus et al., 1996; NOD, 1994). The unemployment rate for persons with disabilities is deplorably high, relationship development may be sub-optimal, and public misperception of the individual with disability is commonplace (Renard, 2001, Rosenau, 2000 & Shapiro, 1993). Although unfair, society can alienate individuals with disabilities by its social reactions. Hahn (1988) reported that society viewed persons with disabilities that impacted their mobility as ugly. Although cruel and perhaps ignorant, this can be particularly important in cultures that define beauty in a narrow and restricted sense. “Persons with mobility disabilities are seen as particularly offensive aesthetically, and they create an apprehension of difference – a kind of xenophobia of nonaesthetics” (Mackelprang & Salsgiver, 1999, p. 92).
It is crucial that LMHCs accurately conceptualize the interplay of environmental and social factors that affect the client’s functioning and overall mental health. Social reactions may play a pivotal role in the presenting problem or have little to do with the client’s dilemma. Along with knowledge of possible social reactions, it is also imperative that the LMHC understand his/her own personal views, biases, values and distortions. These can significantly affect the LMHC’s ability to provide competent treatment for individuals with disabilities. This is directly related to the issue of countertransference. “While we can come to understand that disability is not equated with inferior and different is not negative, as psychotherapists we must still remain vigilant to our deeper reactions” (Grzesiak & Hicok, 1994, p. 248).

**Countertransference**

Countertransference is a concept with which most LMHC’s are familiar. “The therapist’s countertransference is of central importance in the treatment of individuals with disabilities” (Oliveira et al., 2004, p. 431). It has been defined as a set of attitudes, beliefs needs, conflicts, or feelings unconsciously held, or repressed, by the counselor that is triggered by the client (Padrone, 1994). These attitudes, beliefs, or emotions can be positive or negative. Either way, countertransference can interfere with the LMHC’s ability to understand the client and adversely affect the therapeutic technique. “Researchers have speculated that countertransference strongly influences formation of therapeutic bonds, accurate assessment of the client’s presenting problem, and treatment planning” (Kemp and Mallinckrodt, 1996, p. 378).

Some researchers have noted the possible difficulties encountered when attempting to effectively deal with countertransference brought about by interactions with individuals with disabilities (Marshak & Seligman, 1993; Leigh et al., 2004; Olkin, 1999b). Because individuals with disabilities are in the minority, counselors may have limited opportunity for self-examination in this area to experience and become familiar with their own feelings and attitudes.
(Padrone, 1994; Tervo, Palmer, & Redinius, 2004). Yet, issues of mortality, independence, physical vulnerability, and sexuality are all part of the disability experience and can prompt significant emotional reactions.

Research has shown that the presence of a disability can change the course or focus of treatment by a therapist. Kemp and Mallinckrodt (1996) conducted a study in which therapists observed a survivor of sexual abuse who was disabled and one that was non-disabled. The therapists were subsequently asked to provide case conceptualizations. Findings indicated that the therapists emphasized different treatment strategies primarily depending upon whether or not the client had a disability. When the client was disabled, the therapist was more likely to focus on extraneous issues rather than appropriate themes of treatment.

Olkin and Howson (1994) discussed a hierarchy of acceptability of disabilities and emphasized the therapists’ lack of immunity from discrimination against clients with less acceptable disabilities. “Disability forces us to recognize that the world is not just, that lightening can strike anyone, and thus we face our own vulnerabilities. Therefore, in addition to tolerating affect in our clients, we must tolerate in ourselves the strong emotional reactions generated by disability” (Olkin, 1999a, p. 95). As with countertransference generated by sources other than disability, awareness of its presence is critical. It is unrealistic to expect LMHC’s to rid themselves from any trace of countertransference. However, it is important to deal with the manifestation by consulting with colleagues, addressing his/her own personal unresolved issues, or gaining greater knowledge and understanding of the client or population (e.g., individuals with disabilities) that generate this reaction from the counselor (Corey, 1991; Flanagan & Flanagan, 1999).
Legal and Ethical Issues

LMHCs are bound to provide competent services to persons with disabilities from a legal and ethical perspective. In 1990, the U.S. government passed the ADA which extends civil rights protection to persons with disabilities. As a result of the ADA, the responsibility for equality and accessibility transferred from persons with disabilities to employers and providers of public services and accommodations (Strike, 2000). LMHCs, as providers of a public service, became legally obligated to provide non-discriminatory and accessible care to individuals with disabilities (Mackelprang & Salsgiver, 1999). The ADA provided explicit detail regarding the need for such legislation:

…historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem; discrimination against individuals with disabilities persists in such critical areas as employment, housing, public accommodations, education, transportation communication, recreation, institutionalization, health services, voting, and access to public services; unlike individuals who have experienced discrimination on the basis of race, color, sex, national origin, religion, or age, individuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress such discrimination; individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, the discriminatory effects of architectural, transportation, and communication barriers, overprotective rules and policies, failure to make modifications to existing facilities and practices, exclusionary qualification standards and criteria, segregation, and relegation to lesser services, programs, activities, jobs, or other opportunities; census data, national polls, and other studies have documented that people with disabilities, as a group, occupy an inferior status in our society, and are severely disadvantaged socially, vocationally, economically, and educationally; individuals with disabilities are a discrete minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to society;…the continuing existence of unfair and unnecessary discrimination and prejudice denies people with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous…. (ADA, 1990).
The ADA makes clear the need for equal opportunity and treatment regarding individuals with disabilities. It is also evident that services provided by health care providers like LMHCs must adhere to the policies and requirements of the ADA. Although compliance by LMHCs may seem straightforward, complications can arise.

Counselors may encounter conflicts as they attempt to meet ADA criteria and the ethical codes of their profession. “This state of affairs is especially troubling, considering the potentially conflicting ethical requirements that practitioners provide services in a non-discriminatory manner while working only within the bounds of their competence (i.e., training and expertise). Few generalist practitioners have the level of expertise in working with disability issues that these ethical imperatives require” (Renard, 2001, p. 72).

Most LMHCs adhere to a code of ethics provided by the American Counseling Association (ACA). As a parent organization with numerous specialty associations within its fold, ACA and its code of ethics provides guidelines and principles for all counselors who are members of ACA. As part of the ACA code of ethics, the issues of diversity and disability are addressed and counselors are asked to pursue and maintain an understanding of clients’ diverse cultural backgrounds. Counselors are also required to maintain professional competence and skills pertinent to working with clients from diverse populations (ACA, 1995).

Although LMHCs may follow the ethical codes of the ACA, a code more specific to their profession is provided by AMCHA. The AMCHA code endeavors to provide clear and specific parameters for appropriate conduct and practice by mental health counselors. This code addresses ethical issues ranging from confidentiality to internet on-line counseling (American Mental Health Counselors Association, 2000). Persons with disabilities are included in this code under the first principle, Welfare of the Consumer. Under the subheading of Diversity, the code
requires the following behavior of all counselors. “Mental health counselors do not condone or engage in any discrimination based on age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, marital status or socioeconomic status” (American Mental Health Counselors Association, 2000, Code of Ethics, Welfare of the Consumer). It should be noted that this is the only instance in which the term disability is mentioned in the code. Yet, the code presents persons with disabilities as a unique or distinct culture within the general population.

The code emphasizes that all counselors should “actively attempt to understand the diverse cultural backgrounds of the clients with whom they work” (American Mental Health Counselors Association, 2000, Code of Ethics, Principle 1, sec. E). As part of the principle of Competence, the code furthers this emphasis. “Mental health counselors recognize the need for continued education and training in the area of cultural diversity and competency. Mental health counselors are open to new procedures and sensitive to the diversity of varying populations and changes in expectations and values over time” (American Mental Health Counselors Association, 2000, Code of Ethics, Principle 7, sec. C). Including persons with disabilities as part of multicultural issues is an important factor in gaining a greater understanding of this populations’ need and characteristics.

In recent years, issues related to multiculturalism and diversity have become a focal point for many researchers, authors, and clinicians. This is evident by the number of publications and data pertaining to multiculturalism and diversity being produced in the field of mental health counseling (Arredondo & Toporek, 2004; Leigh et al., 2004). It also seems evident that LMHCs are receiving more training, exposure, and opportunity for understanding the various aspects of multiculturalism today than in previous decades (Corey, Corey, & Callahan, 2003). However, it is inappropriate to assume that, because of this, persons with disabilities are now being provided
the types of mental health services afforded to non-disabled clientele. The mere
acknowledgement of a minority population does not equate to the understanding of that population.

Many researchers have discussed the possibility of biased or inaccurate information being
produced or disseminated regarding persons with disabilities (Abrams, Jackson, & St. Claire,
1990; Arredondo & Toporek, 2004; Hahn, 1988; Livneh & Antonak, 1997; Strike et al., 2004).
It is possible that incorrect assumptions are made by LMHCs when utilizing information about
minority populations that is not thorough, substantiated, unbiased, or accurate. Without training
or specific education regarding individuals with disabilities, the general public has many
misperceptions about disability (Shapiro, 1994). There is no reason to assume that LMHCs do
not share these same misperceptions. It has been shown that recently trained counselors report a
low level of both confidence and competence in their ability to provide effective services to
persons with disabilities (Renard, 2001).

Self Awareness/Beliefs/Attitudes Towards Individuals with Disabilities

One may assume that, because of the training and education in multicultural issues, that
LMHCs are more likely to have positive attitudes and beliefs towards individuals with
disabilities. While this may be true, there is no research or professional data to indicate such.
Further, attitudes of health professionals toward individuals with disabilities have been shown to
be poor in some studies (Byron & Dieppe, 2000; Janicki, 1971; Tervo et al., 2004). For the
purpose of this study, it is beneficial to take a closer look at the meanings and concepts of self-
awareness, belief, and attitude as they relate to individuals with disabilities.

Self-awareness regarding disability is a critical issue for LMHCs to examine during and
prior to working with individuals with disabilities. Many counselors may not place much
importance on this issue because biases and perspectives are not self-evident. However, before
LMHCs can work successfully with individuals with disabilities, they must understand how disabilities relate to their own life circumstances. Failure to take a personal inventory regarding attitudes and beliefs on these matters may translate into interactions that serve to interfere with their effectiveness in the counselor's role (Durodoye, Combes, & Bryant, 2004).

“Historically, our language and media images surrounding disability have evoked sympathy, pity, or horror” (Treloar, 1999, p. 1). Although great strides have been made in our understanding of disability, still we may see a person using a wheelchair and inappropriately assume cognitive impairment in addition to physical disability. Viewing each individual with a disability as a person-first, begins with the LMHCs self-awareness of personal biases and assumptions about disability. “De-labeling” our beliefs and perceptions precedes our establishing a therapeutic relationship with a person having disabilities (Taylor & Bogdan, 1993).

It is undeniable that every person brings one’s own cultural “baggage” to every relationship. LMHCs entering into a counseling relationship should be viewed no differently. “One’s own cultural experiences create assumptions and miscommunications that can lead to expectations of behaviors” (Galle, Angelocci, Lacho, & Lacho, 2005, p. 5). Examining and gaining greater self-awareness of one’s beliefs regarding disabilities will serve as a precursor to changes or adjustments in false or inappropriate belief systems. Gaining greater self-awareness and understanding the influence of his/her beliefs upon the LMHCs’ counseling relationship is essential in maintaining a positive working relationship with clients with disabilities. Understanding and modifying self-awareness and beliefs pertaining to disability may also serve as a foundation for a positive attitude towards disability.

A standard definition of attitude can be found in the Merriam-Webster dictionary (2003). The text describes attitude as “a mental position with regard to a fact or state” as well as “a
feeling or emotion towards a fact or state” (Merriam-Webster, 2003, p. 76). In their book on the measurement of attitudes towards individuals with disabilities, Antonak and Livneh (1988) provide one of the most thorough and specific definitions of attitude. The authors begin by describing attitude as comprised of two dimensions. The first dimension is represented on a continuum of abstractness, ranging from concrete to abstract. The second dimension is represented by the extensiveness of the components within the definition. The authors explained that attitudes can be conceived as mediators between specific observed environmental stimuli and specific behavioral responses. With regards to abstractness, they indicate: “as attitudes are judged to be more proximal causes of behavior, the more affect they will be thought to exert on the ensuing behavior and the more specific the definition will become” (Antonak & Livneh, 1988, p. 7).

The second dimension of attitude, extensiveness, provides the basis for conceptualizing the content of attitude. There are three components to the dimension of extensiveness: cognitive, affective, and behavioral. The cognitive component refers to the person’s ideas, thoughts, perceptions, beliefs, or opinions about the attitude referent. It represents how the attitude referent is conceptualized. “The cognitive component, viewed as an index of meaning, is ordinarily measured by such instruments as adjective checklists and by the activity and potency factors of the semantic differential” (Antonak & Livneh, 1988, p. 7). The affective component of attitude reflects the feelings behind the attitude or the emotion that fuels the cognitive component of the attitude. This component is typically expressed in terms of good-bad, like-dislike, and pro-con. Measurement instruments for this component usually include a Likert type scale. The third component of extensiveness is behavioral. This consists of the actual observed or overt reaction to the attitude referent. The behavioral component is usually measured by
social distance scales and through observations of how the person actually behaves when dealing with the attitude referent. The authors summarize concepts related to attitude by discussing common themes in the following paragraph:

“...there appears to be a consensus among scholars and researchers that attitudes have the following elements: (a) attitudes are learned through experience and interaction with other people, social objects, and environmental events, rather than being innately determined, although the role of heredity or constitutional factors in attitude formation has not been fully investigated; (b) attitudes are complex, multi-component, structures; (c) attitudes are relatively stable (even rigid) as evidenced by their resistance to change; (d) attitudes have a specific social object as a referent (e.g., people, situations, events, ideas); (e) attitudes vary in their quantity and quality, possessing differing degrees of motivating force (intensity, strength), and direction (toward, against, away from the attitude referent); and (f) attitudes are manifested behaviorally via predisposition to act in a certain way when the individual encounters the attitude referent” (Antonak & Livneh, 1988, pp. 9-10).

Olkin (1999b) identified numerous factors that influence or shape persons attitudes towards disability. These factors included (but were not limited to): beliefs about disability, amount of contact with individuals who have disabilities, the nature of the disability, significant other’s attitudes, education, mass media, local social norms, and characteristics of the individual who has the disability. Beliefs about disability are developed or affected by prior contact with individuals who have disabilities, significant others’ attitudes, education, and mass media. Interestingly, Olkin (1999b) indicated that mass media has a major impact where there is a lack of other types of information available or when there is limited exposure to the particular disability. This may be of particular importance to LMHCs due to the possible lack of training and education they receive. Information regarding disability provided in curricula and supervised practicum experiences would lead to more positive beliefs about disability on the part of new counselors (Renard, 2001).

Contact can have a positive effect in reducing or eliminating stereotypes when the interaction between individuals is positive or mutually rewarding, characterized by cooperative interdependence between persons of equal status (Olkin, 1999b). Yet, there is a perceived power
and status differential in most counseling relationships that may not conform to the conditions that lead to more positive attitudes via exposure to persons with disabilities (Olkin & Pledger, 2003; Renard, 2001; Smart & Smart, 2006).

The local social norms and attitudes of significant others can influence the type of contact that people have with individuals with disabilities by determining what is “appropriate” or “common”. The type, severity, perceived cause, or potential for transmission also influences attitudes. Characteristics such as age, race, sex, and socioeconomic status of the person with the disability also shape attitudes. Other factors to consider are the individual’s perceived intelligence, social skills, attractiveness, and comfort with his/her disability. Although more educated individuals are associated with more positive attitudes toward individuals with disabilities, Olkin (1999b) indicated “there are no data to support the contention that therapists of any discipline bear attitudes toward disability that are notably different from the general public’s” (p. 65).

Negative attitudes towards individuals with disabilities typically are founded in a lack of knowledge and the perpetuation of incorrect, often negative, stereotypes (Hunt & Hunt, 2004). Such negative attitudes can be the foundation for discrimination, bias, and many other barriers and obstacles. As previously mentioned, this holds true not only for the general public but also for those working in the healthcare arena. “People with disability often identify inappropriate staff attitudes and behaviors as the biggest barrier to accessing health services” (Tervo et al., 2004, p. 908). Research has shown that more positive attitudes towards individuals with disabilities are being reported (Furnham & Thompson, 1994). However, this change may be due to socially desirable answers instead of actual attitude change. The theory of social desirability suggests that people respond favorably to items expressing what is deemed socially proper
(Wright, 1983). “In other words, attitudes towards persons with disabilities may not have changed significantly, instead, individuals may be less willing to convey their true feelings of negativity because they know it is less acceptable now to express prejudices and stereotypes in our society” (Folie, 2006, p. 44).

Many researchers believe that the changing of attitudes is a lofty, long-term goal. “Attitudes toward disability are difficult to change. There are hundreds of studies on this issue and overall the results are not encouraging” (Olkin, 1999b, p. 72). Although negative attitudes towards individuals with disabilities are often difficult to change, it is not impossible and should be considered a worthwhile endeavor; especially when considering the consequences of not changing them (Hunt & Hunt, 2004). Many advocates and researchers believe that changing attitudes is one of the most important factors in improving the overall quality of life for individuals with disabilities (Brodwin et al., 1994; Huit & Elston, 1991; Leigh et al., 2004). “Negative attitudes and beliefs about disability can be changed via (a) exposure to persons with disabilities, (b) conscious evaluation of stereotypical beliefs in light of actual experience, and (c) the development of a larger database of information about the individual, so that no single characteristic stands out so much that it alone represents the individual” (Renard, 2001, p. 69).

In order to provide effective and competent services to individuals with disabilities, the LMHC must gain an awareness and understanding of his/her attitudes toward disability and related issues (Boden, 1992; Hunt, Matthews, Milsom, & Lammel, 2006). If training and education of LMHCs is lacking content that would afford the clinician the opportunity to gain greater awareness and understanding of his/her attitudes toward disability, and contact with individuals who have a disability is occurring, the profession as a whole may be perpetuating professional incompetence. “Human service practitioners who work with persons with
disabilities and their families are often forced to face their own attitudes and values about the meaning of disability and their feelings about those who have disabilities. Professional self-awareness of our attitudes about disability is the first critical component of professional practice” (Mackelprang & Salsgiver, 1999, p. 14).

**LMHC’s Level of Knowledge Regarding Disability**

From a more practical standpoint, the question may be asked: How much do LMHCs really need to know about disability issues? As previously mentioned, there are professions that specialize in the area of disability (e.g.; rehabilitation psychologists, rehabilitation counselors) that can also provide mental health counseling services. Certainly, these professions are alternatives for individuals with disabilities seeking mental health counseling and may be the most appropriate choices; especially if the presenting problem is directly related to the disability. Yet, it is naïve to believe that generalist counselors will treat only those within the general population, exclusive of minorities. “Although it is the case that some clients with disabilities, particularly those with recent onset of disability such as traumatic brain injury, spinal cord injury, or stroke, may be treated primarily by rehabilitation psychologists, most clients with disabilities who seek evaluation or psychotherapy are seen outside the sphere of rehabilitation psychology” (Olkin & Pledger, 2003, p. 296).

Not unlike working in collaboration with other providers such as psychiatrists, psychiatric nurse practitioners, and physiatrists, it is useful for the LMHC to have a general working knowledge of the dynamics and/or conditions of the client in which these other providers specialize. For example, while LMHCs do not typically specialize in psychotropic medication management, most have a general working knowledge of antidepressants and other psychotropic medications. The LMHC may utilize a specialist in disability as a consultant or collaborate with one during the course of care. Moreover, the LMHC should understand how disability can effect
diagnosis, course of treatment and treatment outcome (Olkin, 1999). When the presenting problem arises out of disability or requires in-depth knowledge and expertise pertaining to a specific disability, it may be appropriate for the LMHC to refer out to a rehabilitation counselor (or similar professional) for mental health care. “Nonetheless, MHCs often can provide valuable service to those with disabilities and need not automatically refer these clients to other specialists. When MHCs have participated in short-term training about disability issues, they can differentiate needs arising from the disability from those that are likely to arise from the natural course of life itself” (Hayes & Potter, 1995, p. 18).

**LMHC’s Level of Skill Regarding Disability**

Although an LMHC may possess awareness and knowledge regarding disability issues, it is also imperative that the clinician possess adequate skills when working with this population. Studies regarding mental health professionals’ skills and behaviors when working with clients with disabilities have shown mixed findings. Researchers examined counselors’ skill in the use of unbiased language and noted no main effect was found for the political correctness of language (Arokiasamy, Strohmer, Guice, Angelocci, & Hoppe, 1994). Kemp and Mallinckrodt (1996) examined case conceptualization skills and found that portraying a client as disabled distracted counselors from the theme of sexual abuse. Strike and colleagues noted that “mental health professionals may affect clients with disabilities less by the language they use and more by their conceptualization of cases. Similar variations may be found across other skills and behaviors.” (Strike et al, 2004, p. 322).

As mentioned in previous pages, most counselor training programs, with the exception of specialties such as rehabilitation counseling or rehabilitation psychology, do not provide adequate (if any) training or coursework on disability related issues. (Smart & Smart, 2006). Content analysis of popular textbooks in counselor education programs revealed a lack of
disability topics or worse, biased presentations of persons with disabilities (Rosenau, 2000). Therefore, it may be unreasonable to expect LMHCs to possess adequate counseling skills when working with individuals with disabilities. However, this should not lead one to assume that LMHCs are incapable of treating this population. But even if the clients’ presenting problem is not related to his or her disability, it is still possible that the disability will be a factor in the counseling process.

Understanding the advantages of specific theoretical approaches when treating this population can be a crucial element in the provision of services. For example, some researchers note that “person-centered counseling with its lack of assumptions about how people respond to disability is seen by some to be the least intrusive counseling approach, when compared with psychodynamic and behavioral approaches” (Reeve, 2000, p. 671). In addition to choosing a theoretical approach, other issues such as building and maintaining counselor/client rapport and understanding non-verbal communications and cues may present unique challenges for the LMHC when treating this population.

Summary

This chapter has presented a review of the relevant literature pertaining to LMHCs’ treatment with individuals with disabilities. Demographics of individuals with disabilities were examined and showed this group to be the largest minority population; one that is continues to grow. The profession of mental health counseling was reviewed and was also found to be growing; not only in numbers of practitioners, but in exposure and access to diverse client populations. However, an analysis of literature pertaining to counselor training and preparation showed a probable lack of education and instruction provided to LMHCs in the area of disability. An examination of literature regarding mental health counseling needs of individuals with disabilities showed clear evidence of such needs in the areas of social, relationship, vocational,
and overall life satisfaction. An in-depth look at disability was provided by examining models of psychosocial adjustment, practical issues, health maintenance issues, and social reactions. More specific to the counseling profession was the literature reviewed on countertransference and legal/ethical issues. Finally, an analysis of the literature pertaining to attitudes, knowledge and skills regarding individuals with disabilities was provided with a focus on how these constructs apply to LMHCs.

In chapter 3, the aforementioned information is utilized as a foundation for this author’s research. Specific methods that were used to conduct this study are described along with information regarding the instruments and techniques utilized in gathering data.
CHAPTER 3
METHODOLOGY

This chapter describes the methodology of the study. Topics in this chapter include information regarding the study design, procedures of the study, instrumentation, and statistical analysis. The intent of this study is to examine the amount of contact LMHCs have with individuals with disabilities, and to describe LMHC’s Self-Awareness/Beliefs/Attitudes, perceived Knowledge, and perceived Skills when treating individuals with disabilities. Furthermore, the predictive value of the amount of contact upon LMHCs perceived Knowledge and Skills and the predictive value of LMHC’s Self-Awareness/Beliefs/Attitudes toward disability upon their perceived Knowledge and Skills is examined.

Study Design

This study utilized two separate instruments that were designed to evaluate LMHCs’ amount of contact, Self-Awareness/Beliefs/Attitudes, Knowledge and Skills regarding individuals with disabilities. A five-item questionnaire was also used to gather demographic data of LMHC participants.

The dependent variables are

1) LMHCs’ self-perceived levels of Knowledge regarding disability
2) LMHCs’ self-perceived levels of Skills when working with an individual with a disability

The independent variables are

1) the amount of contact by the LMHC with individuals with disabilities
2) the Self-Awareness/Beliefs/Attitudes reported by LMHCs pertaining to individuals with disabilities

An email was sent to a convenience sample (N=1235) of LMHC’s within the state of Florida requesting their participation in the study (Appendix A). The email provided a link to a
web-based survey site that contained two instruments and a demographic questionnaire. There were numerous reasons for utilizing email and the internet for the dissemination and collection of research data. Studies have shown that this method can increase accuracy of data entry, produce a more timely collection of participant responses, and reduce costs specific to survey replication (Thomas, Rogers, & Maclean, 2003). Furthermore, it provided a more convenient method of participation for the LMHC and allowed this researcher the ability to track response rates as they occur. “Electronic surveys are becoming increasingly common, and research comparing electronic vs. postal surveys is starting to confirm that electronic survey content results may be no different than postal content results, yet provide strong advantages of speedy distribution and response cycles” (Andrews, Nonnecke, & Preece, 2003, p. 186).

The initial email to the sample population included an informed consent letter (Appendix B), described the purpose of the study and requested participation by the LMHC. The parameters of confidentiality, the voluntary nature of the study, and response returns were explained. The completion of the instruments and the demographic questionnaire were estimated to take approximately ten minutes. A second email was sent approximately one week following the initial email to those that did not respond to the first. Collection of data lasted approximately two weeks.

**Selection of Participants**

A convenience sample of individuals (N=1235) was surveyed from a population consisting of active LMHCs in the state of Florida (N=6692). Participants included the entire list of email addresses maintained by Florida’s Department of Health, Division of Medical Quality Assurance. The email addresses were voluntarily provided to the state by LMHCs during the initial or renewal licensure application process. Because it was impossible to accurately predict the number of responses or rate of attrition, and due to the possibility that many of the email
addresses on the list were no longer current or in use, the entire email list (N=1235) was used. Research indicates that online surveys can yield average response return rates that vary from 3% to over 50% (MacElroy, 2000).

A power analysis was conducted in the G-Power statistical program (Cohen, 1977). Results indicated that with a medium effect size of 0.15, Alpha = 0.05, power = 0.90 and 2 predictors, a sample size of approximately N = 123 participants was needed. Participants that left items blank or did not complete any portion of the study were excluded from the final analysis of the data.

**Instruments**

**Contact with Disabled Person Scale**

To measure the amount of contact the LMHC have with individuals with disabilities, Yuker & Hurley’s (1987) Contact with Disabled Persons Scale (CDP) was used (Appendix C). The CDP was created to provide a reliable and valid measure of an individual’s prior contact with people with disabilities. The original version of the CDP was modified to utilize person-first language. The scale contains 20 items and uses a five-point Likert-type scale to measure the amount of contact a person has had with individuals with disabilities. Yuker and Hurley (1987) reported that the scale was reliable with a corrected median split-half reliability coefficient of 0.93 and a median alpha coefficient of 0.92. The reliability of the CDP was high, with a Cronbach alpha coefficient of .87. Correlation coefficients ranged from −0.26 to +0.40, with a median correlation of +0.10.

In response to the 20 items on the CDP, participants are asked to indicate the extent of their contact with an individual with a disability. Each response should reflect the most appropriate one of five choices (1 = never, 2 = once or twice, 3 = a few times, 4 = often, 5 = very often). Some of the items measure only the amount and type of prior contact while other have an
affective component (i.e.; How often have you met an individual with a disability for whom you feel sorry?). Although some items refer to negative contact or interactions with an individual with a disability (i.e.; How often have you been annoyed or disturbed by the behavior of a person with a disability?), all items are scored in the same manner. The scoring is based upon the extent of contact, not whether the contact is positive or negative (Yuker & Hurley, 1987). Scores on the CDP can range from 20, reflecting no contact at all, to 100, representing maximum contact in all areas.

**Counseling Clients With Disabilities Survey (CCDS)**

Three areas of perceived competence reported by study participants were measured utilizing Strike’s Counseling Clients With Disabilities Survey (See Appendix D). This instrument is the only existing instrument that measures mental health professionals’ disability competence.

The Self-Awareness/Beliefs/Attitudes scale of the CCDS is designed to measure the counselors’ awareness, beliefs, and attitudes about the impact of being disabled or non-disabled. The perceived Knowledge scale of the CCDS measures participants’ factual knowledge about disability that includes exposure to or training about disability. The perceived Skills scale of the CCDS measures skills and behaviors that are desirable in mental health practitioners who treat individuals with disabilities. These items convey effort by the participant to be accessible to the individual with a disability (Strike et al., 2004). Each of the three scales contains 20 items, combined for a total of 60 items. The participants can express a range of agreement to disagreement on a 6-point scale. A total score ranging from 20 to 120 is possible on each scale, with higher scores reflecting greater disability competence.

The reliability of the CCDS was tested utilizing Cronbach’s coefficient alpha using data from the Strike et al. (2004) study. A high level of internal consistency, Cronbach’s $\alpha = .94$, was
obtained from the total scale and thus reflected items that were internally consistent. The internal consistencies obtained for each individual scale were as follows: Self-Awareness/Beliefs/Attitudes scale $\alpha = .67$, perceived Knowledge scale $\alpha = .87$, and the perceived Skills scale $\alpha = .90$. Correlations were determined between the Self-Awareness/Beliefs/Attitudes and perceived Knowledge scales (.72), Self-Awareness/Beliefs/Attitudes and perceived Skills scales (.69), and perceived Knowledge and perceived Skills scales (.81), with a positive relationship appearing among Self-Awareness/Beliefs/Attitudes, Knowledge, and Skills. (Strike et al., 2004).

Demographic Questionnaire

Accompanying the CDP and the CCDS was a five-item questionnaire regarding demographic information of the LMHC participant (See Appendix E). The questions consisted of 1) gender type; 2) age range; 3) ethnicity; 4) years of experience in mental health and; 5) the academic background of the LMHC. The demographic questionnaire was reviewed by an expert panel of mental health and disability professionals. This process involved a review and critique of numerous possible demographic items. Only items that were free from ambiguity, applicable to the study, and approved by all members of the expert panel were included. As part of the demographic questionnaire, the participants were asked to report the academic training program from which they earned their degree. Two of the optional answers included rehabilitation counseling and rehabilitation psychology. Because these educational backgrounds would have likely provided extensive training in disability related issues, scores from those individuals would risk skewing the data. Therefore, scores from participants reporting either one of the rehabilitation backgrounds were not included in the analyses of data.
Results from the current study are described below. First, sample characteristics will be reported, followed by measurement reliabilities, and finally results of the analyses addressing each of the three hypotheses.

**Sample Characteristics**

The return rate for this study was better than expected with 243, or approximately 20% of the sample population (N=1235), responding. Of the 243 responses, 221 participants completed all three instruments. Twenty-two participants’ responses were not included in the analyses of the data due to their rehabilitation background. The final sample consisted of 199 licensed mental health counselors practicing in the state of Florida (140 female, 59 male). The sample was primarily Caucasian (78.4%), followed by Latino (10.1%), African American (6.0%), Other (2.5%), Asian/Pacific Islander (2.0%), and American Indian (1.0%). The largest group of participants reported their age to be 50-60 years old (30.2%), followed by 30-40 years old (27.6%), 40-50 years old (26.1%), 60+ years old (12.1%), and 20-30 years old (4.0%).

Participants were asked to report the academic training program from which they earned their degree. Almost half graduated from psychology training programs (47.7%), followed by counselor education (40.7%), social workers (2.5%), and other (9.0%). Additionally, participants reported their years of experience working in the mental health arena as follows: 30.7% had 10-15 years of experience, followed by 28.1% with 20+ years of experience, 21.1% with 5-10 years of experience, 18.6% with 15-20 years of experience, and 1.5% reported 0-5 years of experience. These demographic sample characteristics are illustrated in Table 4-1.
Descriptive and Preliminary Analyses

Measurement Reliability

Reliability statistics for the CCDS (Self-Awareness/Beliefs/Attitudes, Knowledge, and Skills) and CDP appear in Table 4-2. Cronbach’s alpha for the CCDS total scale score was .94. Alpha values for the three subscales of the CCDS were as follows: Self-Awareness/Beliefs/Attitudes subscale alpha = .60, perceived Knowledge subscale alpha = .86, and perceived Skills subscale alpha = .89. This is comparable to previous reports by Strike et al., (2004) (.94, .67, .87, and .90, respectively). Because the alpha for the Self-Awareness/Beliefs/Attitudes subscale was below acceptable standards (approximately .70) adjustments were made to increase the reliability of this subscale. Experts recommend that researchers revise already developed scales by dropping items if reliability coefficients in the study are insufficient (Wilkinson & TFSI, 1999). Therefore, three items were removed from this subscale (items 10, 14, and 18), which increased the reliability to .70. Removing item 18 (Having my mobility temporarily impaired would give me a true picture of living with a mobility disability.) increased the alpha to .66. Removing item 14 (I enjoy hearing about people who overcame their disabilities.), increased the alpha to .68. Finally, the alpha was improved to .70 by removing item 10 (I believe being non-disabled has certain privileges in society.). No further items were removed because doing so only increased the alpha level by small increments (i.e., less than .01 increase). The revised 17-item Self-Awareness/Beliefs/Attitudes subscale was used for all of the analyses in the current study. Reliability for the CDP indicated an alpha level of .92 for the overall scale score, which was used in the current study. This is comparable to previous reports by Yuker & Hurley’s (1987) (.87).
Hypothesis 1

For the first hypothesis (*LMHCs will report between minimum and moderate amounts of contact with individuals with disabilities*), a descriptive analysis was conducted to obtain the mean number of contact hours. Results indicated that participants reported moderate amounts of contact with individuals with disabilities (*M* = 63.23, *SD* = 12.77), with a fairly wide range of scores = 76 (Minimum = 26, Maximum = 100). This was within the predicted direction, but was somewhat on the higher end of the prediction (moderate rather than minimum).

Hypothesis 2

For the second hypothesis (*LMHCs will describe themselves as having higher levels of Self-Awareness/Beliefs/Attitudes toward disability-related issues than perceived Knowledge and perceived Skills, and will describe their levels of perceived Knowledge of disability and disability-related issues to be higher than their perceived Skills, with perceived Skills rated the lowest of the three variables*), three different paired samples t-tests were conducted at the .05 alpha level to compare the means of the three different variables. Significant differences were found between Self-Awareness/Beliefs/Attitudes and perceived Knowledge (*t*(174) = -10.79, *p* < .0001), between Self-Awareness/Beliefs/Attitudes and perceived Skills (*t*(174) = -7.23, *p* < .0001), and perceived Knowledge and perceived Skills (*t*(174) = 2.22, *p* < .0001). The means on these scales in order from greatest to least are: perceived Knowledge (*M* = 82.37, *SD* = 11.96), perceived Skills (*M* = 81.01, *SD* = 13.54), and Self-Awareness/Beliefs/Attitudes (*M* = 75.27, *SD* = 7.32). As previously indicated, a score between 20 and 120 can be obtained on each scale. Higher scores are indicative of greater self-reported disability competence. Yet, high or low disability competence cannot be concluded on the basis of a response to an individual scale. Only one other study utilizing the CCDS is currently published but scores from this study reflect
similar means (Knowledge $M = 76$, Skills $M = 68$, and Self-Awareness/Beliefs/Attitudes $M = 87$) (Strike et al, 2004).

The results from the current study were in the predicted direction for reported levels of perceived Knowledge being higher than reported levels of perceived Skills. However, results were not in the predicted directions for Self-Awareness/Beliefs/Attitudes being higher than perceived Knowledge and Skills with Self-Awareness/Beliefs/Attitudes having the lowest mean of these three variables.

**Correlational Analyses**

Pearson Product Moment correlations, using a criterion level of .001 (2-tailed), were computed between the two criterion variables (perceived Knowledge and perceived Skills) and each of the predictor variables (Self-Awareness/Beliefs/Attitudes and Contact) in an attempt to confirm that the relationships were in the predicted directions.

Participant perceived Knowledge was significantly positively correlated with the perceived Self-Awareness/Beliefs/Attitudes ($r = 0.69, P \leq .001$) and Contact ($r = 0.68, P \leq .010$), which were in the predicted directions. Participant perceived Skills were also significantly positively correlated with perceived Self-Awareness/Beliefs/Attitudes ($r = 0.63, P \leq .001$) and contact ($r = 0.65, P \leq .001$); these were also in the predicted directions. See Table 4-3 for the correlation matrix.

**Regression Analyses**

In order to assess the capacity of the data to meet the normality assumptions of linear regression, the data was subjected to tests of skewness and kurtosis. Results of these analyses indicated that the assumptions for multivariate normality were met. All skewness and kurtosis
estimates for the variables in the current study fell within the generally accepted values of 1 and –1.

**Hypothesis 3**

For the third hypothesis (*LMHCs’ who report more frequent contact with individuals with disabilities and have higher Self-Awareness/Beliefs/Attitudes scores will report higher levels of perceived Knowledge and perceived Skills when working with individuals with disabilities*), two linear regressions were conducted. The first regression analysis tested LMHCs’ amount of contact with individuals with disabilities and their Self-Awareness/Beliefs/Attitudes toward disability as predictors of their perceived Knowledge when working with individuals with disabilities. The scores on the participant’s amount of contact with individuals with disabilities and Self-Awareness/Beliefs/Attitudes variables accounted for significant variation in participants’ perceived Knowledge scores, $F(2, 172) = 130.07, p < .001$ ($adjusted R^2 = .597$). The standardized beta coefficient for the CDP scale ($\beta = 0.426$) was in the positive direction and was significant, $t(172) = 7.35, p < .001$. The standardized beta coefficient for the Self-Awareness/Beliefs/Attitudes subscale ($\beta = 0.453$) was also significant and in the positive direction, $t(172) = 7.83, p < .001$. The direction of effects indicated that LMHCs that reported higher levels of Self-Awareness/Beliefs/Attitudes and reported higher levels of contact with individuals with disabilities, were more likely to report having higher levels of knowledge about disability. This supported the hypothesis that these criterion variables tend towards the direction of higher levels of perceived Knowledge in LMHCs represented by a large effect size, accounting for approximately 60% of the variance in LMHCs’ perceived Knowledge.

The second regression analysis tested the degree to which LMHCs’ amount of contact with individuals with disabilities and their Self-Awareness/Beliefs/Attitudes toward disability predict their perceived Skills when working with individuals with disabilities. The scores for the
participant’s amount of contact with individuals with disabilities and Self-Awareness/Beliefs/Attitudes variables accounted for significant variation in participants’ perceived Skills scores, $F(2, 172) = 94.81, p < .001$ (adjusted $R^2 = .519$). The standardized beta coefficient for the Self-Awareness/Beliefs/Attitudes subscale ($\beta = 0.381$) was significant and in the positive direction, $t(172) = 6.01, p < .001$ and the standardized beta coefficient for the CDP ($\beta = 0.439$) was also significant and in the positive direction, $t(172) = 6.93, p < .001$. The direction of effects indicated that LMHCs that endorsed higher levels of Self-Awareness/Beliefs/Attitudes about the impact of being disabled or non-disabled and reported higher levels of contact with disabled persons, were more likely to report having higher levels of skills and behaviors that are desirable in mental health practitioners who treat individuals with disabilities. This supported the hypothesis that these criterion variables tended towards the direction of higher levels of perceived Skill in LMHCs represented by a large effect size, accounting for approximately 52% of the variance in LMHCs perceived Skills.

**Summary**

Three different analyses were conducted to investigate the three hypotheses in the current study concerning the amount of contact LMHCs have with individuals with disabilities, and the relationships between LMHCs Self-Awareness/Beliefs/Attitudes, perceived Knowledge and perceived Skills in working with individuals with disabilities and their reported levels of contact with individuals with disabilities.

The descriptive analysis of Hypothesis 1 variables indicated that LMHCs reported moderate amounts of contact with individuals with disabilities. This was at the higher end of the predicted directions and suggests that clinicians are interacting with this population on a regular basis and may possibly be providing mental health treatment as a reason for these interactions. This issue will be examined in more detail in chapter five.
For Hypothesis 2, results from three paired sample t-tests indicated that LMHCs reported higher levels of perceived Knowledge about disability than possessing skills and behaviors that are desirable in mental health practitioners who treat individuals with disabilities, or LMHCs’ reported Self-Awareness/ Beliefs/Attitudes regarding disability. LMHCs also reported possessing higher levels of skills and behaviors that are desirable in mental health practitioners who treat individuals with disabilities than their reported levels of Self-Awareness/ Beliefs/Attitudes regarding disability.

Lastly, regression analyses for Hypothesis 3 indicated that counselors with higher levels of Self-Awareness/ Beliefs/Attitudes, as well as higher levels of reported contact with individuals with disabilities, had higher levels of perceived Knowledge and Skills. These variables accounted for approximately 60% and 52% of the variance respectively.
<table>
<thead>
<tr>
<th>Demographic Variables</th>
<th>Frequency (f)</th>
<th>Percentage(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>59</td>
<td>29.6</td>
</tr>
<tr>
<td>Female</td>
<td>140</td>
<td>70.4</td>
</tr>
<tr>
<td>Total</td>
<td>199</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>12</td>
<td>6.0</td>
</tr>
<tr>
<td>American Indian</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>4</td>
<td>2.0</td>
</tr>
<tr>
<td>Caucasian</td>
<td>156</td>
<td>78.4</td>
</tr>
<tr>
<td>Latino</td>
<td>20</td>
<td>10.1</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-30 years old</td>
<td>8</td>
<td>4.0</td>
</tr>
<tr>
<td>30-40 years old</td>
<td>55</td>
<td>27.6</td>
</tr>
<tr>
<td>40-50 years old</td>
<td>52</td>
<td>26.1</td>
</tr>
<tr>
<td>50-60 years old</td>
<td>60</td>
<td>30.2</td>
</tr>
<tr>
<td>60+ years old</td>
<td>24</td>
<td>12.1</td>
</tr>
<tr>
<td><strong>Academic Training</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselor Education</td>
<td>81</td>
<td>40.7</td>
</tr>
<tr>
<td>Psychology</td>
<td>95</td>
<td>47.7</td>
</tr>
<tr>
<td>Social Work</td>
<td>5</td>
<td>2.5</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>9.0</td>
</tr>
<tr>
<td><strong>Years Experience in Clinical Work</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5 years</td>
<td>3</td>
<td>1.5</td>
</tr>
<tr>
<td>5-10 years</td>
<td>42</td>
<td>21.1</td>
</tr>
<tr>
<td>10-15 years</td>
<td>61</td>
<td>30.7</td>
</tr>
<tr>
<td>15-20 years</td>
<td>37</td>
<td>18.6</td>
</tr>
<tr>
<td>20+ years</td>
<td>56</td>
<td>28.1</td>
</tr>
</tbody>
</table>
### Table 4-2 Paired Samples T-Tests for Knowledge, Skills, and Self-Awareness Subscales

<table>
<thead>
<tr>
<th>Pairs</th>
<th>Mean Difference</th>
<th>Std. Dev.</th>
<th>Std. Error Mean</th>
<th>Lower</th>
<th>Upper</th>
<th>t</th>
<th>df</th>
<th>Sig (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge-Skills</td>
<td>1.29</td>
<td>7.71</td>
<td>.58</td>
<td>.14</td>
<td>2.44</td>
<td>2.22</td>
<td>174</td>
<td>.028</td>
</tr>
<tr>
<td>Knowledge-SelfAwareness</td>
<td>-7.10</td>
<td>8.70</td>
<td>.66</td>
<td>-8.40</td>
<td>-5.80</td>
<td>-10.79</td>
<td>174</td>
<td>.001</td>
</tr>
<tr>
<td>SelfAwareness-Skills</td>
<td>-5.81</td>
<td>10.63</td>
<td>.80</td>
<td>-7.39</td>
<td>-4.22</td>
<td>-7.23</td>
<td>174</td>
<td>.001</td>
</tr>
</tbody>
</table>

### Table 4-3 Measurement Reliabilities for the CCDS and CDP

<table>
<thead>
<tr>
<th>Scale</th>
<th>N</th>
<th>Alpha</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCDS Total Scale</td>
<td>175</td>
<td>.94</td>
<td>.001</td>
</tr>
<tr>
<td>Self-Awareness</td>
<td>175</td>
<td>.70</td>
<td>.001</td>
</tr>
<tr>
<td>Knowledge</td>
<td>175</td>
<td>.86</td>
<td>.001</td>
</tr>
<tr>
<td>Skills</td>
<td>175</td>
<td>.89</td>
<td>.001</td>
</tr>
<tr>
<td>CDP</td>
<td>198</td>
<td>.92</td>
<td>.001</td>
</tr>
</tbody>
</table>

### Table 4-4 Pearson Product Moment Correlations Matrix

<table>
<thead>
<tr>
<th>Measures</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CDP</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Self-Awareness</td>
<td>.56**</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Knowledge</td>
<td>.68**</td>
<td>.69**</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>4. Skills</td>
<td>.65**</td>
<td>.63**</td>
<td>.82**</td>
<td>1</td>
</tr>
</tbody>
</table>
CHAPTER 5
DISCUSSION

Summary of Findings

A sample of 199 LMHCs in the state of Florida participated in the current study. The sample population was mostly Caucasian, predominately female, with over half of the participants reporting to be more than 30 years of age. Nearly all of the participants graduated from either psychology or counselor education training programs. Approximately 80% reported having 10 or more years of clinical experience.

The findings regarding Research Question #1 (What is the amount of contact with individuals with disabilities reported by LMHCs?) were consistent with Hypothesis #1 (LMHCs will report between minimum and moderate amounts of contact with individuals with disabilities). Participants reported moderate amounts of contact (M = 63.23) with individuals with disabilities.

The findings regarding Research Question #2 (Do LMHCs rate their levels of Self-Awareness/Beliefs/Attitudes, perceived Knowledge and perceived Skills in different ways?) revealed some inconsistencies with Hypothesis #2 (LMHCs will have higher levels of Self-Awareness/Beliefs/Attitudes toward disability than perceived Knowledge and perceived Skills, with perceived Skills rated the lowest of the three variables.). Perceived Knowledge had the highest reported average score (M = 82.37), followed by perceived Skills (M = 81.01), and finally Self-Awareness/Beliefs/Attitudes (M = 75.27).

The findings regarding Research Question #3 (Does the amount of contact LMHCs have with individuals with disabilities and their Self-Awareness/Beliefs/Attitudes toward disability predict their perceived Knowledge and perceived Skills?) were consistent with Hypothesis #3...
Research Question #1 Discussion

The findings regarding Research Question #1 indicated that LMHCs in Florida have moderate amounts of contact with individuals with disabilities. The average score for the CDP was approximately 63, on a scale of 20-100. This amount of contact is supported by literature that reports the large number of individuals with disabilities in society. Further, researchers have shown that individuals with disabilities are becoming more mainstreamed and likely to seek the care of generalist counselors. One cannot assume, based on this data, that all LMHCs will evaluate or treat individuals with disabilities. The type of contact examined in this study is not limited to clinical or treatment interactions. However, the diversity and multicultural makeup of the LMHC client population is evident and data from this study support the likelihood that individuals with disabilities are a component of that population.

The implications of this finding suggest that LMHCs are indeed in contact with individuals with disabilities and it is reasonable to assume that at least some of this contact takes place in a clinical setting or during the provision of services. More specific assessments of LMHCs regarding the number of clients with disabilities would clarify this issue. However, as previously stated, counselors are ethically bound to provide unbiased, competent treatment to all clients and it would seem likely that individuals with disabilities represent a portion of that clientele.

Research Question #2 Discussion

The findings regarding Research Question #2 indicated that LMHCs’ perceived Knowledge had the highest reported average score, followed by perceived Skills, and then Self-Awareness/Beliefs/Attitudes. As previously mentioned, the comparatively low score of the Self-Awareness/Beliefs/Attitudes scale was inconsistent with the previous research regarding
attitudes towards disability in the study utilizing the CCDS (Strike et al., 2004). However, data from this current study should not be interpreted in a way that represents LMHCs as having poor or negative attitudes. The CCDS Self-Awareness/Beliefs/Attitudes scale has a scoring range of 20-120, and it is inappropriate to assume that a score average of approximately 75 reflects a poor or negative attitude. Yet, given that: 1) past research has found positive attitudes towards individuals with disabilities by mental health professionals (Carney & Cobia, 1994; Gordon et al., 1990; Huit & Elston, 1991), 2) researchers have shown inadequacies in counselor training and education regarding disability knowledge and counseling skills (Rosenau, 2000; Smart & Smart, 2006), and 3) the previous study utilizing the CCDS found the Self-Awareness/Beliefs/Attitudes scale to have the highest average score of the three scales, it is reasonable to expect findings different from those in this study.

A possible reason for the difference in outcomes may be due to the small range of score averages in the three scales. There was approximately a 7-point difference between the highest average (perceived Knowledge = 82.37) and the lowest (Self-Awareness/Beliefs/Attitudes = 75.27). This makes the possibility for changes in rank more likely. In the previous study utilizing the CCDS, score averages on the three scales were also similar to one another (Self-Awareness/Beliefs/Attitudes = 88.63, perceived Knowledge = 80.56, and perceived Skills = 73.41). Sample size for the current study was N=199. For the previous study, sample size was N=108. With smaller sample sizes and similar score averages, the rank or order of the three scales could be more susceptible to change based upon a few individual participant responses.

The significance of the findings from Research Question #2 in the current study point toward the possibility that LMHCs’ perceived Knowledge, perceived Skills, and Self-Awareness/Beliefs/Attitudes regarding disability may need improvement. The scores from the
aforementioned CCDS studies support this opinion. In the current study, the highest scale average score was 82.37 out of a possible score of 120. This is an overall average of approximately 60%. As will be discussed in more detail in the upcoming section regarding limitations of this study, there is no baseline or standard for comparison when utilizing the CCDS. Therefore, one cannot confidently state that LMHCs’ scores were poor, average, or good in the current study. However, based upon the range of possible scores, it would seem appropriate to state that there is room for improvement in the CCDS scores from the current study.

**Research Question #3 Discussion**

Findings from Research Question #3 indicated that counselors with higher levels of Self-Awareness/Beliefs/Attitudes, as well as higher levels of reported contact with individuals with disabilities, had higher levels of perceived Knowledge and perceived Skills. However, one should not interpret that merely having more contact with individuals with disabilities or having a greater self-awareness or more positive attitudes regarding disability necessarily results in greater knowledge or skills when treating this population. Higher levels of contact and Self-Awareness/Beliefs/Attitudes are simply predictors of higher scores on the perceived Knowledge and perceived Skills scales for this particular study. Implications of these findings could be that as counselors experience more contact with individuals with disabilities, their understanding of issues specific to this population improve. Further, as LMHCs’ understanding of issues and dynamics specific to individuals with disabilities improves, their attitudes and awareness regarding disability are enhanced. However, if these assumptions are true, then such scenarios could equate to a “learn-as-you-go” type situation. It is reasonable to state that much of a counselors’ growth and education occurs outside of a classroom or training session. Clinical experience is perhaps the greatest teacher of all. Yet, the preparedness to treat individuals with
disabilities has been questioned within the professional literature and contact and attitudes are not adequate training modules. Findings from this research question may, however, assist educators in focusing their training of future counselors in the direction of attitudes, beliefs, and self-awareness regarding disability issues.

**Limitations of the Study**

The current study did not utilize random sampling to create the population of participants. Instead, a convenience sample derived from a list of email addresses of LMHC’s maintained by Florida’s Department of Health, Division of Medical Quality Assurance was used. The entire list of email addresses (N=1235) was used, which represented approximately 20% of the entire population of LMHCs in Florida (N=6692). Factors such as a possible low response rate, possible incomplete responses, and a required sample size of 123 prevented this researcher from gathering a random sample from the aforementioned email list. In future research, it is recommended that a random sample from the entire LMHC population in Florida (or elsewhere) be conducted.

Another limitation to this study was the limited reliability and validity data available for the CCDS. Although initial reliability and validity data was promising, additional data would require continued use of the CCDS. Also, in future studies, it is recommended that the CCDS be administered along with instruments that minimize error due to socially desirable responding (Strike et al., 2004).

The lack of generalizability represented an additional limitation, as the study was geographically limited to Florida. The resulting data could be skewed when compared to similar data gathered from a nationwide sample. As mentioned previously, Florida is in the middle of the spectrum in most disability categories. However, Florida’s population of older adults exceeds the national average which may bring about an increase in the percentage of individuals
with disabilities (National Organization on Disability, 2004). Therefore, one cannot extrapolate data from this study to help determine national or global scenarios.

A decision not to differentiate among a variety of disability groups or types may also be considered a limitation of this study. While the broad definition of disability used by the author for this study may be appropriate at this exploratory stage of research, more valuable information might be obtained if specific types or categories of disability were examined. For example, future research may include a comparative analysis of visible versus invisible disabilities and how these two types of disabilities affect LMHCs’ competency factors.

The definition of contact as it pertains to the CDP limits the applicability of data from this study. The contact as described in the CDP does not differentiate between contact in a clinical or counseling setting and other types of contact such as personal. For example, an LMHC may report frequent contact with an individual with a disability that could be a parent or neighbor. That same LMHC may have never had a client with a disability. It would be helpful to have a better understanding of the environment in which contact took place and, more specifically, if that contact was between counselor and client.

Finally, this author noted the lack of normative data for both the CDP and the CCDS pertaining to the sample population. As previously noted, the CCDS has been used in only one previously published study, at which time the sample population consisted of psychiatrists, psychologists, social workers, career counselors, disability specialists, and other mental health professionals. Although the average scores for the three sub-scales (Self-Awareness/Beliefs/Attitudes, perceived Knowledge and perceived Skills) were similar to the score in this study, the scoring order of those results differed. In the current study, the Self-Awareness/Beliefs/Attitudes scale had the lowest average while in the previous published study
it was the highest. With the lack of additional studies with which to compare, it is difficult to draw conclusions as to which data (if any) may be suspect. The same limitation applies regarding the CDP and this study. There is no baseline or average score with which to compare LMHCs’ amount of contact. Therefore, it is difficult, if not impossible, to place a value on all the scores obtained in this study.

**Recommendations for Future Research**

In addition to addressing the above-mentioned limitations, researchers may consider alternative approaches to exploring questions pertaining to LMHCs’ interactions with and treatment of individuals with disabilities. An examination of the specific types of contact (i.e., clinical, social, etc.) LMHCs have with individuals with disabilities would help clarify the frequency and type of interactions that are taking place between the two groups. This, in turn, may assist researchers in determining the need for further training.

A closer, and more current examination of the content of educational programs for counselors would be beneficial in determining the amount of preparation students are receiving with regards to providing services to individuals with disabilities. As previously noted, researchers have found that students in counselor training programs are not required to learn about individuals with disabilities and textbooks used in these programs rarely address disability issues. Further, when disability issues are addressed, they provide biased presentations of persons with disabilities. Performing a more current content analysis of counselor training programs may provide a more accurate understanding of LMHCs’ preparedness and training regarding disability issues.

A content analysis of continuing education courses, seminars and post-graduate training would also be worthy research to determine the amount of disability education LMHCs receive. Based upon the findings of this current study, it is apparent that LMHCs have at least moderate
contact with individuals with disabilities and could improve their awareness, skills, and knowledge regarding disability issues. It would therefore seem important to determine the availability of training and education for practicing counselors, and whether or not counselors are participating in such training.

Researchers may also consider alternative formats of research that do not have the limitations associated with survey research or analogue research. Qualitative research that includes actual counselors and clients with disabilities in clinical counseling settings could provide more in-depth information about the counseling process. For example, such studies could help researchers understand how counselors’ disability-related competence affects the counseling process and outcome.

**Conclusion**

Individuals with disabilities are one of the largest minority groups in the United States. Based upon a review of the literature, the frequency of exposure LMHCs have to this population is largely unknown. However, if such interactions are taking place, as is suggested in this study, it is necessary to consider the implications of this contact on both the client and the counselor. There are many issues to be explored within the realm of these relationships. Counselor competence, ethical considerations, client/counselor rapport, and accessibility issues are only a few of the areas that would warrant further research. However, groundwork must first be established to determine the frequency with which LMHCs work with clients with disabilities. One could argue that, even if the frequency of exposure is miniscule, it matters not whether the contact or provision of services occurs one time or one million. However, if the exposure that LMHCs have to persons with disabilities were significant, then appropriate training and continued education in the treatment of this population would clearly be warranted.
The findings in this study also indicate that LMHCs’ may benefit from additional training or education to increase their disability competency. Literature supports the theory that LMHCs are not adequately trained in the area of disability competency (Renard, 2001; Rosenau, 2000; Smart & Smart, 2006). This current study supports the possibility of inadequate LMHC training while also reporting moderate contact with individuals with disabilities.

LMHCs are bound to provide competent services to individuals with disabilities from legal and ethical perspectives. Without specific training or education, the general public has many misperceptions about disability (Shapiro, 1994). It is inappropriate and perhaps dangerous to assume that LMHCs are drastically different from the general population in that regard. Further research is necessary to ensure that this important client population is being served in the manner in which they, and all individuals, disable and non-disabled, deserve.
APPENDIX A
EMAIL COVER LETTER

Dear Counselor,

The University of Florida is sponsoring research on licensed mental health counselors and their interactions with individuals with disabilities. We ask that you click on the attachment to this email to learn more about the study and how very helpful it will be to us if you would spend a few minutes of your valuable time to complete this brief survey. If you have difficulty opening the attachment, but would like to complete the survey, you may go directly to the survey by clicking on:

http://www.surveymonkey.com/s.aspx?sm=gNm0sdHai9rg2INlpsfWqg_3d_3d

Your anticipated participation is greatly appreciated!
APPENDIX B
INFORMED CONSENT

This is a research study conducted by Grant McDougall, a doctoral candidate from the Department of Rehabilitation Science at the University of Florida. This study examines licensed mental health counselors (LMHCs) and their perceived competence when working with clients with disabilities. You have been selected from the total population of LMHCs within Florida. Although this study will assess several aspects of LMHCs involvement with individuals with disabilities, no prior training or experience working with this client population is required to participate in this study.

You are being asked to complete two surveys and a demographic questionnaire online, at your convenience, through SurveyMonkey.com. The instruments will take approximately 8-10 minutes to complete. Participation in this research project is voluntary. You do not have to answer any questions you do not wish to answer, and you are free to withdraw your consent and to discontinue your participation at any time without consequence. You will not be asked to write your name on the research project forms. Your response is anonymous. No personal/professional identifying information or IP addresses will be collected or retained.

Potential benefits of participation include increasing counselors’ awareness regarding disability issues and positively impacting future training and education of counselors in the area of disability studies. There are no known risks or potential harm to the participants in this study. No compensation for participation is provided.

The measures will be kept secure and only accessible to Grant McDougall and his faculty supervisor, Linda R. Shaw, Ph.D. Data will be kept confidential to the extent provided by law and individual data will not be shared.

Questions concerning your rights as a research participant can be directed to the UFIRB, Box 112250, University of Florida, Gainesville, FL, 32611-2250.

If you have any questions about this study please contact Grant McDougall at grantmcd@bellsouth.net, or Dr. Linda R. Shaw, Department of Rehabilitation Counseling, (352) 273-6745.

By choosing "yes", I provide my informed consent to participate in this study.

☐ YES  ☐ NO
APPENDIX C
CONTACT WITH DISABLED PERSONS SCALE

Contact With Persons With Disabilities Scale

Please circle the number to the right of each statement indicating your answer to each question. Use a number from 1 to 5 to indicate the following: 1 = never; 2 = once or twice; 3 = a few times; 4 = often; 5 = very often.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often have you had a long talk with a person with a disability?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>2. How often have you had a brief conversation with persons with disabilities?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>3. How often have you eaten a meal with a person with a physical disability?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4. How often have you contributed money to organizations that help persons with disabilities?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>5. How often have persons with disabilities discussed their lives or problems with you?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>6. How often have you discussed your life or problems with a person with a disability?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7. How often have you tried to help persons with disabilities with their problems?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>8. How often have persons with disabilities tried to help you with your problems?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>9. How often have you worked with a client, student, or patient with a disability on the job?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>10. How often have you worked with a co-worker with a disability?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>11. How often has a friend with a disability visited you at your home?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>12. How often have you visited persons with disabilities in their homes?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>13. How often have you met a person with a disability you like?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>14. How often have you met a person with a disability you dislike?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>15. How often have you met a person with a disability that you admire?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>16. How often have you met a person with a disability for whom you feel sorry?</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
17. How often have you been annoyed or disturbed by the behavior of a person with a disability? 1 2 3 4 5

18. How often have you been pleased by the behavior of a person with a disability? 1 2 3 4 5

19. How often have you have you had pleasant experiences interacting with persons with disabilities? 1 2 3 4 5

20. How often have you have you had unpleasant experiences interacting with persons with disabilities? 1 2 3 4 5

21. How often have you had a long talk with a person with a disability? 1 2 3 4 5

22. How often have you had a brief conversation with persons with disabilities? 1 2 3 4 5

23. How often have you eaten a meal with a person with a physical disability? 1 2 3 4 5

24. How often have you contributed money to organizations that help persons with disabilities? 1 2 3 4 5

25. How often have persons with disabilities discussed their lives or problems with you? 1 2 3 4 5

26. How often have you discussed your life or problems with a person with a disability? 1 2 3 4 5

27. How often have you tried to help persons with disabilities with their problems? 1 2 3 4 5

28. How often have persons with disabilities tried to help you with your problems? 1 2 3 4 5

29. How often have you worked with a client, student, or patient with a disability on the job? 1 2 3 4 5

30. How often have you worked with a co-worker with a disability? 1 2 3 4 5

31. How often has a friend with a disability visited you at your home? 1 2 3 4 5

32. How often have you visited persons with disabilities in their homes? 1 2 3 4 5

33. How often have you met a person with a disability you like? 1 2 3 4 5

34. How often have you met a person with a disability you dislike? 1 2 3 4 5

35. How often have you met a person with a disability that you admire? 1 2 3 4 5
36. How often have you met a person with a disability for whom you feel sorry? 1 2 3 4 5

37. How often have you been annoyed or disturbed by the behavior of a person with a disability? 1 2 3 4 5

38. How often have you been pleased by the behavior of a person with a disability? 1 2 3 4 5

39. How often have you had pleasant experiences interacting with persons with disabilities? 1 2 3 4 5

40. How often have you had unpleasant experiences interacting with persons with disabilities? 1 2 3 4 5
APPENDIX D
COUNSELING CLIENTS WITH DISABILITIES SURVEY

Counseling Clients With Disabilities Survey

Please read each statement carefully and circle the number that best describes you from Strongly Agree (1) to Strongly Disagree (6). Please do not skip items.

For the following items, the term disability is defined as a physical or mental impairment that substantially limits one or more major life activity (e.g., hearing, seeing, speaking, breathing, walking, thinking/learning, feeling/behaving, keeping house, living independently, or working).

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Slightly Agree</th>
<th>Slightly Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have respect for people with all types of disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>2. I feel trusted by people with disabilities as much as people without disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>3. If I had a different disability status (disabled or nondisabled) than my clients, it would impair our working relationship.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>4. I believe people with disabilities are stigmatized in our society.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>5. I have thought about how worldviews are influenced by disability status (disabled or nondisabled).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6. I think most people with disabilities wish they were nondisabled.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7. I think people with disabilities are generally more dependant than people without disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>8. I can identify a wide variety of individual differences among people with the same type of disability.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>9. I try to examine my stereotypes about various disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>10. I believe being nondisabled has certain privileges in society.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Slightly Agree</td>
<td>Slightly Disagree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>---</td>
<td>----------------</td>
<td>-------</td>
<td>----------------</td>
<td>-------------------</td>
<td>---------</td>
<td>------------------</td>
</tr>
<tr>
<td>11. I consider people with disabilities to be a minority group.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>12. I try to talk with others who have different points of view on disability.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>13. It is difficult for me to understand how disability could be a source of pride for people with disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>14. I enjoy hearing about people who overcame their disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>15. I believe disability is essentially a medical problem to be cured.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>16. I believe most disability rights activists promote telethons to raise money to cure disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>17. I have participated in events where the majority of people attending had disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>18. Having my mobility temporarily impaired would give me a true picture of living with a mobility disability.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>19. I have thought about how a disabling illness or injury would affect my work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>20. I feel satisfied with my level of awareness about disability issues in my work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>21. I understand terms used in the ADA, Americans with Disabilities Act, of 1990 (e.g. “reasonable accomodations”)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>22. I understand terms used in the disability community (e.g., ableism, disability culture).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>23. I can state the educational significance of Section 504 of the Rehabilitation Act of 1973.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Slightly Agree</td>
<td>Slightly Disagree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>---</td>
<td>----------------</td>
<td>-------</td>
<td>----------------</td>
<td>-------------------</td>
<td>---------</td>
<td>------------------</td>
</tr>
<tr>
<td>24. It is unfair to accommodate college students with disabilities by treating them differently than their peers (e.g., extra time).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>25. I do not follow current court cases about the legal rights of people with disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>26. I believe that unemployment/underemployment is common among people with disabilities in the U.S.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>27. I feel that people with disabilities are portrayed accurately in the media.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>28. I am familiar with the sociopolitical history of people with disabilities (e.g., the disability civil rights movement).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>29. I can name famous people known to have disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>30. I can name well-known counseling theorists who have disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>31. In my field, professionals with disabilities are underrepresented.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>32. I have learned about disabilities through professional development activities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>33. I have a general knowledge of all the following types of disabilities: learning, psychiatric, vision, hearing and mobility.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>34. I am familiar with the distinction between hidden disabilities and readily observable disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>35. I think English is the native language of Americans who are deaf from birth.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Slightly Agree</td>
<td>Slightly Disagree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>---</td>
<td>----------------</td>
<td>-------</td>
<td>----------------</td>
<td>-------------------</td>
<td>----------</td>
<td>-------------------</td>
</tr>
<tr>
<td>36. I do not know where the accessible entrances are in my place of employment.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>37. If I had a new client who is blind coming to my office, I could give directions without using visual references.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>38. I recognize signs/symbols of access that welcome people with disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>39. I am not familiar with adaptive technology (e.g., screen readers, captioning).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>40. I feel satisfied with my level of knowledge about disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>41. I am not sure if the terms I use to refer to disabilities are preferred by people with disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>42. I know how to obtain alternate formats of printed material (e.g., Braille, large print).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>43. If I had a new client who is hard of hearing, I would know how to modify my verbal and nonverbal behaviors.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>44. I am experienced using TTY/TDD or the state Relay Services to communicate with people with hearing/speech disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>45. I am experienced with communicating through a sign language interpreter.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>46. In first appointments, I routinely ask clients if they have disabilities/medical conditions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>47. I know how to determine if a DSM-IV diagnosis is a disability.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Slightly Agree</td>
<td>Slightly Disagree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>---</td>
<td>----------------</td>
<td>-------</td>
<td>----------------</td>
<td>-------------------</td>
<td>---------</td>
<td>------------------</td>
</tr>
<tr>
<td>48. I could take a client’s disability into account when interpreting the results of assessments instruments.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>49. I know how to write letters documenting how disabilities affect clients in their work/academic environments.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>50. If I had a new client with a disability, I would hypothesize that adjusting to the disability is a problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>51. I have learned about disability identity development (e.g., Carol Gill’s model).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>52. I am not aware how disability may interact with human sexuality (e.g., family planning).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>53. I would find it hard to deal with strong negative feelings expressed by a client with a disability.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>54. I lack confidence with my ability to deal with transference and countertransference about disability.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>55. I have advocated in the interests of people with disabilities (e.g., removal of architectural barriers, passage of legislation)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>56. I have had opportunities to work effectively with colleagues and/or supervisors who have disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>57. I can readily obtain information/resources about specific disability issues (e.g., disability onset later in life).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Slightly Agree</td>
<td>Slightly Disagree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>---</td>
<td>----------------</td>
<td>-------</td>
<td>----------------</td>
<td>------------------</td>
<td>---------</td>
<td>------------------</td>
</tr>
<tr>
<td>58. I would have difficulty locating a disability expert to consult with regarding a client with a disability.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>59. I know when to refer clients to agencies that specialize in serving people with disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>60. I feel satisfied with my level of skill to work with clients with disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
APPENDIX E
DEMOGRAPHIC INFORMATION

Please choose the items that best describe you.

1. Gender
   □ Female       □ Male

2. Your current age is:
   □ 20-30
   □ 30-40
   □ 40-50
   □ 50-60
   □ 60+

3. Ethnicity:
   □ African American – Black
   □ American Indian
   □ Asian – Pacific Islander
   □ Caucasian – White
   □ Hispanic – Latino
   □ Other

4. I have ___ many years working in the mental health arena.
   □ 0-5 years
   □ 5-10 years
   □ 10-15 years
   □ 15-20 years
   □ 20+ years

5. The academic program/training for which I earned my above mentioned degree is best described as:
   □ counselor education
   □ rehabilitation counseling
   □ psychology
   □ social work
   □ rehabilitation psychology
   □ other
LIST OF REFERENCES


Olkin, R. (1999a). The personal, professional and political when clients have disabilities. *Women & Therapy, 22*(2), 87-103.


Alfred Grant McDougall was born on December 9, 1967 in Punta Gorda, Florida. The youngest of four children, he was raised in Punta Gorda and Tallahassee, Florida by his mother. He graduated from Godby High School in 1985. He was a professional musician and toured the United States and Canada for two years before earning his A.A. at Tallahassee Community College. He went on to earn his B.S. in Communications from Florida State University in 1993. He worked in marketing for Eastman Kodak Company for several years before entering into the Department of Rehabilitation Counseling at the University of Florida. He worked as a rehabilitation consultant and earned his M.H.S. in 1997. He became licensed as a mental health counselor and worked as a psychotherapist in private practice as he entered into the Rehabilitation Science doctoral program.

Upon his completion of his Ph.D. program, Grant will continue to work as a psychotherapist specializing in counseling individuals with disabilities. He also hopes to teach on the collegiate level. Grant has been married to his wife, Michele McDougall, for 16 years. They have two sons; Sam, age 10 and Drew, age 7.