

Infusing Disability Culture into Multicultural Courses in Counselor Education Programs

Sheri Ann Rawlings, LPC, & Terri Longhurst, M.S.
University of Wyoming
Wyoming Institute for Disabilities (WIND)

Abstract: The article addresses the absence of discussion of disability culture and related issues in a counselor education training program at the University of Wyoming. It is likely that counselors will work with people who have disabilities because people with disabilities constitute the largest minority group in the United States. To assess the current level of awareness and perceived level of benefit of infusing disability culture into the counseling program, 19 masters' students participated in training on disability culture, and then discussed what they learned in focus groups. The students reported subscribing to several common stereotypes about disability and expressed the belief that learning about this population is an important aspect of a counselor education program.

Key Words: counselor, disability culture, cultural competence

Introduction

Almost 50 million Americans over the age of five have a disability. People with disabilities comprise more than 19% of the entire population, making them the largest minority population in the United States (Waltrap & Stern, 2003). The Council for the Accreditation of Counseling and Related Educational Programs (CACREP, 2001) alludes to the recognition of disability as a multicultural issue that programs should include in their counselor preparation. CACREP lists "mental and physical characteristics" and "unique characteristics of individuals" in the Social and Cultural Diversity section of its standards. According to the American Counseling Association (ACA) Code of Ethics (2005), counselors are expected to have a certain amount of competency in multicultural and diversity counseling (F.11.c). Although the ACA Code of Ethics recognizes disability as a culture (E.8), educators sometimes fail to consider disability in the context of discussing multicultural issues.

Some terms related to disability are potentially confusing and often misused. *Impairment* is the actual physical or structural difference that a person with a disability has (Olkin, 1999). An example of impairment is a person having a leg amputated. The term *disability* refers to the consequences or changes, real or perceived by the individual and others, in performance resulting from the impairment (Olkin, 1999; Reeve, 2000). For example, a person who has had her legs amputated would lose functioning of her legs. Some disability scholars would also include the reactions and attitudes of other people to the impairment as a component of disability. In this context, an example would be a person who has an impairment not being hired for a job that he or she is capable of doing—this employment discrimination is part of the disability. The term *handicap* refers to an environmental obstacle or barrier that prevents a person from participating in

activities or from going certain places. An example is a theatre with no ramp to the stage, preventing a person who uses a wheelchair from performing on the stage (Olkin 1999). According to the Olkin (1999), the term *full inclusion* refers to participation by persons with disabilities in all aspects of society (i.e., social, political, economic, educational, entertainment, recreational, and personal) to the extent they want to participate. *Accessibility* refers to both a lack of environmental barriers preventing people from participating in activities and a lack of attitudinal barriers that prevent acceptance and equality in treatment and opportunity. The *moral model of disability* contends that disability is caused by a sin or moral transgression, whereby the disability is viewed as a punishment. In this model, disability is viewed as a tragedy and as something to be pitied. The *medical model of disability* views a person with a disability as broken and in need of a cure. The person is viewed as having a decreased value because he or she is not seen as a whole person. The term *minority model of disability* refers to a set of beliefs that peoples' attitudes about disability are more problematic for people with disabilities than the actual impairment is. In addition, this model views the disability as natural and not something that needs to be cured or fixed.

As a person who graduated from the University of Wyoming counselor education program, Sheri Rawlings noticed a lack of conversation related to people with disabilities. Instructors discussed issues associated with racial and ethnic minorities, but the issue of disability was rarely mentioned in the classroom. The training Sheri Rawlings completed at the Wyoming Institute for Disabilities (WIND) forms the foundation of her knowledge about people with disabilities:

“WIND provides teaching, research, information services, and technical assistance to both the University and Wyoming at large. Its major functions include preparing university students to help persons with disabilities live and work in more inclusive communities and providing current information about the broad area of disabilities...to Wyoming residents and professionals” (Wyoming Institute for Disabilities, n.d., ¶1).

However, there is mention of disability in only one of the counselor education syllabi, indicating that the subject may not be a prominent part of the current curriculum.

Absence of training about disability culture in counseling programs does not appear to be a problem that is exclusive to this western university. Korinek and Prillaman (1992) conducted a study of counseling programs' preparation of school counselors to work with students with disabilities. Although more than 90% of the 238 respondents reported they believed it was important to offer instruction and training in this area, only about 30% of the respondents thought their programs were prepared to offer adequate training around disability culture. A similar study by McEachern (2003) echoed these results with 35% of the 146 responding schools requiring counseling students to enroll in courses related to working with students with disabilities. Some people assume that counselors and other helping professionals are more likely to have positive attitudes about people with disabilities, but according to Nathanson (1979), this does not appear to be the case. Counselors experience the same negative images and stereotypes about people with

disabilities as people in the general public. Although counselors are encouraged to examine their racial and ethnic biases and stereotypes, often the discussion of stereotypes about disability are left unrecognized and unaddressed (Reeve, 2000). Although the Nathanson (1979) study, is over 30 years old, the results of this current study suggest that counselor attitudes have not changed over this period of time.

The purpose of the current research project was to pilot a program for increasing counselor students' awareness about the importance of including disability culture in the current curriculum. Counseling students had the opportunity to discuss their perceptions of the potential benefits of such an addition. The long term goal of this research is to have the topic of disability culture added to the multicultural course at the University of Wyoming, as well as other courses in the program. The purpose of adding disability culture to the curriculum is to increase counselor competence in working with clients with disabilities. This increase is expected to lead to greater client satisfaction and reduction of biases and oppression. According to Beecher, Rabe, and Wilder (2004), a "lack of disability knowledge and training may increase counselors' discomfort in interacting with persons who have disabilities" (p. 85). Since people with disabilities make up the largest minority population, it is very likely that counselors will interact, directly and indirectly, with people who have different types of disabilities.

Disability as a Culture

Barnes and Mercer (2001) state that, "Disability culture presumes a sense of common identity and interests that unite [people with disabilities]..." (p. 522). DePoy and Gilson (2004) described culture more specifically as, "A circumscribed group in which members share common experiences, symbols and meanings, tacit rules, language, history, discourse and cultural identity" (p. 81). Disability culture shares many obstacles experienced by other minority cultures. People with disabilities face prejudice, discrimination, and stigma due to their impairments. They may be overlooked for jobs because employers either underestimate what the person is able to accomplish or feel uncomfortable about the disability (Olkin, 1999). Other common characteristics of minority populations include a shortage of public role models with whom to identify, a lack of representation in professional roles, and political under-representation (Olkin, 1999). People with disabilities are also underrepresented in groups used in normalizing assessment instruments, therefore are often subjected to inappropriate use of tests (Olkin, 1999).

Disability, as a cultural minority, differs from ethnic minority populations in some ways too. Disability is a category that a person can enter into and exit. A person can get into a car accident at any time, become paralyzed, and become a person with a disability. A person who has lost the use of an arm may regain use of it through surgery and no longer have a disability. People with disabilities are often subject to separate but equal status, as evidenced by separate transportation, entrances, and water fountains. A person with a disability is often the only person in an immediate family or neighborhood that has a disability. There is rarely a preexisting sense of *disability pride* in the family. Some people who have disabilities do not self-identify as being disabled (Olkin, 1999). People

who are able to carry out all the functions of every day life that permit them to live independently, may not feel that they have a disability.

Some counselors may think it unnecessary to learn about this population because counselors are supposed to have unconditional positive regard for all their clients. Unconditional positive regard is a term that is common to the field of mental health. It refers to the idea that all people have value and should be treated in an accepting and caring manner. This regard is important, but not sufficient, because the counselor needs to make certain behavioral and physical accommodations that they may be unaware of unless taught (Reeve, 2000). A large number of problems that people with disabilities experience are environmental and outside of their control. For example, buildings without elevators or ramps, aisles too narrow for a wheelchair, lack of accessible parking, and signs without Braille. Most counselors focus on facilitating personal change within the client, but if the counselor does not recognize or address the environmental stressors, the client may not feel heard (D'Andrea, Skouge, & Daniels, 2006). Counselors' lack of knowledge about the needs of this population further alienates and marginalizes people with disabilities.

Marginalization of People with Disabilities

Historically, people with disabilities have been devalued and marginalized. They were locked up in asylums, put on display in "freak shows," and involuntarily sterilized to prevent reproduction (Fishley, 1992). Today, people with disabilities are frequently misrepresented in the media and are rarely portrayed as everyday human beings (Shapiro, 1994). The media often portray people with disabilities according to stereotypes --as persons suffering from personal tragedies, as sources of great inspiration, or as mean and embittered recluses who are miserable because of their impairments (Reeve 2000; Shapiro, 1994).

Marginalization continues to occur in multiple ways. For example, stigma surrounds people with disabilities enjoying a sex life and wanting to reproduce (Ward & Pointon, 2004). Eugenics is still being practiced in the United States. Eugenics is a belief that a higher quality of the human species can be created by preventing people with certain characteristics from reproducing ("Eugenics," n.d.). This is evidenced by the common practice of doctors testing for abnormalities in fetuses by way of amniocentesis. If fetal abnormalities are present, doctors sometimes recommend the mother terminate the pregnancy by way of a therapeutic abortion. The term therapeutic abortion refers to an abortion performed to prevent the birth of an infant with a birth defect ("Therapeutic abortion," n.d.).

Leaders of the disability movement want to move away from the mindset of disability as devalued to that of equal value (Olkin, 1999). The disability movement is striving toward full inclusion (Olkin, 1999). People with disabilities want to be able to participate in all aspects of life to the extent the person desires, not limited by environmental and attitudinal barriers. The minority model promotes the mindset that disability is natural and people with disabilities should be seen as people first.

It Is More than Just a Name Change

Person First Language (PFL) puts the person before the disability. The purpose of PFL is to reaffirm that disability is not the most important aspect of a person. Non-PFL is common in most medical settings. It is part of the practice in which professionals refer to clients by their symptoms: the cancer patient, the schizophrenic man, the alcoholic family, the blind client. A study by Arokiasamy, Strohmer, and Guice (1994) examined how clients with disabilities perceived their counselors' credibility. The counselors used different types of communication styles, varying between ultra-correct (euphemistic terms for disability), correct (PFL), and incorrect (Non-PFL). The researchers concluded that the different types of language use did not significantly impact the clients' perceptions about their counselors' credibility.

Perhaps these results are indicative of the need for deeper changes. Person First Language is more than a language style; it is an attitude and mindset. Changing the terms without changing the attitude does not change the message. A personal experience comes to mind that supports this view. One week after receiving training on disability etiquette and PFL, a counseling student was talking about a sports event she had watched the previous night. Commenting on the way the players performed she stated, "Those guys played like a bunch of special needs kids." She changed the terminology; she did not say "retards," but her attitude about people with disabilities had not changed. She was still demonstrating the attitude that people with disabilities are "less than" people without disabilities. If a counselor is not demonstrating an accepting attitude, using PFL will probably not improve the relationship between the counselor and the client.

Stereotypes and Biases about People with Disabilities

Counselors need to examine their personal biases about people with disabilities in order to competently counsel people in this population. As is the case with other minorities, there are a number of stereotypes and assumptions about people with disabilities. The researchers limit the discussion of these myths to those most prevalent in and relevant to the counseling setting.

Disability as a Piece, Not the Whole

In general, people without disabilities often perceive the disability to be the person's biggest issue. However, people with disabilities often feel that other peoples' attitudes and inaccessible environments are the biggest problem they face (Swain, Griffiths, & Heyman, 2003). While people with disabilities most often view disability as one spoke in the wheel of their lives, people without disabilities perceive the disability as the hub of the wheel (Olkin, 1999). It is important to remember that all people have multiple roles and identities.

More specifically, when a person with a disability comes to counseling, counselors often assume that the disability is the presenting problem (Smart & Smart, 2006). The

counselor may assume that the disability is causing the problems that the client has reported (Reeve, 2000). The disability may or may not have anything to do with the counseling issue. If a person with a disability is experiencing symptoms of depression or is feeling angry, counselors may assume this to mean the person has not “come to terms” with his or her disability. Counselors sometimes forget that personality characteristics range as much for people with disabilities as they do for people without (Olkin, 1999).

Having a Disability Does Not Imply a Lower Quality of Life

It is inaccurate to assume that a person with a disability has a lower quality of life than a person without a disability. People frequently make comments that indicate they think this way such as, “I would rather be dead than live like that.” Many people with disabilities are not waiting to be cured or fixed. Judy Heumann, a disability rights activist stated, “Disability only becomes a tragedy for me when society fails to provide the things we need to lead our lives – job opportunities or barrier-free buildings, for example. It is not a tragedy to me that I’m living in a wheelchair” (as cited in Shapiro, 1994, p. 20). The tragedy assumption is prevalent even among counselors, as found by Parkinson (2006), where 75% of the 25 participants, admitted to viewing disability in terms of tragedy or irrevocable loss.

One Impairment Does Not Imply Impairments in Other Areas

Disability as a characteristic has a large “spread.” “Spread refers to the power of single characteristics to evoke inferences about a person” (Olkin, 1999, p. 55). For example, a common assumption is that if a person has one disability, it leads to impairments in other parts of that person’s life. Some people assume that a person with a visual impairment also has a hearing impairment, as demonstrated when people talk slowly and loudly to a person who has a visual impairment. People with speech impairments are often assumed to have cognitive impairments. Speech impairments can be caused by a variety of disabilities that do not impact cognitive abilities. “Our society automatically underestimates the capabilities of people with disabilities...A disability, of itself, is never as disabling as it first seems” (Shapiro, 1994, p. 18).

Another common misperception is that people with cognitive disabilities are eternal children or childlike. This is apparent when adults with cognitive disabilities are given children’s toys and stuffed animals. Sometimes people will even talk to a person with a cognitive impairment in baby talk or talk about that person right in front of them. People with cognitive disabilities are often concerned about the same issues as people without these impairments: intimate relationships, paying bills, and getting along with coworkers. It is important to keep in mind that there are varying degrees of impairment associated with cognitive disabilities, as apparent by the different levels of severity described in the *Diagnostic and Statistical Manual of Mental Disorders(DSM-IV-TR)* (American Psychiatric Association, 2000).

In order to increase counselor awareness about disability culture, Sheri Rawlings presented a one-hour training on disability culture to first year masters' counseling students at University of Wyoming. The goal of the training was to have students examine their personal beliefs and biases about people with disabilities. The training included a discussion about common myths held about people with disabilities. The training was firmly grounded in the minority model of disability studies and included the rationale behind why disability qualifies as a culture. The session included a summary of how the disability movement has changed over time.

Method

Eighteen first-year masters' students and one second-year masters' student in a counselor education program volunteered to participate in this study. Participants were recruited by one of the researchers going to both of the counselor practicum classes and asking for volunteers. The classes were told that the research would include training about disability and would include focus group discussion. Every student from the practicum classes voluntarily participated in the research study. This study did not have a control group. Descriptive data was not collected about the participants for this research study. Participants did not receive monetary compensation for their participation. They were provided a pizza lunch since the research study took place during lunchtime.

Materials

Vignette

Participants received a vignette describing a client coming to counseling. This vignette depicted typically occurring presenting concerns: the client with a diagnosis of Mental Retardation was experiencing job dissatisfaction, relationship problems related to communication problems, and dissatisfaction with her sexual relationship. The vignette included four discussion questions to gain understanding of the way the participants conceptualized the case, what other information they would like to know about the client, ethnic and cultural concerns related to the client, and possible resources and recommendations that the counselor would explore with the client.

Disability Etiquette Handout

Participants received a two-sided, one page handout about disability etiquette. The purpose of this handout was threefold: to eliminate the participants' need to take notes, to increase their participation during the presentation, and to provide them with something to remind them of their learning.

Disability Culture Training

Participants learned for an hour about disability culture. This training focused on multiple aspects of disability culture, including disability etiquette, stereotypes, myths, and person first language. The presentation included a definition of disability culture and

rationale for why it qualifies as a culture. The presenter also introduced the participants to the three most common models of disability studies: moral, medical and minority. Participants watched video clips from two videos; *Without Pity: a Film about Abilities* (Mierendorf, 1996) and *Murderball* (Mandel & Shapiro, 2005). Both of these movies feature people with disabilities. The researcher also presented counseling concerns of people with disabilities that are similar to the concerns of people without disabilities and those that would differ between the two populations. Examples of differing counseling concerns included stress from prejudice and discrimination about the disability, living with chronic physical pain, end of life issues, and not having relatives or family members with a disability with whom the person can identify.

Focus Group Discussion Questions

Each group received the same set of questions to facilitate the focus group discussions. The participants were asked to reflect on their previous experience with disability, both personally and in the counselor education program. The participants discussed what knowledge they gained from the presentation and they shared how the information they learned would impact their counseling skills. The participants were asked about what past stereotypes and myths they had been exposed to. They also discussed what information they thought was most important to share with other counselors.

Procedure

After obtaining informed consent, participants were given a vignette describing a client coming in to counseling. The participants were given 15 minutes to answer the questions at the bottom of the vignette. The participants were instructed to use a different color pen to add notes or make changes to the treatment plans for their vignettes as the training progressed. The researcher presented a one-hour training on disability culture. Following the lecture, participants were randomly divided into five groups. Four groups had four participants, and one group had three participants. Each group had a group facilitator who facilitated group discussions of the set of questions. The discussion was limited to 30 minutes. After the participants finished their discussions in their groups, the researchers allowed them to make changes to the treatment plans, based on the knowledge gained from the training.

Results

Two participants did not return the vignettes at the end of the research study as the researcher only received 17 back from the participants. Nine of the 17 participants (approximately 52%) mentioned disability or Mental Retardation somewhere in the treatment plans for the vignettes. Five of these nine participants were interested in knowing the severity of the Mental Retardation of the client in the vignette. Three of the nine participants wanted information about how the fiancé views disability. Only two participants recognized disability as a culture in the treatment plans. Only one participant made changes to the vignette after receiving the training, limiting the amount of discussion about this part of the research.

Discussion

In addition to the 19 research participants, five staff members from the Wyoming Institute for Disabilities (WIND) were present throughout the presentation. These people were also the focus group facilitators. One of the counseling education department professors was also present in the training, but did not participate in the focus group discussions. Having these additional people present during the training may have led some participants to be nervous, and possibly not share as much as they may have otherwise.

The researcher does not know why two participants did not return the vignettes. One of these participants is likely to be one who showed up to the presentation late, and that person may not have had time to complete the treatment plan.

Only one student made changes to the vignette after the training. The researcher allowed the students to make the changes throughout the presentation, but did not set aside a specific time for the participants to make the changes. It is likely that more participants would have made changes to the treatment plans had time been allotted specifically to that. The lack of changes on the vignettes made it difficult for the researcher to track any mindset changes the participants may have had during the training.

Themes and Discussion about the Focus Groups

Participants' Experience with Disability

The first question asked participants to discuss their experiences with disability, both personally and in the counselor education program. All but one of the 19 participants stated they had personal experience with people with disabilities. Many of these experiences included occupations that led to interactions with people with disabilities. The participants discussed working with youth with hearing impairments, directing recreational activities for people with various types of disability, and working with children in special education classroom settings. Some participants discussed more personal interactions with family members, friends and classmates with disabilities, and one participant mentioned that he had a disability.

Only four of the 19 participants stated that they had experiences with disability in their counselor education program. One student reported having a classmate with a disability, who shared information about her disability in a class. One student reported having a client with a disability in her pre-practicum class. Two students reported learning a small amount about disability in the diagnosis and psychopathology course in the program. One student stated, "This is the first that I have encountered, except for maybe in diagnosis we talked about some of the disabilities people might experience because of a diagnosis" (personal communication, November 7, 2006).

What Participants Learned About Disability from the Training

The second question asked participants what they learned about disability from the training. Eight participants expressed that they were surprised that not all people with disabilities want a cure for their impairment. One responded stated, “That is something I wasn’t at all aware of ... their not wanting to change their disability.” Four participants stated the training was their first exposure to person first language and four participants reported they had never heard about the models of disability studies before. Three participants stated that they would have assumed that a person with a disability coming to counseling would be coming to counseling to discuss problems related to the disability. Other statements participants made included the different myths and stereotypes about disability, the importance of education about disability and disability etiquette, how attitudes about disability impact the way people with disabilities are treated, and learning the importance of asking the person before helping. A participant said, “I would usually just do it for them instead of asking them if they want help. It really made me aware that I assume a lot about their abilities”

Participants’ Prior Attitudes and Stereotypes about People with Disabilities

The third question asked participants about attitudes and stereotypes they had about people with disabilities prior to the training. Seven participants stated that they had previously assumed that a person with a disability would want to be cured if the opportunity were available. One person stated, “I had never thought that someone would not want a cure...I will be thinking about that for awhile.” Another person similarly stated, “I always assumed that of course they would want to be back to normal or whatever. I think that was my own assumption that needed to be challenged.”

Five participants stated that they had previously used inappropriate language to refer to people with disabilities, or would use words that refer to types of disability as put-downs for people (i.e., not using person first language, calling a person a “retard,” or telling a person their idea is “retarded”). Three participants said they had assumed that people with disabilities were unhappy and had a lower quality of life than people without disabilities. One person stated, “I made the assumption they are probably not happy and they would want to be different.” Two participants stated they assumed that a person’s disability would be the reason why that person would come to counseling.

Other statements the participants made included previously treating adults with disabilities as children, seeing the person as a disability and not as a person, speaking to an interpreter instead of the person with a hearing impairment, and feeling sorry for a person because they have a disability. A participant mentioned that he had an “instantaneous reaction to treat someone childlike or talk to them in a different way than I would someone else. “I have to stop and tell myself to talk to this person just like they are, as an individual.” Another participant mentioned having a brother that had multiple disabilities that are not visibly apparent. He said, “I noticed when I tell people before they meet my brother they are going to treat him different than if I just let them figure it out.”

Two participants stated that they had previous stereotypes and had made assumptions about people with disabilities prior to the training, but they did not specify what those were. Six people in several different discussion groups brought up an interesting topic that was not addressed in the presentation. When participants were talking about people with physical disabilities, they would say they had “never thought of the person as being disabled.” That viewpoint was typically presented when the participant was commenting that the person with the disability was intelligent and “perfectly functioning.” The researcher has recognized a need to further educate the counseling students about people with cognitive impairments. It seems once the participants became more comfortable with physical disabilities, they viewed that type of impairment as more acceptable. It is possible that the training did not spend enough time going over cognitive impairment for the participants to become more comfortable with people from that population.

How Participants Intend to Use the Information Learned in the Training

The fourth question asked participants to comment on how they intended to use the information they learned in their counseling practices. Each participant was able to identify a way in which they could apply the knowledge gained from the presentation. These applications seemed appropriate for the field and fairly easy to implement.

Eight participants stated that they would not assume that a person’s disability is the reason the person is coming to counseling. A participant mentioned the importance of “considering the fact that the disability is not the reason they are there. There are other things, regular life things that come into play.” Another person stated, “It’s not the very first thing you need to ask about. Assess what they are there for and if they bring it up, fine. But don’t make it an issue if they don’t feel it is one.” Two participants stated they would use the etiquette tips and person first language with clients. Two participants said they will treat people with disabilities like “normal” people. Other things participants said they would do is learn more about people with disabilities, not treat adults with disabilities like children, not make assumptions about the person, and not assume the person wants a cure for their impairment. A participant stated, “It has challenged some of my assumptions. Most of the time I like to think of myself as colorblind, and that I treat everyone the same. I’m wondering as a new counselor if someone came to me who has a disability, what would be my first human reaction or assumption.”

One participant who has a client with a disability plans to change the questions she was going to ask her client in their next therapy session. She said, “I’m already thinking about how much I am going to change things with the client I am working with now. The questions that I was planning on asking in the next session, I am not going to ask those.” The researcher felt it was significant that this one participant was planning to change the focus of the therapy session after receiving the training. This may indicate the training impacted her view of disability to a strong degree.

What Participants Think is Most Important for Counselors to Know about Disability

The last question asked participants to discuss, in one minute, what they would tell incoming counseling students about disability. Several new topics came up in the discussion about this question. Participants focused on how important it is for counselors to learn about people with disabilities. One participant stated, "I would say that it is a critical piece of the content of the program and they should also seek additional opportunities to learn more information." Each participant was able to identify at least one area that they felt was critical to a counseling program. The responses to this question indicated the participants truly believed it would be beneficial. Five participants stated they would encourage new students to learn about disability. One person said, "We have to learn about it because we are going to have clients who are going to be looking to us, so they don't have to be continually educating us, so we can get to the work of counseling." The following three recommendations were each brought up by four participants: (1) exploring their personal attitudes and stereotypes about disability, (2) viewing the clients' disability as a piece of the person, not the entire person, and (3) not assuming the disability is the presenting problem. The following three recommendations were each brought up by two participants: (1) acquiring knowledge about disability is a critical piece of counselor education training, (2) using person first language, and (3) not assuming a person wants a cure for a disability.

Conclusion

The research showed that the counseling students at the University of Wyoming knew little about disability culture. The participants indicated that they valued the material they learned by the comments made in the focus group discussions. This would indicate that incorporating disability content into counselor education programs would be well received by most students. The students were able to identify ways in which they could benefit from learning about this population. There are topics of disability that need further attention, especially information about cognitive impairments. Several professors in the counseling department have since mentioned that the students still bring up topics addressed in the training during their classes. This indicates to the researcher that the participants find the material applicable to their profession.

A one-hour training is not sufficient to teach counseling students all they need to know to adequately prepare for working with people with disabilities. It is important that these topics continue to be addressed in multiple courses and contexts within the program. Overall, the project seems to have made a positive contribution to the counseling students and the researchers hope this will continue in the program for years to come.

Sheri Ann Rawlings, LPC. Sheri received her Master of Science degree from the Department of Counselor Education from the University of Wyoming. She was a graduate assistant for the Wyoming Institute for Disabilities for two years. She is a mental health therapist at Peak Wellness Center in Cheyenne, Wyoming.

At the time of the study, **Terri Longhurst** worked at the University Of Wyoming, Wyoming Institute for Disabilities as the Associate Director of Disability Studies and the

Coordinator of Interdisciplinary Training. She is now the Executive Director of the Hospice of Laramie. She has a MS degree in Child Family and Consumer Sciences with an emphasis in Family Policy from the University of Wyoming and is currently completing her PhD in Educational Leadership, Renewal and Change at Colorado State University.

References

- American Counseling Association (2005). *Code of Ethics*. Retrieved from <http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx>
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders*, (4th ed., text rev.). Arlington, VA: American Psychiatric Association.
- Arokiasamy, C., Strohmer, D., & Guice, S. (1994). Effects of politically correct language and counselor skill level on perceptions of counselor credibility. *Rehabilitation Counseling Bulletin*, 34, 304-314.
- Barnes, C., & Mercer, G. (2001). Disability culture: Assimilation or Inclusion? In G. L. Albrecht, K. D. Seelman, & M. Bury (Eds.), *Handbook of disability studies* (pp. 515-534). Thousand Oaks, CA: Sage.
- Beecher, M., Rabe, R., & Wilder, L. (2004). Innovative practice: Practical guidelines for counseling students with disabilities. *Journal of College Counseling*, 7, 83-89.
- CACREP—Council for the Accreditation of Counseling and Related Educational Programs. (2001). *2001 Standards*. Retrieved from <http://www.cacrep.org/2001Standards.html>
- D'Andrea, M., Skouge, J., & Daniels, J. (2006). Life, liberty, and the pursuit of happiness: Expanding the multicultural-social justice family to include persons with disabilities. *Guidance & Counseling*, 21(2), 70-78.
- DePoy, E., & Gilson, S. F. (2004). *Rethinking disability: Principles for professional and social change*. Belmont, CA: Brooks/Cole – Thomson Learning.
- Eugenics. (n.d.). In *Dictionary.com Unabridged* (v 1.0.1). Retrieved from <http://dictionary.reference.com/browse/eugenics>
- Fishley, P. (1992). I am john. *Health and Social Work*, 17(2), 151-157.
- Korinek, L., & Prillaman, D. (1992). Counselors and exceptional students: Preparation versus practice. *Counselor Education and Supervision*, 32(1), 3-11.

- Mandel, J., & Shapiro, D. A. (Producers) & Rubin, H. A., & Shapiro, D. A. (Directors). (2005). *Murderball* [Motion picture]. United States: ThinkFilm.
- McEachern, A. (2003). School counselor preparation to meet the guidance needs of exceptional students: A national study. *Counselor Education and Supervision, 42*, 314-325.
- Mierendorf, M. (Director). (1996). *Without pity: A film about abilities* [Motion picture]. United States: HBO.
- Nathanson, R. (1979). Counseling persons with disabilities: Are the feelings, thoughts, and behaviors of helping professionals helpful? *The Personnel and Guidance Journal, 233-237*.
- Olkin, R. (1999). *What psychotherapists should know about disability*. New York: The Guilford Press.
- Parkinson, G. (2006). Counselors' attitudes towards disability equality training (DET). *British Journal of Guidance & Counseling, 34*(1), 93-105.
- Reeve, D. (2000). Student perspectives: Oppression within the counseling room. *Disability & Society, 15*(4), 669-682.
- Shapiro, J. (1994). *No pity: People with disabilities forging a new civil rights movement*. New York: Three Rivers Press.
- Smart, J., & Smart, D. (2006). Models of disability: Implications for the counseling profession. *Journal of Counseling & Development, 84*, 29-40.
- Swain, J., Griffiths, C., & Heyman, B. (2003). Towards a social model approach to counseling disabled clients. *British Journal of Guidance & Counseling, 31*(1), 137-152.
- Therapeutic abortion (n.d.). In *The American Heritage® Stedman's Medical Dictionary*. Retrieved from <http://dictionary.reference.com/browse/therapeutic-abortion>
- Waltrop, J., & Stern, M. (2003). *Disability status: 2000*. United States Census Bureau. Retrieved from <http://quickfacts.census.gov/qfd/states/56000.html>
- Ward, R., & Pointon, C. (2004). Thoughts on therapy and disability. *Counseling & Psychotherapy Journal, 15*(8), 18-20.
- Wyoming Institute for Disabilities (n.d.). *About WIND*. Retrieved from <http://wind.uwyo.edu/wind/about/about.asp>