A Guide to Cultural Competence in the Curriculum

Rehabilitation Counseling

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A GUIDE TO CULTURAL COMPETENCE IN THE CURRICULUM: Rehabilitation Counseling

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Preface

Purpose of this Guide

This curriculum guide has been prepared by the Center for International Rehabilitation Research Information and Exchange (CIRRIE) under a grant from the National Institute for Disability and Rehabilitation Research. Its purpose is to provide a resource that will assist faculty in rehabilitation counseling programs to integrate cultural competency education throughout their curriculum.

CIRRIE's current work with pre-service university training, complements previous CIRRIE publications designed primarily for in-service training, most notably a 12-volume monograph series, *The Rehabilitation Service Provider's Guide to the Cultures of the Foreign Born* (CIRRIE, 2001-2003), and *Culture and Disability: Providing Culturally Competent Services,* a book that summarized the series (Stone, 2005). Because of CIRRIE's funding mandate from the National Institute for Disability and Rehabilitation Research, its focus in the area of cultural competency is on the cultures of persons who have come to the US from other countries. Consequently, the primary focus of this guide is on the cultures of recent immigrant groups, rather than US-born persons. Cultural competency education should certainly address issues related to US-born minorities and Dr. Lee addresses her activities to both recent immigrants and US-born persons from a variety of cultural backgrounds.

Philosophy and Approach

This Guide is a curriculum guide. Its objective is to provide a resource to faculty who wish to include or strengthen cultural competency education in their program and courses. Certain limitations are inherent in all curriculum guides. While there are certain common elements or competencies in most professional programs, there are also variations among different institutions in how these are organized into specific courses. Moreover, even courses that have similar objectives may use different titles. We have attempted to provide material that could be included in most rehabilitation counseling programs, regardless of their specific curriculum structure. Its purpose is to enhance existing curriculum by making available to instructors resources, case studies, and activities. This material can be adapted by the instructor as needed, in courses that are specific to cultural competence, or infused into other courses in the curricula.

At the university level the CIRRIE approach to cultural competency education includes four main principles.

1. Integration of cultural competency into existing courses, rather than creation of new courses

Although the academic credentialing standards for programs in the rehabilitation professions now require cultural competence, the curricula of most programs are already overloaded. This makes it difficult to add new courses and as a consequence, content involving cultural competence usually becomes incorporated into existing courses retrospectively and in small doses. More importantly, a separate course on cultural competence can make the topic appear to students as isolated from the "real" set of professional skills that they are required to master. Students may consider it an interesting topic but one of little practical importance. Moreover, by

separating cultural competence from courses that develop practice skills, it becomes abstract and difficult to relate to practice.

Another reason for integrating cultural competence into existing courses is that students have an opportunity to see its implications and apply its principles in a variety of contexts. They also see that it is not just a special interest of one faculty member but an integral part of many aspects of their future practice that is supported and embraced by all faculty. When it reappears in their coursework each semester, their knowledge, attitudes, and skills in this area develop and deepen. The CIRRIE curriculum development effort has identified specific types of courses in the rehabilitation counseling curriculum where cultural competence may be most relevant, and we have identified or developed activities and materials that are appropriate across the curriculum.

2. Development of cultural competence education that is profession-specific, rather than generic

CIRRIE's prior experience with providing cultural competency workshops for in-service training strongly suggests that an off-the-shelf generic approach is less effective than training that is specific to the profession in which the competence is to be applied. Generic training must be understandable by all rehabilitation professions, so examples, terminology, and concepts that are specific to one profession must be avoided. As a result, cultural competence becomes more abstract. With profession-specific training, students are better able to see the relevance and applicability to their profession, not as something outside its mainstream. Consequently, CIRRIE's approach is to work with faculty from each profession to analyze their curriculum and incorporate cultural competence into it in ways that seem most relevant to that profession.

3. Multi-disciplinary case studies

Although CIRRIE's general approach is profession-specific, we have found that studies developed in one program can sometimes be adapted for use in other programs. For example, a case scenario developed for a course in rehabilitation counseling may be useful in courses in occupational therapy, physical therapy, or speech therapy. The general facts of the case may be presented to students from each program, but many of the problems, questions and assignments related to the case may be different for each of the professions. The use of common case studies provides an opportunity to analyze cultural factors from a multi-disciplinary perspective, which is often the type of setting in which rehabilitation is practiced.

4. *Making materials available to instructors*

Most instructors realize the need for the infusion of culture into their curricula, but they may be reticent to incorporate culture into their courses if the burden of creating new materials is added to their normal course preparation. CIRRIE has approached this dilemma through specific strategies to allow instructors easy access to cultural content. Hence this guide was written. These materials are also available online at http://cirrie.buffalo.edu/curriculum/. The website was created to organize cultural materials into inter-disciplinary and discipline-specific assignments, case studies, lectures, reference materials, and classroom activities. This information will be expanded and revised based on feedback from users in universities nation-wide.

How to Use this Guide

Curriculum committees and other faculty groups may wish to consult this guide to examine the ways that cultural competency can be infused across a curriculum and identify ways in which this approach may be adapted to the specific context of their program.

Individual course instructors can identify the sections of this guide that relate most closely to the courses they teach. They can then see how others have included cultural competency in such courses. The resources that are suggested in the guide may be seen as a menu from which instructors can select those that fit their course and their teaching style.

Prior to the main portion of this guide that pertains specifically to rehabilitation counseling, we have included a section that presents suggestions and resources that are generic in nature and could be used in any of the programs.

We hope that this guide will be useful to those who are committed to strengthening this aspect of our professional programs in rehabilitation. We also understand that many institutions have created or identified resources that are not found in this guide. We welcome your comments and suggestions to increase the usefulness of future versions of this guide.

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Mary Matteliano, PhD, OTR/L, is a clinical assistant professor in the Department of Rehabilitation Science at the University at Buffalo. She has her BS and MS in Occupational Therapy and a PhD in Sociology. Additionally, she has over 20 years of rehabilitation experience in the area of adult physical disabilities. She is the project director for "Cultural Competence in the Curriculum" a NIDRR funded project through the Center for International Rehabilitation Research Information and Exchange (CIRRIE). Dr. Matteliano has also participated in and co-directed the study abroad program, Health in Brazil, in 2004, 2006 and again in 2009. Her research explores the provision of culturally competent health care services to individuals from underserved groups.

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While the purpose of the primary author is to gather and collate information in the field of rehabilitation counseling and multiculturalism, I would like to acknowledge several colleagues who are expert researchers and educators in multiculturalism, rehabilitation counseling and counseling psychology, Dr. Edil Torres Rivera, Dr. Amy Reynolds, Dr. Melody Schobert, Dr. Nanzhang Hampton, and Dr. Charles Degeneffe for their expertise and willingness to share their valuable resources with me.

Part I: Transdisciplinary Instruction for Cultural Competence

Mary A Matteliano, PhD, OTR/L, Project Director of Culture in the Curriculum, CIRRIE

Introduction

Rehabilitation services for persons with disabilities are provided in a variety of settings including medical facilities, schools, and the community. The recipients of these services are referred to as patients, students, clients, and consumers, depending on the setting. Henceforth, for the purpose of this guide, we will refer to the recipients of services as clients and students. In all settings, the team approach is valued, and the client or student benefits when each discipline is able to focus on its area of expertise in a collaborative manner. It is not unusual for clients or students to receive therapy from a variety of professionals during their course of treatment. In fact, a client or student may receive some combination of occupational therapy, physical therapy, rehabilitation counseling, and speech-language therapy simultaneously. Additionally, rehabilitation professionals frequently request consultations from other professionals and ask for another discipline's involvement in a case. As a result of these frequent interactions among rehabilitation professionals, a team approach develops in which each provider recognizes and often supplements the unique role of other professionals. Likewise, rehabilitation professionals learn from each other in these settings and are provided with opportunities to appreciate their commonalities. Therefore, it seems fitting that CIRRIE create not only guides that are discipline specific, but also transdisciplinary, containing foundational information for use in all four programs. By providing general content, the expressed needs for cultural competence education can be transferred across rehabilitation programs and serve to unify this intent. With this in mind, the transdisciplinary section of this guide was written to provide an introduction to cultural competence instruction for occupational therapy, physical therapy, rehabilitation counseling, and speech-language therapy programs.

Rehabilitation disciplines use various frameworks and models of service provision that are specific to their practice. A conceptual framework that shows utility for all rehabilitation programs is the International Classification of Functioning, Disability and Health (ICF) (World Health Organization [WHO], 2001). The ICF can be used by rehabilitation professionals to organize and identify relevant domains for assessment, treatment, and evaluation of outcomes (Reed et al., 2005; Rentsch et al., 2003). It also provides a common language for health care providers, thereby enhancing communication among disciplines (Rentsch et al., 2003). By examining the ICF and its classification system, we can further understand the areas of concern that impact the provision of culturally competent rehabilitation services. The ICF guides rehabilitation specialists in the assessment process by providing a framework that addresses client or student needs beyond the impairment level, thus establishing their capacity to perform within the natural environment (American Occupational Therapy Association, 2002). Contextual considerations, the external or internal influences on the client or student, impact the rehabilitation process and must be addressed. For example, external contextual influences may include the individual's immediate environment as well as cultural and societal influences. Internal influences are more personal in nature and include the individual's gender, race, ethnicity, and educational level, among others (WHO, 2001). It is useful for us to use the ICF as a framework that addresses individuals' performance capacity within the context of their

personal and external environment. By understanding this, rehabilitation professionals will improve their ability to address the influence of culture on client or student performance. In the next section we will examine a model that will be used to specifically guide the infusion of cultural competence into the curriculum for rehabilitation programs.

Although there are several models to choose from that can be used to guide curriculum planning, we have chosen the *Campinha-Bacote* model as a guide for teaching cultural competency to students who are enrolled in rehabilitation programs (Campinha-Bacote, 2002). According to this model, achieving cultural competence is a developmental process, not a onetime event. The *Campinha-Bacote* model (2002) consists of five constructs: (1) cultural awareness, (2) cultural knowledge, (3) cultural skill, (4) cultural encounters, and (5) cultural desire. These constructs are intertwined; cultural desire is the foundation of this process and provides the energy that is needed to persevere on this journey (Campinha-Bacote, 2002). Cultural awareness, the ability to understand one's own culture and perspective as well as stereotypes and misconceptions regarding other cultures, is a first step (Campinha-Bacote, 2002; Hunt & Swiggum, 2007). The development of cultural knowledge can be introduced and explored throughout the curriculum, both in courses that are general as well as courses that teach specific therapeutic skills. Cultural skills, the ability to evaluate a client or student and develop a treatment plan, build on the foundations of cultural awareness and knowledge. Courses that emphasize clinical and educational skills can be used to help students develop a skill set that will address the unique needs of the individual. Cultural encounters can be dispersed throughout the curriculum, with the emphasis on the application of practice skills, as the student advances in the program.

Implementation of the Campina-Bacote Model into Curriculum Design

The next section of the guide is organized into five objectives that reflect the Campinha-Bacote model for achieving cultural competency. The objectives are further divided into specific goals along with suggestions, activities, and resources to achieve the stated objective.

Objective 1: Students will Improve their Cultural Awareness

1a. Students will demonstrate the ability to examine and explore one's own culture (including family background and professional program).

1b. Students will identify stereotypes, biases, and belief and value systems that are representative of the dominant culture in the United States.

1c. Students will demonstrate an understanding of how one's own biases and belief system may subtly influence the provision of rehabilitation or educational services and lead to cultural imposition.

In our experience, we have found that courses that emphasize communication and therapeutic interaction offer opportunities for exploration and understanding of one's own culture. These courses are usually taught to students prior to acceptance into a professional program or during the first year. These introductory courses will sensitize students by providing information that promotes cultural awareness and knowledge, although a comprehensive program should emphasize a continuum of cultural competence that is threaded throughout the curriculum

(Campinha-Bacote, 2002; Kripaiani, Bussey-Jones, Katz, & Genao, 2006). Assignments that are specific to cultural awareness may include a class exercise in which students write about their own ethnicity/racial background. This leads to a class discussion about cultural awareness, stereotyping, and variations among cultures. Several exercises may be used within and outside of the classroom to assist students in improving their cultural awareness. They may be worked on independently or in small groups. Examples of classroom activities that may be adapted depending on the program are included in Appendix A.

Students may benefit from taking the "Implicit Association Tests" online and discussing the results in class. Project Implicit is a collaborative research effort among researchers from Harvard University, University of Virginia, and the University of Washington. There are several exercises offered on this website, and the general purpose is to elicit thoughts and feelings that are outside of our conscious control. Those who participate in these exercises are provided with a safe and secure virtual environment in which to explore their feelings, attitudes, and preferences toward ethnic groups, race, and religion. The outcome of this exercise is for students to understand that they may have an unconscious preference for a specific race, skin tone, religious group, or ethnic group. Students are provided with the opportunity to understand innate and unconscious attitudes that might influence their decision making ability in a rehabilitation setting. Refer to Appendix B for the Project Implicit (2007) website.

The Village of 100 activity takes about 10 minutes to complete and will also lead into some good classroom discussion (Meadows, 2005). Students must imagine that if the Earth's population was shrunk to 100 persons what the representation of certain racial/ethnic groups would be like in areas that include religious representation, sexual orientation, literacy, wealth, education, and living conditions. Many students are not aware of the privilege they have experienced by living in the US and are enlightened once they examine the rates of poverty and general deprivation that are experienced by the global community. Again see Appendix B for the Village of 100 website.

Many readers may already be familiar with the body ritual among the Nacirema vignette, but we have found that it continues to facilitate self-reflection among students (American Anthropological Association, 1956). Nacirema is American spelled backwards, and this narrative describes the daily rituals of American life from an outsider's perspective. Many of our commonly accepted practices seem very strange when seen through an outsider's lens. The purpose of this exercise is to help students understand that although the customs and rituals of persons from other cultures may seem strange, our customs and rituals may also appear odd. Bonder, Martin and Miracle (2002) have concluded that an ethnographic approach, such as the one used in the Nacirema vignette, helps students to gain a different perspective on their culture. Appendix B details information on the Nacirema website.

Self-assessment questionnaires and surveys encourage student self-reflection and lead to group discussions and the development of cultural awareness, cultural sensitivity, and appreciation for diversity (Spence-Cagle, 2006). Several activities that enhance student self-awareness include the *Self-test Questionnaire*: *Assessing Transcultural Communication Goals*, the *Cultural Values Questionnaire* (Luckman, 2000) and the *Multicultural Sensitivity Scale* (MSS) (Jibaia, Sebastian, Kingery, & Holcomb, 2000) (Appendix C). *The Self-test*

Questionnaire, Assessing Transcultural Communication Goals, was developed to help students understand their knowledge and comfort level with various individuals and groups that reside in the US. Some examples of groups that are represented on this self-test are: Native Americans, Mexican Americans, prostitutes, the elderly, and persons with cancer. The objective of the self-test is to facilitate discussion and develop insight among students on their preferences and knowledge about persons who are different from themselves.

The *Cultural Values Questionnaire* asks students to rate their agreement with a series of statements. Some of the statements demonstrate values that reflect mainstream society in the US including timeliness, stoicism, individuality, while other statements reflect values that might be preferred by societies that value interdependence over independence. This exercise can be used to facilitate discussion among students on values that may be preferred by the rehabilitation provider. Students can develop strategies that tailor rehabilitation programs for persons whose values are different from the provider or the institutions that provide services.

The *Multicultural Sensitivity Scale* consists of 21 statements, and students rate their agreement with the statements on a scale of one to six. The statements ask students to rate their comfort level and willingness to accept various cultures that are different from their own. This scale can be taken on an individual basis and then used to enhance classroom discussion on students' ability to accept, interact, and feel comfortable with clients or students who are from diverse backgrounds.

Objective 2: Improve Student Knowledge of Diverse Cultures and Practices

2a. Students will understand various health, education, and disability belief systems and practices.

2b. Students will familiarize themselves with disability prevalence and risk factors among different racial/ethnic groups.

2c. Students will understand and identify racial and ethnic disparities in rehabilitation and educational services in the United States.

2d. Students will recognize and understand various cultural worldviews and disability beliefs and explanatory models.

2e. Students will identify instances when religious or traditional views may influence the client's participation in rehabilitation and educational regimens.

After general and self-awareness exercises, students can progress to the development of knowledge about other cultures. Encounters in non-traditional settings offer opportunities for students to try out new skills with clients from diverse cultures with guidance and feedback from their instructors (Luckman, 2000; Parnell & Paulanka, 2003). Students may increase their knowledge about different cultures by visiting ethnically diverse neighborhoods, exploring ethnic supermarkets and restaurants, attending religious services that are different from their own religious backgrounds, and observing programs in ethnically and racially diverse neighborhood community centers (Jeffreys, 2006; Luckman, 2000; Hunt & Swiggum, 2007). These

introductory observational opportunities should be set-up as non-threatening encounters that lead to self-reflection through written assignments and group discussions (Hunt & Swiggum, 2007). A by-product of this self-reflective process is the development of an appreciation for ethnic diversity, religious practices, food preferences, family values, health beliefs, and neighborhood community programs (Griswold, Zayas, Kernan, & Wagner, 2007). Furthermore, encounters in ethnically and racially diverse settings allow students to develop confidence when encountering clients from diverse backgrounds (Hunt & Swiggum, 2007). However, both the instructor and students must keep in mind that one or two visits to a "different" neighborhood merely introduces students to the most obvious aspects of a cultural community. Only living and interacting with members of a community on a daily or long term basis truly opens students to a culture.

The acquisition of knowledge about specific cultures can be approached in several ways. Students can access the Center for International Rehabilitation Research Information and Exchange (CIRRIE) on-line monograph series (CIRRIE, 2003). The monographs focus on the top eleven countries of origin of the foreign-born population in the US, according to the US Census Bureau: Mexico, China, Philippines, India, Vietnam, Dominican Republic, Korea, El Salvador, Jamaica, Haiti, and Cuba. There is an additional monograph on the Muslim perspective. Assignments can be provided using a case study format with the monograph series as a resource.

Prior to clinical encounters, the use of case studies is also helpful in developing clinical decision making, self-reflection, and examining ethical dilemmas (Spence-Cagle, 2006). The case study format has been used to help students process, problem-solve, and apply strategies that will enhance their knowledge of culturally competent service (Lattanzi & Purnell, 2006). Therefore, case studies encourage the examination of the professional's explanatory model and clients' explanation of their illness experience. Explanatory models are the perceptions and beliefs that rehabilitation providers, clients, students, and their families construct about illness and disability (Kleinman, 1988; McElroy & Jezewski, 2000). They are cognitive and emotional responses based on cultural experiences (Kleinman, 1988). Therefore, explanatory models are not always transparently logical, and if the rehabilitation provider's communication skills are based on their own perspective, the client or student may experience discrimination. In addition, through the case study format, students can be encouraged to develop *culture-brokering* skills that further expand their appreciation of various belief systems (Kleinman, 1988; Jezewski & Sotnik, 2005). Examples of case studies and case scenario assignments, that are applicable across disciplines, are found in Appendix D.

We refer to the *culture-brokering* model in this guide because it has been shown to be useful in training rehabilitation personnel in identifying and devising solutions for culturally related problems. The *culture-brokering* model was adapted by CIRRIE for rehabilitation systems, and a training workshop was designed based on the model (Jezewski & Sotnick, 2005). The model has three stages: (1) problem identification, (2) intervention strategies, and (3) outcomes. *Problem identification* includes a perception of a conflict or breakdown in communication. *Intervention strategies* include establishing trust and rapport and maintaining connections. Stage three is *evaluating outcomes*, both successful or unsuccessful. Success is achieved if connections are established between consumers and the rehabilitation system, as well as across systems. What

makes this brokering model a *culture-brokering* model is a fourth component, *Intervening Conditions.* These are culturally based factors that must be considered at all three stages: analyzing the problem, devising appropriate strategies, and evaluating outcomes. The intervening conditions include a variety of factors including type of disability, communication, age of the client or student, cultural sensitivity, time, cultural background, power or powerlessness, economics, bureaucracy, politics, network, and stigma. The model is not a set of rules or steps to follow. Rather, it is a conceptual framework that can guide the service provider in analyzing problems and devising culturally appropriate solutions. For a more detailed description of this *culture-brokering* model, including its applications to case studies, see Jezewski and Sotnick (2005).

When implementing the culture-brokering model, students must understand that health and education seeking behaviors are shaped by the individual's cultural context, and most cultural groups are heterogeneous (Rorie, Pain & Barger, 1996; Menjívar, 2006). Caution within training programs should be exercised. Knowledge of various cultures and their practices, if not considered within the context of individuals and their unique circumstances, can result in destructive stereotyping. Stereotypes that are associated with particular cultures may affect the provision of rehabilitation services in adverse ways. Therefore, although knowledge of cultures is important, students must refrain from stereotyping and be aware constantly of the heterogeneity of persons within cultural groups (Campinha-Bacote, 2002; Juckett, 2005). There are many reasons for intra-cultural variations including the individual's level of education, socioeconomic status, reasons for immigration, and regional and local differences within the country of origin. In addition, the process of immigration is complex. Immigration may be voluntary, or it may be a decision based on persecution or economic hardship. This affects the immigrant's ability to improve social status and assimilate into a new culture. Assimilation is also affected by the human, cultural, social, and economic capital that accompanies the immigrant into the destination country (Alba & Nee, 2003).

Objective 3: Improve the Student's Skill in the Assessment of Clients from Diverse Cultures and Practices

3a. The student will learn to determine client and student needs within the context of their culture.

3b. The student will become familiar with and demonstrate the use of assessments that respect and explore client and student culture and the impact it has on their disability.

3c. The student will identify culturally biased assessments and demonstrate the ability to modify or adapt the assessment to fit client and student needs.

3d. The student will utilize the client's family and/or extended family in the assessment process, if designated by the client or student.

3e. The student will demonstrate the ability to use a professional interpreter in the evaluation process.

Students' ability to develop cultural skill depends on the first two constructs that were explored, awareness and knowledge. Skill development overlaps with practice and cultural encounters. Students in rehabilitation professions must understand how to use the interview process to formulate relevant treatment options for their client. Students must then be provided with clinical encounters that allow for the development of skill when working with clients or students from diverse cultures (Campinha-Bacote, 2002). Neighborhood community centers, schools, and adult day care facilities are several examples of potential sites that may offer diversity and contribute to students' fieldwork experiences (Griswold et al., 2007; Hunt & Swiggum, 2007). Through observations and clinical encounters, students develop and expand on their interviewing techniques, including the use of interpreters, the ability to become flexible with traditional assessment procedures, and an appreciation for the client's narrative (Hunt & Swiggum, 2007). The personal narrative, listening to clients or students tell their story, is best learned through clinical encounters (Griswold et al., 2007; Kripaiani et al., 2006). Students must learn when to leave aside traditional assessment procedures and encourage interviewees to describe their illness experience in their own words (Griswold et al., 2007; Kleinman, 1997). The person's view of disability does not necessarily surface when using standardized assessments that are popular among professionals (Ayonrinde, 2003; Becker, Beyene, Newsom, & Rodgers, 1998). Another approach is to adapt current assessment/evaluation methods and identify culturally relevant assessments within each rehabilitation field.

To understand the participant's perception of disability, interviewers can use a semi-structured format that incorporates the ethnographic principles of open ended questions (Babbie, 2004). Changes and adaptations can be made to the interview questions, according to the interviewee's responses. This format may facilitate the emergence of the interviewee's personal story. Students may also use a modified version of Kleinman's eight questions and incorporate this into their interview schedule. The questions may help providers understand clients by asking for a description of what their disability means to them (Kleinman, Eisenberg & Good, 1978). Caution should be used when incorporating these questions into the interview schedule since some individuals may not choose to discuss their disability experience in this manner. See Appendix E for Kleinman's eight questions.

There are many factors that should be considered by rehabilitation providers in culturally diverse settings, and a number of these should be elaborated on and examined in depth in the academic setting. Examples are:

- Cultures vary on their expectation of formality in clinical situations. For example, Asian Americans may be more formal, especially elders (Liu, 2005; Wells & Black, 2000). Thus, clinical encounters should reflect this style of interaction.

- Some cultural groups communicate in ways that are different from the direct style of communication favored by Americans. For example, some cultures communicate in a less direct manner and rely on the context and subtleties in style to get their message across (Jezewski & Sotnik, 2005).

- Many Latin and Middle Eastern cultures do not value time in the same way as Americans. They may prioritize personal commitments over time commitments in business encounters or in adherence to clinical appointments (Sotnik & Jezewski, 2005).

- Some cultures, for example those of the Middle East, expect long greetings and inquiries about family members and their states of health. They may also expect offerings of food and drink (Ahmad, Alsharif, & Royeen, 2006).

- The assistance of an interpreter should be used to facilitate communication; however, family members should not be used in this role, if possible. The dual role of family member and interpreter may cause conflict, and valuable information may be omitted (Dyck, 1992). Clinicians must become familiar with techniques on how to use an interpreter and seek interpreters who are well-trained and artful in the subtle negotiation process between client and provider (Ayonrinde, 2003).

- In some cultures, such as the Hmong, a husband or oldest son will make decisions for all members of the clan. The individual's wishes are deferred to a designated member in the clan (Leonard & Plotnikoff, 2000). Thus, it is important to ascertain who is the primary decision maker in the family and enlist his or her help in the diagnostic and rehabilitation process.

- All clients have a history prior to their disability. Providers must balance clients' history, present condition, and potential for the future. This process is best accomplished through the dual contributions of provider and client (Fleming, 1991).

- Certain occupations and daily activities may be defined in ways that are not familiar to the provider. For example, some cultures prioritize certain daily activities (e.g. hygiene, dressing, and eating) whereas others do not (Zemke & Clark, 1996).

- Assessment tools that evaluate individual differences and preferences, including the personal narrative, should be included in the rehabilitation process (Clark, 1993).

Objective 4: Improve the Student's Ability to Develop Treatment Plans for Clients and Students from Diverse Cultures

4a. Students will apply previously learned knowledge and skills to develop culturally competent treatment plans in medical, educational, and neighborhood community settings.

4b. Students will utilize the "Culture Brokering Model" to recognize and identify conflict that is a result of cultural beliefs and values.

4c. Students will demonstrate the ability to use strategies that result in better rehabilitation and educational services for clients and students.

4d. Students will demonstrate advocacy skills for those groups that are underrepresented in the rehabilitation and educational systems and will negotiate and network among providers to assist clients and students in achieving adequate services.

Cultural encounters allow students to apply classroom knowledge and techniques into real world settings. Students gain knowledge about different cultural backgrounds and achieve skill by learning verbal and non-verbal communication techniques. Effective learning is developed through experiences that help students become self-aware and appreciate cultural differences, thus developing acceptance and advocacy (Jeffreys, 2006). Just as students in health related curricula must fulfill fieldwork requirements to ensure that they are competent practitioners, they should also be provided with opportunities to demonstrate competence with culturally specific interactions. Provision of opportunities to gain exposure to various cultural and ethnic groups can be dispersed throughout the curriculum, at many different levels (Kripaiani et al., 2006). The progression may start with encounters that are mostly observational and progress to interactions that require formulating a plan of action, a treatment plan, or a community-based intervention. Our students have performed service work and implemented programs at refugee centers, neighborhood youth programs, international institutions, and community after school programs. As students progress through the curriculum, their cultural encounters will reflect their acquisition of cultural competence skills (Campinha-Bacote, 2002; Griswold et al., 2007; Hunt & Swiggum, 2007).

Contextual considerations that include the individual's process of immigration and assimilation should be incorporated into the assessment process. Several situations that are a result of immigration may impede rehabilitation. Therefore, students should pay attention to such factors as the disruption of family support systems and social networks, post-traumatic disorders experienced by asylum seekers and refugees, and the withholding of information that characterizes undocumented immigrants' worry about deportation (Ayonrinde, 2003). The *Culture-brokering* model (Jezewski & Sotnik, 2005) can be used to demonstrate to students that treatment planning is a process of negotiation. This problem solving model will help students recognize and identify problems related to cultural preferences or beliefs, facilitate conflict resolution through the process of negotiation and mediation, and better prepare them to advocate and network on the client's behalf.

Objective 5: Students will Develop the Desire for Cultural Competency and Understand that It is a Life-Long Process

5a. Students will develop and demonstrate the ability to empathize and care for clients and students from diverse racial/ethnic groups.

5b. Students will demonstrate flexibility, responsiveness with others, and the willingness to learn from others.

5c. Students will exhibit "cultural humility," the ability to regard clients and students as cultural informants.

By using the Campinha-Bacote Model, it is hoped that students will develop the final construct of this model, Cultural Desire. “It has been said that people don’t care how much you know, until they first know how much you care” (Campinha-Bacote, 2002, p. 182-183). Cultural desire is a result of successful cultural encounters. Successful cultural encounters are the result of good preparation and the support and guidance offered to the student throughout the process. The student should understand that this is a life-long pursuit for the professional who has a true desire to practice in a culturally responsive manner.

Griswold et al. (2007) discuss the development of empathy and cultural humility among medical students who have participated in refugee clinics. During an encounter with an elderly Vietnamese woman, a medical student tossed his checklist aside as the patient began to cry and tell him about the loss of her family members. The student discusses a transformation in his approach: “…I was going through the checklist…as she started to cry it shook me…I stopped the interview…as the empathy kicked in, the checklist started to fall out of my head” (Griswold et al., 2007, p.59). Students may find interviews particularly challenging with persons who have suffered grave personal loss or who have been victims of torture. They may at first meet failure because they are unable to show openness and flexibility during the initial assessment. Since these encounters may be difficult, they will need to be provided with opportunities to debrief and discuss their cases with instructors and other students. Opportunities for self-reflection regarding their feelings, as well as the needs of their clients, should be encouraged by their instructors (Griswold et al., 2007). Self efficacy, the belief that one can achieve competence in areas of practice, motivates students to overcome obstacles and embrace the learning experience (Jeffreys, 2006). It is our goal that the outgrowth of these exercises will provide students with positive cultural experiences that improve their confidence, engage their interest, develop their ability to empathize, and result in the desire to provide culturally responsive rehabilitation services across settings.

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Appendix A: Cultural Competence Classroom Activities

Many of these activities involve encouraging students to meet and interact with individuals from diverse backgrounds. While the experience is important, it is the opportunity to reflect upon the interactions and perceptions that will heighten cultural awareness. Reflection can be encouraged through journal writing, class discussion and debates, and role playing.

Activities

a**. Who Am I?** Students begin the process of cultural awareness by exploring their own backgrounds. **Student Assignment:** Investigate your own cultural background. Try going back three generations. Make a genealogical map of your ancestors including their country of origin, family, language(s) spoken, religion, education, occupation, and beliefs regarding health/disease, disability, and education. Be prepared to discuss how you obtained your biographies, from whom, and the information that was omitted or obscure. Other areas that define the culture may be included such as family roles and rules, family support networks, music, food preferences and eating styles, entertainment, clothing, child rearing practices. Think about and be prepared to discuss how cultural influences have been maintained, changed, or have disappeared across generations.

b**. Story Teller.** Ask students to interview someone in their own family who is an especially good story teller about family life. **Student Assignment:** Interview an individual in your family who has a repertoire of family stories. Record the story(ies) he or she tells about your family's history. What is the story about, and what does it reveal about your cultural, ethnic, linguistic, religious, and racial background? What did you learn from this interview that you did or did not know about your history? Ideally, this story telling activity should be audio/video taped so that it can be presented to the class.

c**. Pix Share**. Visual history helps students understand their cultural background. Ask students to share pictures of their family and the area in which they have lived most of their life. **Student Assignment:** Find family pictures across generations, if possible. Discuss how these pictures reveal your cultural, ethnic, linguistic, religious, racial background, and living environments. What did you learn from these pictures that you did not know about your family? To whom did you go for the pictures and information about their content? Discuss how the pictures are similar or different across class members.

d**. Family Differences.** Have students discuss how their own views on cultural issues such as family, religion, health, education, and disability differ from that of their parents or grandparents. **Student Assignment:** What are your family's views on family, religion, health, education, and disability? Compare your views on these topics with that of your parents and grandparents. Also discuss family perceptions of disability especially if there is a family member who has a disability. What rehabilitation services did the family and individual access and to what success? How does your the family view disability and rehabilitation services?

e**. I See My Community.** Ask students to make a video tape of what they think best represents their individual cultural background in their home community. **Student Assignment:** Prepare a video and audio presentation that illustrates what you think is important about your community. Topics might include description of your physical and social neighborhood, education and health care options, transportation, language(s) spoken, icons that represent the community, arts, schools, and assets and problems. Compare and contrast the presentations across students.

f**. New Arrival.** Have students interview someone who has recently immigrated to the US from another country. If the individual does not speak or has limited ability in English, students should use an interpreter. Keep in mind that these are sensitive topics and not all recent immigrants may want to discuss them. Only students who are especially sensitive and grounded in cultural issues should do this assignment. **Student Assignment:** Interview a recent immigrant to the US on topics related to why the individual came to the US, the process and problems in coming, similarities and differences between the old and new communities in which the individual lives, and views on healthcare, education, and disability. Another important topic is the meaning and structure of family in the culture. If the immigrant does not speak English, you may need to work with an interpreter. Class discussion should also focus on several issues including (a) how the interviewer felt working with an interpreter, (b) problems in doing the interview, and (c) belief systems that emerged regarding health, education, and disability. This interview might be repeated with someone who immigrated 10+ years ago to determine how time in the US influenced perceptions of health, education, and disability.

g. **Exchange.** Discuss the experiences students have had to open them to other cultures; e.g. travel, having an exchange student in their home or high school, and living or working with students from other countries. **Student Assignment:** Through what experiences have you opened yourself to other cultures? Describe these. What did you personally gain from traveling throughout the US or other countries or interacting with an exchange student? What issues did you face when you spent time in another country and culture? How did these issues change over time? How do you maintain contact with persons you met from another country? Compare your perceptions from before the cultural exchange, during, and now. How have your perceptions changed?

h. **Getting to Know You.** Encourage students to "get to know" someone from a different culture during the semester and keep a journal about the experience. Remember that visiting another community for a shopping experience will not fulfill the goal of this assignment. **Student Assignment:** Ask a fellow student from another culture if you might spend some time with him or her at home. Immerse yourself in another culture by participating in family and community activities, shopping in the community, and attending church, celebration, or other activities that represent the culture. You might also tutor or mentor a student from a diverse background and discuss this experience. What did you learn about the culture? What experiences were most revealing to you? How do you think you were perceived as a visitor to the community? What will you do to maintain contact with the individuals you met for this assignment?

i. **Cultural Conflict**. Another topic for discussion is cultural conflict. Ask students what cultural conflicts occur in their community and why. **Student Assignment:** What can be done to diminish or erase cultural conflicts? Discuss how media such as television, radio, and other

entertainment venues reflect general American culture and how this is interpreted in various cultures in the US as well as around the world.

j. **Community Visits.** Have students visit a school and a hospital that are comprised primarily of those from diverse backgrounds. **Student Assignment:** Visit a school, hospital, or other agency that delivers rehabilitation services to children and/or adults who are from diverse backgrounds. Discuss how the facility reflects various cultural backgrounds – e.g. staff, language, type and style of delivery of services or classes, inclusion of family, programming, architecture and design, etc. What differences in quality of health care and educational services are apparent?

k. **Continuing Education Possibilities.** Rehabilitation students need to realize that cultural competence is a "profession-long" process. **Student Assignment:** How can rehabilitation specialists increase or improve their cultural competency once they have completed their professional degrees? What types of continuing education programs are available through local, state, or national professional organizations? What other venues are available for continuing education regarding multicultural issues?

l. **Multicultural Preparation.** Caseloads in all types of rehabilitation settings reflect an increase in clients from diverse backgrounds. **Student Assignment:** Interview a variety of rehabilitation professionals who work with multicultural populations on their caseloads regarding their academic and clinical preparation for this type of client. How well prepared were they and what have they done post graduation to improve their cultural competency? What suggestions on cultural diversity do they have for clinicians entering today's profession?

Appendix B: Website Resources

Center for International Rehabilitation Research and Information Exchange (CIRRIE) monographs:
http://cirrie.buffalo.edu/monographs/index.html

The Project Implicit (2007) website:
https://implicit.harvard.edu/implicit/demo/selectatest.jsp

State of the Village Report website:
http://www.sustainer.org/dhm_archive/index.php?display_article=vn338villageed

Nacirema website:
http://en.wikisource.org/wiki/Body_Ritual_among_the_Nacirema

Appendix C: Self -Tests and Questionnaires

The reader may refer to the CIRRIE Cultural Competence Website http://cirrie.buffalo.edu/curriculum/activities/index.html for information on the following questionnaires and resources:

- *Self-test Questionnaire: Assessing your Transcultural Communication Goals and Basic Knowledge*
  Reprinted with permission from: Randall-David, E., (1989). *Strategies for working with culturally diverse communities and clients.* Association for the Care of Children's Health (ACCH), Bethesda MD.

- *Cultural Values Questionnaire*
  Thiederman, S. B. (1986). Ethnocentrism: A barrier to effective health care. *Nurse Practitioner, 11*(8), 52-59.

- *Muticultural Sensitivity Scale*
  Reprinted with permission from: Jibaja, M. L., Sebastian, R., Kingery, P., & Holcomb, J. D. (2000). The multicultural sensitivity of physician assistant students. *Journal of Allied Health, 29*(2), 79-85.

- Classroom Activities: *Cultural Visit, Observation Visit, and Participant Observation Visit.*
  Adapted with permission from: Luckman, J. (2000). *Transcultural communication in healthcare.* Albany: Delmar Thompson Learning.

Appendix D: Case Studies

The following case studies are designed for students and readers across disciplines. One is specific to one or two professions (Study 1), some are designed for all disciplines (Study 2 and 4), and one is specific to speech-language pathology (Study 3). The case studies also differ in their design; some providing more detailed backgrounds (Study 2 and 3), others more study questions and cultural information (Study 2 and 4). Pseudonyms are used in all cases.

Case Study #1 for PT and OT: Middle Eastern Low Back Pain Patient

Background

Farideh Daei (*pseudonym*) is a 25 year old woman from Iran. Her physician has recommended a consult for physical therapy for low back pain. During the initial evaluation, Mr. Daei, her husband, answered all the questions directed to Farideh. When asked to rate her pain on a scale of one to ten, the husband answered, "I really don't think her pain is that bad, you can give her a three." The wife compliantly allowed her husband to answer all questions. The PT attempted a physical assessment of the back but had to limit her examination due to Farideh's reluctance to disrobe. The PT was upset after the initial evaluation and was not sure how to go about helping her client's back pain because she was unable to conduct a standard evaluation.

The physical therapist recommended a home assessment by an occupational therapist because Farideh has two children that she picks up and carries, a 2 year old and a 5 month old baby. The OT scheduled a visit to observe Farideh carry out her daily routine and made some suggestions for modifying her child care activities to protect her back. When the OT arrived at the house, she was surprised to find Mr. Daei home. He did not allow the OT any time alone with his wife and answered all questions. The OT found the situation disconcerting since she had to go through a third party in order to understand her client's daily routine. She did not feel she was able to truly assess her client's situation although she was able to show Farideh how to wrap the baby in a sling close to her body when carrying the infant. Farideh and Mr. Daei seemed agreeable to this modification.

Student Reading

Ahmad, O. S., Alsharif, N. Z., & Royeen, M. (2006). Arab Americans. In M. Royeen & J. L. Crabtree (Eds.), *Culture in rehabilitation* (pp. 181-202). Upper Saddle River, NJ: Pearson Education Inc.

Hasnain, R., Shaikh, L., & Shanawani, H. (2008) Disability and Islam: An introduction for rehabilitation and healthcare providers. *The rehabilitation provider's guide to cultures of the foreign-born*. Buffalo, NY: CIRRIE.

Discussion Questions

1. What can both therapists do to gain Mr. and Mrs. Daei's trust?

2. Do you feel angry at Mr. Daei for not allowing his wife to participate in the evaluation procedure? Why?

3. What are some other examples of how gender can have a strong influence on communication between the client and clinician?

Case Study #2 for SLP, OT, and PT: Hispanic TBI Client

Background

Hernando Gonzales (*pseudonym*), age 63, incurred a traumatic brain injury (TBI) to the left and right frontal lobes and the left temporal lobe and a broken right shoulder and leg during a car accident on March 15th of this year. Mr. Gonzales was born and resides in Mexico and was visiting his sister, Maria, for a two month vacation when the accident occurred. This was his first visit to Buffalo, NY, though he has visited Miami, Florida, and San Antonio, Texas, several times in the past 20 years. Mr. Gonzales has been a widower for 6 months and has four adult children who reside in Mexico. Mr. Gonzales completed 9th grade in Mexico and works as a security guard at an industrial site. He speaks fluent Spanish and reads and writes Spanish at about a 6th grade level. Although he has taken English emersion classes for several years and his auditory comprehension of English is good, his spoken English is limited. Reading and writing English are basic and inconsistent. He is an ardent soccer fan, enjoys Mariachi music, and attends church on a regular basis.

According to his sister, Mr. Gonzales has a history of hypertension, prostate cancer, and osteo-arthritis. He had a partial knee replacement to the right knee three years ago. He wears corrective lenses that were broken during the car accident, and during the optometric evaluation to replace his lenses, early stage bilateral cataracts were noted. Three years ago Mr. Gonzales was diagnosed with a mild bilateral sensori-neural hearing loss during an employment hearing evaluation but refused amplification.

Following the TBI, Mr. Gonzales made good physical recovery. He received intensive occupational and physical therapy for four weeks in a medical rehabilitation unit. Therapies focused on gaining independence in activities of daily living (ADLs). Although Mr. Gonzales made marked improvement in ADLs, he continued to need prompting and reinforcement to initiate and complete activities such as dressing, grooming, and bathing. He still has some difficulties with walking and balance. Cognitive-communicative therapy was also implemented and stressed word retrieval strategies, sentence production related to ADLs, auditory comprehension and verbal expression, and executive skills such as planning, problem solving, and self-evaluation. All therapy stressed the use of English language. Each therapist commented that Mr. Gonzales had difficulty following simple commands given in English and preferred to communicate in Spanish even though only the speech-language pathologist was somewhat fluent in Spanish. He switched between Spanish and English during most informal conversations.

Mr. Gonzales enjoyed inpatient therapies but seemed to want to socialize with other patients and clinicians more than do therapy. Other patients did not understand his overtures spoken in Spanish. Mr. Gonzales became increasingly distracted and uncooperative when tasks involved speaking or understanding English. The female clinicians also noted that Mr. Gonzales infrequently made direct eye contact with them during therapy activities. They were also

concerned about some of what they considered inappropriate comments about female patients and therapists. Continued home-care based PT, OT, and SLP therapies were recommended at time of discharge. Mr. Gonzales stated that he would like to return to his job on a part-time basis when he returns home in several months.

Mr. Gonzales's sister, Maria Lopez (*pseudonym*) age 70, is a widow and resides in an apartment with her adult daughter Rose, age 36, who works as an accountant for a national hotel chain. Rose travels frequently for her employment and relies on friends and neighbors from their church to help her mother. Mrs. Lopez speaks only limited English and prefers to communicate in Spanish. Her daughter says that her mother actually understands English relatively well but is "insecure" about her spoken English skills with those outside the home. Mrs. Lopez indicated through her daughter that she does not want her brother sent to a nursing home and will provide care for him on an extended basis. Mrs. Lopez visited her brother almost daily while he was in medical rehabilitation, often bringing him herbal drinks, sweets, and prayer cards. Therapists noted that Mr. Gonzales became more passive when his sister visited, and he expected her to meet his needs. Thus, Mr. Gonzales will reside with his sister for the next three to four months to receive home care therapy before returning to Mexico. His adult children will visit intermittently to help with care but will be available on an irregular basis. Only two speak English fluently.

You are the speech-language pathologist, physical therapist, or occupational therapist assigned to do home care with this patient. You do not speak Spanish fluently but know some social Spanish. Consider the following questions as you prepare to work with this client in his sister's home.

Discussion Questions

1. In reviewing the background information, what cultural, physical, cognitive, communication, and environmental factors would you need to take into consideration in working with this client in a home care situation?

2. How might cultural differences be confused with or compounded by other physical, cognitive, communicative, or environmental characteristics in this case? Why is it important to differentiate cultural differences from those related to the client's other characteristics?

3. What adjustments might you make in both your assessment and intervention based on this client's cultural and linguistic background and his traumatic brain injury?

4. How would you enlist the help of this client's family, particularly his sister, to facilitate therapy? What problems might you have in working with them to enhance therapy effectiveness?

Resources for Working with Hispanic Clients

American Speech-Language-Hearing Association. (1985). Clinical management of communicatively handicapped minority language populations. *ASHA*, 27, 29-32.

Battle, D. (1993). *Communication disorders in multicultural populations*. Boston: Andover Medical Publishers.

Brice, A. et al. (1998). Serving the Hispanic population: Creative solutions for therapy. *Annual Convention of the American Speech-Language-Hearing Association.* Available at http://www.asha.ucf.edu/ashasic98.html.

Centeno, J. (2005). Working with bilingual individuals with aphasia. The case of a Spanish English bilingual client. *Newsletter of the ASHA Special Interest Division 14: Communication Disorders and Sciences in Culturally and Linguistically Diverse Populations,* 12, 2-7.

Cheng, L. (1989). Intervention strategies: A multicultural approach. *Topics in Language Disorders, 9,* 84-93.

Goldstein, B. (2000). *Cultural and linguistic diversity resource guide for speech-language pathologists.* San Diego: Singular Publishing Group.

Kohnert, K. (2005). Cognitive-linguistic interactions in bilingual aphasia: Implications for intervention. *Newsletter of the ASHA Special Interest Division 2: Neurophysiology and Neurogenic Speech and Language Disorders, 15*, 9-24.

Langdon, H. (1992). The Hispanic population: Facts and figures. In H. Langdon and L. Cheng (Eds.), *Hispanic children and adults with communication disorders: Assessment and intervention*. Gaithersburg, MD: Aspen Publishers.

Marrero, M., Golden C., & Espe-Pfiefer, P. (2002). Bilingualism, brain injury and recovery. Implications for understanding the bilingual and for therapy. *Clinical Psychological Review, 22,* 463-478.

Morgenstery, L., Steffen-Batey, L. et al. (2001). Barriers to acute stroke therapy and stroke prevention in Mexican Americans. *Stroke, 32*, 1360-1364.

Ruoff, J. (2002). Cultural-linguistic considerations for speech-language pathologists in serving individuals with traumatic brain injury. *Newsletter of the ASHA Special Interest Division 14: Communication Disorders and Sciences in Culturally and Linguistically Diverse Populations, 8*, 2-5.

Santana-Martin, S., & Santana, F. (2005). An introduction to Mexican culture for service providers. In J.H. Stone (Ed.). *Culture and disability: Providing culturally competent services* (pp.161-186). Thousand Oaks, CA: Sage Publications.

Case Study #3 for SLP: Korean Child with Asperger's Syndrome

Background

David Lee (*pseudonym*), age five years ten months, was diagnosed recently with Asperger's syndrome. His parents, Lisa and Adam Lee, followed the recommendation of their pediatrician, Dr. Su, to have David evaluated by the Child Study Team at Children's Hospital four months

after his fifth birthday. Dr. Su was concerned about David's lack of interactive communication skills and his preoccupation with cars. The Lees believed that David's lack of age appropriate socialization was due to being an only child who was cared for by Mr. Lee's mother on a daily basis. Mrs. Soon Young Lee (*pseudonym),* a widow, immigrated to the US from Korea three years ago to help care for her grandson while her son and daughter-in-law completed their doctoral and post doctoral programs in chemical engineering at a local university. Adam Lee, the eldest child and only son in his family, was born in Korea and came to the US for his undergraduate education at age 19 where he met and married Lisa seven years ago. Adam has no interest in returning to Korea to live and is presently negotiating a research and development position for a chemical company in the US. Lisa was born in the US shortly after her parents emigrated from Korea. Lisa is not fluent in Korean. Lisa's parents now reside in California and visit several times per year but cannot provide daily help to Adam and Lisa. Both parents are 30 years old, and Mrs. Lee is pregnant with their second child. The Lees are practicing Christians, and Mr. Lee's mother is a Buddhist.

David received a complete neurological, cognitive, and communicative evaluation at Children's Hospital several months ago. Results indicated that David verbally interacted only when spoken to and that he had difficulty with turn taking and coherence in conversations. Although David used complete sentences and a sophisticated vocabulary about his favorite topic of cars, his speech lacked inflection and sounded "robot-like." David responded to his name inconsistently, and showed little interest in play activities offered to him by either the clinicians or parents. His use of nonverbal communication, such as gaze and gestures, was also inappropriate for a child his age. The Lees stated that they believed that David's communication style in Korean is similar to what he exhibited on the day of the evaluation. David demonstrated some repetitive routines such as stacking and restacking papers and books. David has a special interest in cars and can identify cars by maker and year with precision. He brought several books on cars with him to the Child Study Team evaluation and focused on them even when his parents tried to engage him in conversation. The Lees also commented that David had advanced ability in mathematics and performed at a 5^{th} grade level. David is expected to enroll in kindergarten this fall where he can receive speech-language therapy on a daily basis if the parents agree to the recommendations provided at by the Child Study Team. He has not attended preschool and has little socialization opportunities with peers other than when he attends church activities.

The Lees are concerned about their son's lack of interaction skills and the recent diagnosis of Asperger's syndrome. They are also concerned because Adam's mother, who provides most of David's daily care, denies that there is any type of problem. Mrs. Soon Young Lee, a former middle school mathematics teacher in Seoul, speaks Korean to her grandson and believes that he is a gifted child, not one with a communication difficulty. She encourages David's interest in both mathematics and cars and praises his precociousness to family in Korea. She told her son and daughter-in-law that they should be glad that their child is "quiet and smart; he does not talk back to adults, and that is good." She admonished them for "even thinking" that there was something wrong with their first son. Adam also indicated that there is friction with his mother because of his conversion to Christianity and what she considers his "disrespect" for her as the elder in the family.

The Lees are dependent on Mrs. Soon Young Lee for financial aid, help in the home, and child care. Mrs. Soon Young Lee has recently lent her son money for a down payment on a home. They are also concerned that Mrs. Soon Young Lee's criticism of and unwillingness to participate in therapy programs for their son will be detrimental. She has indicated that David should be placed in a school for gifted children and not labeled with Asperger's syndrome or receive any therapies. Mr. Lee states that he wants to do the best by his son, but that his mother's influence in his home is great and that to disregard her wishes will cause greater tension within the family. Mrs. Soon Young Lee has no plans to return to Korea in the near future as she will provide child care for the new baby and David.

Discussion Questions

1. What problems might a multi-generational and multi-cultural family such as this have in understanding Asperger's syndrome?

2. Why do you think the grandmother is so averse to her grandson being labeled with Asperger's syndrome and receiving therapy? How much of her perception is cultural? Related to her personality?

3. Suppose you were the clinician working with this child in kindergarten in a public school, how important would it be to work with the grandmother regarding the nature of and treatment for Asperger's syndrome? What are the advantages and disadvantages of enlisting her help or providing information to her?

4. What referral(s) might be useful in this case? To whom would you refer, and how would you convince the Lees to follow through on the referral?

5. What other issues other than cultural differences toward disability emerge in this case?

6. What resources can you find on Korean culture that might help you to understand the grandmother's perspectives on Asperger's syndrome? Compile a reference list.

Case Study #4 for OT, PT, SLP and RC: Hispanic Physical and Communication Disability

The following case scenario is an example of a culture bound syndrome that is a health belief among some Hispanics. Answer the questions that follow, relying on the *culture-brokering model* and Kleinman's eight questions to assist you with your approach.

Background

Carlos Garcia (*pseudonym*), a 50 year old Mexican man, is the foreman of a construction crew. He was experiencing chest pain one day at work but did not tell anyone until the pain became so unbearable that he collapsed. An ambulance was called, and Mr. Garcia was taken to the local county hospital. Although he speaks some English, he was not able to provide his medical history due to his severe pain. Mrs. Garcia, who speaks very little English, arrived at the hospital extremely distraught. The Garcias do not have medical insurance and usually rely on the local *curandero* for health advice.

Mr. Garcia was stabilized, and he eventually underwent an angioplasty of the Left Anterior Descending coronary artery with the insertion of a stent. Although the procedure was successful, Mr. Garcia suffered a minor stroke while on the operating table. He presents with mild to moderate slurring of his speech (dysarthria) and a clumsy hand. Upon discharge from the hospital, his physician recommended cardiac rehabilitation, occupational therapy, and speech therapy, but since Mr. Garcia does not have health insurance, he refused. While Mr. Garcia was recovering at home, his wife would not allow him to do anything around the house, even his normal household chores. His wife was clearly close to exhaustion herself since she also cares for her two small grandchildren.

Mr. Garcia has been very depressed. He is worried about working again and if he will be able to continue to earn a living. He is also very scared about having another heart attack. Mr. Garcia is having trouble sleeping, has nightmares, and is losing weight. Mr. Garcia complains, "I no longer feel like a man."

Mrs. Garcia is taking her husband to a local *curandero,* who is treating him for *susto*, "soul loss." She is using various herbal remedies and a change in diet, which relies on the hot and cold model. Because heart conditions are considered hot illnesses, the *cuandero* is recommending whole milk and coconut.

Upon his follow-up visit, the physician assistant, who speaks Spanish, referred Mr. Garcia to the clinic's insurance facilitator. He was qualified for a health maintenance Medicaid insurance program. He will be attending a cardiac rehabilitation program that is run by a physical therapist. Occupational and speech-language therapists will see him in the home setting, and a referral has been generated for rehabilitation counseling to evaluate his potential to return to work.

Discussion Questions

1. How would you approach this case and what are your primary concerns?

Students should be concerned first and foremost for Mr. Garcia's health. This can only be accomplished if students understand Mr. Garcia's explanatory model for what has happened. This model may be different from the health care provider, and communication may involve a process of negotiation and strategies to overcome conflict and advocate for Mr. Garcia's well being. The provider must realize that Mr. Garcia is mourning the strength he once had and his role as the provider of his family. Through education and monitored involvement in activity, Mr. Garcia may gain confidence and realize that he is not as fragile as he thought and that he can once again regain his role as the breadwinner of the household. His resumption of work may depend on work modifications and the practice of energy conservation techniques. Contact with his employer may be helpful if Mr. Garcia is willing to adjust his work load as needed.

2. Who are the major players, and what would you do to gain their trust?

Students should realize that Mrs. Garcia and the *curandero* play an important role in Mr. Garcia's health and should be included in the treatment negotiations. Treatments can be discussed with the *curandero,* and suggestions and adaptations to the regime may be negotiated. For instance, skim milk or 1 percent can replace whole milk, and defatted coconut milk is available. Mrs.

Garcia's role as caregiver should also be considered. She may be concerned that her husband will die, and that fear motivates her to assume his chores around the house. Work simulations with careful monitoring might help Mr. Garcia to gain confidence and help his wife to realize that he is not an invalid. Her role should not be diminished but redirected to facilitate the therapy goals.

Assigned Readings

CIRRIE Monograph Series: http://cirrie.buffalo.edu/monographs/

Jezewski, M.A., & Sotnik, P. (2005). Disability service providers as culture brokers, In J. H. Stone (Ed.), *Culture and disability: Providing culturally competent services*. Thousand Oaks, CA: Sage Publications.

Santana–Martin, S., & Santana, F. O. (2005). An introduction to Mexican culture for service providers. In J. H. Stone (Ed.), *Culture and disability: Providing culturally competent services*. Thousand Oaks, CA: Sage Publications.

Thompson, T., & Blasquex, E. (2006). The smorgasbord of the Hispanic cultures. In M. Royeen & J. L. Crabtree (Ed.), *Culture in rehabilitation: From competency to proficiency*. Upper Saddle River, NJ: Pearson Education Inc.

Learn More about the Client

As you are reading background information on Mexican and Hispanic cultures, pay attention to several outstanding themes that will affect delivery of services to persons from this particular background. Under each heading, write several examples of the Hispanic view regarding the topics. Note contrasts and similarities between the dominant white culture in the US and Hispanic beliefs and values. Note: Realize that Hispanic culture is heterogeneous and that the examples in the readings are general and they are subject to individual variations and community influences. An individual's level of acculturation is affected by a variety of factors including but not limited to education, migration patterns, family influence, and socioeconomic status.

Concepts of Disability and Illness

Persons from Mexico and other Hispanic cultures may not differentiate between physical and mental illness. The balance between a person and his or her environment is considered important to one’s health. Health is a balance of one's emotional well being, spirituality, physical health, and God's will. Genetic problems or developmental disabilities may be viewed with shame and guilt, blamed on the parents, and looked upon as some type of divine retribution. Mental disability carries more stigma than physical illness. The family and community also feel a joint responsibility for the person with a disability, and institutionalization is rare.

Independence versus Interdependence

Nurturing those who have disabilities is considered an important role. Conflicts may result if rehabilitation personnel are working toward independence, but the family does not want to give up the role of caregivers. Independence may not be valued; relationships and roles may be based on interdependence. Evaluation tools that measure the level of caregiver assistance may not truly reflect rehabilitation potential or the ability to assume a role in the family and society. For example, the Functional Independence Measure (FIM™) is a measurement of Independence in

Activities of Daily Living. Scores are based on the amount of assistance that is needed from the caregiver.

Machismo and Marianismo

Machismo is sometimes seen as having a negative connotation. It can also be positive in that a man protects and provides for his family and defends them. In Hispanic families, the man assumes the responsibility for providing for his household. Role conflicts may emerge when families are separated because of job opportunities in the US or when there is a disability or illness. When Hispanic women assume the breadwinner role, there may be conflict with traditional values within the home. Traditionally, boys are given greater freedom than girls, and men are expected to be strong.

A woman's role may be viewed according to the concept of marianismo. Marianismo is based on the Catholic interpretation of the Virgin Mary, who is both virgin and mother. Women are considered spiritually superior to men and capable of enduring suffering.

Personalismo

Personalismo refers to the Hispanic custom of making small talk before getting down to business. Showing an interest in the other person is considered polite before approaching matters at hand. This may result in misunderstandings and poor communication of vital information in busy hospitals, clinics, and agency settings where a person is expected to provide important medical or personal information upon request. Hispanic persons may also inquire about the service provider’s personal life. This reflects a desire to understand something about the person who is providing the care. Health care providers who do not understand this may avoid answering questions about themselves. In the US, provision of personal information about oneself to a client is considered unprofessional.

Alternative Health

Curandereos and Espiritualistas

Curanderos are traditional Mexican healers; *Yerbalistas* are herbalists; and *Espiritualistas* are spiritualists. One may first procure the services of a traditional healer before utilizing Western Medicine. Physicians and health care providers have been known to work with *Curanderos* and spiritual healers and negotiate positive results for the client.

Beliefs Regarding Hot and Cold Remedies

The hot-cold model refers to a Hispanic belief that diseases and disorders can be classified into hot or cold groups. A hot condition must be treated with a cold food or medicine, and a cold condition must be treated with a hot food or medicine.

The following conditions are considered hot illnesses: skin aliments, pregnancy, ulcers, and heart problems. Some cold foods are milk, bananas, coconuts, and beer. Cold ailments may include those that are invisible or that result in immobility such as painful conditions, arthritis, menstrual problems, and colds. Hot foods are evaporated milk, chocolate, onions, and liquors. Penicillin is considered a hot medicine. An example of a conflict that might arise because of this hot-cold

belief is when a physician advises a cardiac patient to avoid high cholesterol foods such as whole milk or coconuts.

Health Risks for Hispanics

- Diabetes is two times more prevalent among Hispanics
- Hypertension is common
- Obesity
- Cervical cancer is double among Hispanic women
- Higher mortality rates from cancer

Questions for Students about Hispanic Cultures

1. Identify the variety of cultures that fall under the umbrella of "Hispanic." Note the variation in their migration practices. Discuss the problems that have accompanied various Hispanic groups in the US.

   Students should discuss the various waves of Hispanic immigration from Castro's Cuba (first wave and recent), refugees from El Salvador, Guatemala and Nicaragua, and Mexican immigrants, both legal and illegal. They should be aware of the problems that are encountered due to language, poor socioeconomic status, access to health care, and the problems that are unique to illegal immigrants.

2. Compare concepts of work and activities of daily living among Mexican or Hispanic persons to the values generally purported by the US. How does this affect those who are disabled?

   Those who are disabled, including members of society who are not able to work or earn money, may still be valued and serve other purposes in the community. Visiting, planning community events, helping others, and talking with others are valued roles within a community.

3. The commodity based society in the US differs drastically from the matriarchal society. Explain the differences and the impact this has on disabled persons.

   The student should note that in a matriarchal society the roles of the mother, for example caring for others, are valued. In contrast, a patriarchal society values earning money. An elderly person, or one who is disabled, may still feel valued in a matriarchal society and fulfill a role. For example, cooking for others is valued and fulfills a role. In a commodity based system, if one does not earn money, their "work" may not be valued.

4. Discuss the barriers that Hispanic immigrants face when they are disabled or ill (structural and cultural barriers). What health risks affect Hispanic immigrants, and why are these risks more common among this group?

   Students should be aware of the structural and cultural barriers that play a role in access to health care. Structural barriers include language, transportation, insurance, and the

ability to pay for medical services. Cultural barriers may include mistrust of the medical system, the practice of seeking native healers first, and different explanatory models regarding illness, and disability.

Some of the health risks, such as diabetes, have an evolutionary and genetic component. It is thought that high blood sugar was an evolutionary survival adaptation among native persons. Many of the risks may be due to lack of preventative care secondary to lack of resources and insurance.

Activities to Improve Knowledge about Hispanic Cultures

- Visit a market in a Hispanic neighborhood. Ask the store personnel about different foods that are unfamiliar to you and how to prepare them.
- Visit a *Botanica*, a market where natural remedies and herbs are sold. Discuss healing rituals and practices with the store personnel.
- Visit a *cuandero* or folk healer and learn about the different healing modalities that are used.

Appendix E: Kleinman's Eight Questions to Assess the Patient's Perspectives (Kleinman, 1978)

Note: Rehabilitation professionals provide services to clients who not only have experienced illness, but long and short term disabilities that may be a result of developmental disorders, illness, or an accident. The following questions were modified in order to include those who are experiencing a disability.

1. What do you think caused your problem (disability)? Remember that in some cultures it is inappropriate to question why something occurred.
2. Why do you think your problem (disability) started when it did?
3. What do you think your sickness (disability) does to you? How does it work?
4. How severe is your sickness (disability)? Will it have a short or long course?
5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to obtain from this treatment?
7. What are the chief problems your sickness (disability) has caused you?
8. What do you fear most about your sickness (disability)?

Part II: Cultural Competency in the Rehabilitation Counseling Curriculum

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Overview

The mission of rehabilitation counseling academic programs is to produce qualified professionals at the graduate level who provide counseling and other rehabilitation services to people with a wide variety of disabilities. Disabilities may derive from the physical, emotional/psychological, cognitive, developmental, and vocational domains.

Rehabilitation counseling is a unique profession that addresses both personal adjustment and vocational rehabilitation among persons with disabilities (Perrone, Perrone, Chan, & Thomas, 2000). Rehabilitation counselors focus on issues related to clients and to the broader psycho-social environment in which they live and work. This creates a holistic approach to counseling that includes empowerment, self-determination, individualization, and equality of opportunity. These concepts are important for clients from mainstream and multicultural backgrounds.

According to the US Census Bureau News (2008) released by the US Census Press Release dated May 1, 2008, the US population is becoming more racially and ethnically diverse. The US Census reports indicate that the nation's overall minority population, as of July 2008, consisted of 104.6 million, or 34% of the total population. The increase is expected across all ethnic groups, but the largest growth in percentage is in the Hispanic American population. The estimated percentage increase in 2008 (which will be confirmed in the 2010 Census) for the Hispanic Americans was 3.3%, followed by Asian Americans (2.9%), Native Hawaiians and other Pacific Islanders (1.6%), African Americans (1.3%) , and American Indians and Alaska Natives (1.0%).

The Disability Statistics Report (2008) indicates that among the four ethnic groups, Native Americans constituted the highest prevalence rate of disability (22.5%), followed by African Americans (17.0%), Hispanic Americans (13.3%), and Asian Americans (6.3%). In addition, both Hispanic Americans and African Americans are reported to have more severe disabilities across all age groups (Capella, 2002), and people with disabilities from racial and minority background tend to have higher rates of work injury and more severe disability than European Americans (National Center for the Dissemination of Disability Research, 1999).

In reviewing the outcomes of rehabilitation services among minorities with disabilities, there is some evidence to support that they are underserved. For instance, European Americans are

accepted for state vocational rehabilitation services at a higher rate as compared to African Americans or Hispanic Americans (Dziekan & Okocha, 1993; Feist-Price, 1995). Other researchers speculate that European Americans are more likely to receive services in college, vocational training, business and on-the-job training than African Americans (Spitznagel & Saxon, 1995; Wheaton, Finch, Wilson, & Granello, 1997). Capella's (2002) study indicates that acceptance for vocational service rates and employment outcomes favor European over African Americans. Cardoso, Romero, Chan, Dutto, & Rahimi (2007) indicate that European Americans with traumatic brain injury (TBI) are 1.27 times more likely to obtain a job as compared to Hispanic clients with TBI and that Hispanic clients have a lower odds ratio of returning to work. The authors further discuss that Hispanic Americans with disabilities have more unmet basic needs (e.g., food, shelter, and transportation) and that employment services are provided less often for this ethnic group as compared to European Americans.

Rehabilitation counselors (RCs) are now working with increasingly larger numbers of clients from racial and ethnic minority backgrounds. However, RCs who are predominantly European Americans may hold a different worldview than their ethnic and racial minority clients. For instance, Wilson and Senices (2005) state that challenges exist for rehabilitation counselors from the mainstream culture, as they may not be familiar with the minority cultures or lack the language skills and appropriate multicultural rehabilitation counseling competencies to work effectively with them.

It is evident that ethnic minorities with disabilities have increasing needs for rehabilitation and that they tend to be underserved. The rehabilitation counseling profession is cognizant of the needs and challenges faced in providing quality and appropriate services for those clients. Another body of research is dedicated to investigating multicultural challenges as well as competency training among rehabilitation counseling students and practitioners. For instance, Rosenthal and researchers conducted a series of research studies that investigated how the race and perceptions of rehabilitation counselors or counselors-in-training may affect clinical judgment. Generally speaking, some results indicate that European American rehabilitation counselors rate African American clients with less potential for education and employment and a higher level of psychopathology (Rosenthal, 2004; Rosenthal & Berven, 1999). Other studies, however, do not show any biases (e.g. Rosenthal, Wong, Blalock & Delambo, 2004).

Specifically related to multicultural competency research among rehabilitation counselors, Cumming-McCann and Accordino (2005) report that counselors who are at different subsets of a psyche state of unachieved racial consciousness (i.e., avoidant, dependent and dissonant) may engage in different multicultural experiences but are either unaware of race in their relationships or uncomfortable with engaging in meaningful therapeutic relationships. For instance, individuals who are at the dependent state tend to adhere to positive stereotypes for the mainstream culture as well as negative stereotypes for minority cultures. They tend to develop a negative perception of multicultural relationships. Individuals who are at the dissonant state can be described as uncertain, incongruent, and confused. They may perceive themselves as lacking competence, knowledge, skills, and abilities in working with minority clients. The authors discuss that rehabilitation counseling educators should be cautious, but not about students entering the dissonant status during their education. Rather, educators should focus on examining

teaching strategies that enhance and support self-exploration of racial attitudes. They should work with students to process though their negative stages.

Consistently, Bellini (2002) indicates that, while an abundance of research focuses on generic counselors' multicultural competency levels, only a few studies focus on rehabilitation counseling practitioners (e.g. Wheaton & Granello, 1998). Wheaton and Granello (1998) indicate that participation in multicultural competency workshops improves statistically significant scores on the counselors' perceived level of multicultural skills, knowledge, and awareness domains, but not in the domain of client/counselor relationship. In Bellini's study, the author investigates the effects of multicultural training on European American rehabilitation counselors' clinical skills. Regression analysis results indicate that counselors' demographic variables, their cultural experiences, and their multicultural training explain 33% of the variance for multicultural counseling competency scores. Specifically, counselors' race, gender, participation in a graduate class in multicultural counseling, and participation in a greater number of workshops on multicultural issues over the previous five years significantly predict multicultural competency scores.

Rehabilitation counseling researchers and educators are cognizant of the importance of multicultural counseling training and its impact on minority clients being served. Rehabilitation counseling adopts a broad definition of multiculturalism that concurs with the Association of Multicultural Counseling and Development (AMCD, 2009). The AMCD and its Professional Standards Committee (AMCD, 2009; Arredondo et al., 1996; Sue, Arredondo, & McDavis, 1992) is a specialty subset of the American Counseling Association. Table 1 illustrates the many characteristics that may contribute to multiculturalism as defined by AMCD (AMCD, 2009; Arredondo et al., 1996; Sue et al., 1992), as well as other researchers (Atkinson, Thompson, & Grant, 1993; Hays, 2001). The following categorization of the various dimensions is adapted based on Torres-Rivera (2009, personal communication). Dimension A refers to inherited or socially acquired characteristics. Dimension B refers to characteristics that are temporal and variable. Dimension C refers to characteristics that transcend generations. According to their criteria, the concept of multiculturalism encompasses inclusive and multiple aspects of individuals whose differences extend beyond their ethnic group.

Table 1. Multidimensional Characteristics of Multiculturalism in Counseling

Dimension A	Dimension B	Dimension C
Age/generational	Citizenship status	Political moments/eras
Culture	Educational background	Socio-political history
Ethnicity	Geographical location	
Gender	Hobbies and interests	
Indigenous heritage	Income	
Language	Marital status	
National origin	Military experience	
Physical disability	Religion	
Race	Work experience	
Sexual orientation		
Social class		

Rehabilitation counselors need to remember that individuals with disabilities from a multicultural background are one type of minority and may actually encompass more than one minority status. Dworkin and Dworkin (1982) define a minority group as characterized by four qualities: 1) identifiability, 2) differential power, 3) differential and pejorative treatment—a behavioral response by dominant groups and their perception that resources are finite— resulting in discrimination, and 4) group awareness—recognition of a common societal position/fate, and the realization that common goals and cooperation will result in improved status for the group. Thus, individuals with a disability and from a multicultural background bring a complex set of characteristics and needs to the counseling endeavor.

The rehabilitation counseling profession first emerged based on a mandate from the government that quality rehabilitation counselors were needed to provide employment and job placement services for war veterans with physical disabilities (Obermann, 1965). The Soldier Rehabilitation Act in 1918 was the first legislation to support such services. Employment services then expanded to civilians with physical disabilities through the Smith-Fess Act of 1920 and to those with mental illnesses in the Barden-LaFollette Act of 1943. The 1954 Vocational Rehabilitation Act Amendments focused on the specific academic training of rehabilitation counselors. The Rehabilitation Act of 1986 also stipulated that rehabilitation services be delivered by qualified personnel. Further, the Rehabilitation Act Amendments of 1992 addressed the realization that public rehabilitation programs needed to be more effective in serving culturally diverse populations (Lewis, Head, Shamburger, Armstrong, & West 2007). This mandate emanated from higher rates of disability, under-representation in the public vocational rehabilitation system, and poorer outcomes among culturally diverse populations.

Thus, the rehabilitation counseling profession has expanded its scope of services and training to encompass a variety of skills. Rehabilitation counselors now serve individuals with disabilities and who are multicultural through vocational counseling and placement, independent living, integration into the community, stress management, and case management. Such complex services require that rehabilitation counselors are well grounded in the nature of multiculturalism and have specific skills for providing quality services to them.

In responding to the need to embrace cultural competency in working with the multicultural rehabilitation population, the following discussion and activities focus on self-awareness and attitudes toward multicultural issues, knowledge about one's own and other cultures, and skills in working with these individuals in a counseling context. This model may be used as a basis for specific multicultural courses in rehabilitation counseling or add units on this topic in more general courses or practicum experiences.

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The Rehabilitation Counseling Curriculum and Cultural Competency

One important and current issue that rehabilitation counseling training programs must face in their curriculum design is how to ensure that their graduates are best prepared to work with individuals from multicultural backgrounds. Similar to other rehabilitation professional training programs, including occupational and physical therapies and speech-language pathology, rehabilitation counseling programs must have both a commitment and realistic ways to include cultural diversity issues throughout their curriculum. This may be through specific coursework, infusion across coursework, and/or through immersion in practica with clients from diverse backgrounds. Curricular design begins with a definition of cultural competence that serves as a basis for the content and outcomes of the curriculum.

Cultural Competency

The AMCD (2009) and its Professional Standards Committee (Arredondo et al., 1996; Sue et al., 1992, p. 481) define three specific dimensions of cultural competency for counseling professionals. Culturally competent counselors should: 1) be aware of their own assumptions about human behavior, values, preconceived notions, limitations, and biases; 2) have an active understanding of the worldview of their clients who are culturally different from them, without imposing negative judgments; and 3) develop and practice appropriately with culturally different clients. This provides a model for curriculum design and the appropriate learning activities to develop broad cultural competencies. It should be noted that awareness and knowledge are frequently developed through the same activities. Educators and instructors should feel free to mix and match activities to best meet their rehabilitation counseling students' curricular needs.

Awareness of Attitudes and Beliefs

The AMCD model (AMCD, 2009; Arredondo et al., 1996; Sue et al., 1992) asserts that cultural competency begins with the awareness and sensitivity to one's own cultural heritage and its potential impact on professional practices. Rehabilitation counselors must recognize that their own cultural background and experiences influence their attitudes, biases, and values about psychological processing, disability, and their role in the whole rehabilitation experience. Awareness inherently involves being cognizant of the cultural background that clients bring to the rehabilitation counseling context. Counselors must also appreciate the limits of their multicultural competency and thus acknowledge the importance of pre- and post-professional education in multicultural foundations, referral, and consultation. The ultimate goal of self-awareness is to value and respect differences between rehabilitation counselors and the individuals they serve as a foundation for quality services.

Cultural Knowledge

The AMCD model (AMCD, 2009; Arredondo et al., 1996; Sue et al., 1992) maintains that culturally competent counselors should acquire specific knowledge about their own racial and cultural heritage and that of the clients they serve. This experience affects their professional work with clients from a variety of cultural backgrounds. Knowledge again begins with self-knowledge regarding how one's own culture influences basic availability and provision of services and ultimately interactions with clients. Knowledge of clients' diverse cultures and

experiences is also essential. Finally, rehabilitation counselors must acquire specific knowledge of appropriate and sensitive diagnostic and intervention methods for working with clients from diverse backgrounds. One of the goals of developing this knowledge base in the rehabilitation curriculum is to instill the belief that as one learns more about various cultures, there is more to learn.

Skills

Once counselors have basic awareness and knowledge regarding their own cultural background and that of the clients with whom they work, the next step is to put this knowledge base into practice. Skills emanate from this metacognitive awareness and academic foundation but are operationalized through interaction with individuals from multicultural backgrounds and through supervision from colleagues. This interaction might take place first in informal and nonprofessional contexts and will eventually extend to professional interactions. Skills need to be developed that incorporate the client's worldview of disability and intervention and appropriate, though sometimes, nontraditional assessment and intervention techniques. Skills can focus on interaction with clients and their families or advocacy with larger institutional entitities. Finally, skill development should also stress recognizing the limits of one's own competencies and the need for referral, consultation, or further education.

Cultural Competency in Rehabilitation Counseling Practice

Students and professionals in rehabilitation counseling must be aware that their professional practice is guided by the Code of Professional Ethics for Rehabilitation Counselors. This document states that professionals must "assure the community that the rehabilitation counseling profession accepts its responsibility to provide caring services to persons with disabilities" (Commission on Rehabilitation Counselor Certification [CRCC]). Specifically, Section A.2. "Respecting Diversity" discusses three areas of diversity practice:

1) Respecting Culture – the demonstration of respect for clients' cultural background.

2) Interventions – the development and adaption of interventions and services that incorporate clients' cultural perspective. It is imperative for counselors to recognize barriers external to the clients that may interfere with the process of effective rehabilitation outcomes.

3) Non-discrimination – Do not condone or engage in discrimination based on such factors as age, color, culture, ethnic groups, race, gender, religion, sexual orientation, marital status, socioeconomic status and disability.

This ethical mandate was created to provide appropriate and sensitive services to clients from multicultural backgrounds. It helps to guide curricular design and implementation of professional training as well as professional practice.

The Rehabilitation Counseling Curriculum

Generally speaking, the rehabilitation counseling degree offered in the US is a two-year curriculum at the graduate level and can be accredited by the Commission on Rehabilitation Education (CORE). With a program being accredited by CORE, the master's degree in rehabilitation counseling prepares graduates to be nationally certified. While program curricula

vary somewhat from university to university, rehabilitation counseling programs typically have classes that address multicultural issues in either individual courses and/or are infused into a variety of courses and clinical experiences. Multiculturalism is typically infused throughout rehabilitation coursework content (See Table 2). The left column represents coursework that are foundational to counseling-related degrees (e.g. school counseling, mental health counseling). The right column represents coursework that are unique to rehabilitation counseling.

Table 2. Sample Content of Coursework Related to Multicultural Competencies in Rehabilitation Counseling.

Foundational Content	**Specialized Content**
Consultation	Medical and Psychosocial Aspects of Disability
Counseling Theories and Foundations	Physical Rehabilitation and Intervention
Ethics and Legal Perspectives	Psychiatric Rehabilitation and Intervention
Group Counseling	Rehabilitation and Vocational Assessment
Human Growth and Development	Rehabilitation History and Systems
Multicultural Counseling	Rehabilitation Resource and Development
Psychopathology and Evidence-based Practice	Rehabilitation Services
Research and Program Evaluation	Substance Abuse and Intervention
Social and Cultural Diversity	Vocational Rehabilitation for People with Disabilities

Teaching methods in rehabilitation counseling include lecture, discussion, and experiential training in each of the three major domains of awareness, knowledge, and skills (Leal-Idrogo, 1997). The range of teaching methods includes information acquisition, small group discussion in class, videos and films, guest speakers, exposure exercises, role playing exercises, and case studies. In addition, students are required to practice the knowledge learned in the classroom in practicum and internship contexts.

Learning about multicultural issues cannot be relegated to professional education only. Sue and Sue (1999) indicate that being a culturally competent counselor is not a task that one can master by attending a finite number of lectures. Becoming a counselor who can capably serve multicultural clients is a life-long learning experience. Professional organizations, colleges, and universities conduct national conferences where scholarly exchange and training are provided through continuing education on regular bases. See Appendix A for a list of possible conferences that focus on multicultural issues in rehabilitation counseling and education.

The activities in this Guide can also be used for individual study or for study groups of professionals interested in improving their own knowledge base with regard to multicultural topics.

Rehabilitation Counseling Coursework Related to Multicultural Competency

According to Leal-Idrogo (1997), the primary goals of a focused multicultural counseling course in rehabilitation are to:

1) Develop an awareness of and sensitivity to one's own cultural heritage;

2) Value and respect cultural differences;
3) Become more aware of sociopolitical influences (e.g., discrimination, racism);
4) Acquire specific information about the socioeconomic-political history, experiences, values and lifestyles of various cultural groups;
5) Gain specific knowledge and information about the major cultural groups in the United States, including their health and disability experiences;
6) Develop a philosophy and methods for providing effective, culturally competent services to consumers who are culturally unique;
7) Be able to select and use counseling approaches and techniques that are appropriate and consistent with the client's worldview and lifestyle;
8) Acquire intervention skills that dismantle community barriers that negatively affect the client's rehabilitation process; and
9) Use community outreach and out-of-office intervention strategies (pp. 231-232).

Focused multicultural coursework typically has units devoted to demographics and history of multicultural issues in the US, and to rehabilitation strategies for working with these populations. Other topics may focus on individual minority groups and their perceptions of disability and rehabilitation as well as suggestions for best practice with these groups. For example, Leal-Idrogo (1997) suggests that discussions emphasize African Americans, Hispanic Americans, Native Americans, Asian Pacific Americans as well as those from a variety of other diverse groups. Not only will such courses highlight the myriad characteristics and belief systems of multicultural groups, but also provide opportunities to develop practice skills and research methods as applied to diversity. Finally, the content of such courses encourages students to assist clients to advocate for themselves and to promote awareness of disability and minority issues in the community.

References

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Commission on Rehabilitation Counselor Certification (CRCC). The Code of Professional Ethnics for Rehabilitation Counselors. Retrieved July 24, 2009, from http://www.crccertification.com

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Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development, 70*, 477-486.

Sue, D. W., & Sue, D. (1999). *Counseling and therapy with specific populations. Counseling the culturally different, theory and practice*. New York: John Wiley & Sons, Inc.

Teaching Materials

The activities and resources gathered for this guide are based on at least three different methods. The first is adaptation of existing readings and exercises used by faculty experienced in rehabilitation counseling from multicultural backgrounds. The second source of information is based on published texts, professional articles, and videos. The author also added other activities based on personal experience.

It is difficult to tease out the materials that are specifically used for the tripartite model (Awareness of Beliefs/Attitudes, Knowledge, and Skills) of multicultural competencies since readings and activities can at times overlap in their content and learning outcomes. Increases in self-awareness and knowledge go hand in hand and are not necessarily sequentially acquired. As students learn more about themselves and others, their awareness of what they need to know grows and stimulates more refinement of awareness and information, and eventually skills for working effectively with clients from diverse backgrounds.

Assumptions

The readings and activities described here are for both entry-level classes and for students with more advanced knowledge and experience in rehabilitation and multicultural training. Educators and instructors should choose the readings and exercises based on the students' level of understanding and the learning expectations for the class. Activities are designed for individual and small group assignments as well as short and long term projects.

It is also assumed that educators and instructors will upgrade their own knowledge base regarding multicultural issues prior to using these materials. Equally important is that educators and instructors should be able to facilitate class discussions of sensitive topics. Respect for diverse opinions should be the cornerstone of class discussions, and is created through a safe and trusting learning environment. Students should always have the option of not expressing their ideas. Finally, some activities might be co-taught with faculty members who have more expertise in specific areas of multiculturalism.

Evaluation Methodology

Student evaluation of the activities presented in this guide can be accomplished using five methods described below. While not all activities can be evaluated by all the methods, instructors should use their discretion to apply methods that are the most appropriate. In general, evaluation is achieved by focusing on one or more of the following dimensions: 1) Accuracy; 2) Writing or presentation content style; 3) Self evaluation; 4) Peer evaluation; and 5) Consistency across multiple evaluations.

Method 1: Accuracy

Evaluation of accuracy is generally accomplished through objective means and addresses mastery of factual information presented in lectures, readings, and videos. This can be achieved

by traditional objective style questions such as multiple choice, short answers, or essays that test students' accuracy in recalling and identifying factual information.

Method 2: Writing and Presentation Content and Style

Students' writing and presentation content style will need to be evaluated in some activities. Both written papers and oral presentations should be evaluated on content and depth of information, clinical application, use of appropriate resources, and use of Standard American English for writing and speaking style.

Method 3: Self-Evaluation

Since many of the activities focus on developing self-insight and meta-cognitive critiques of one's own thinking and performance, such evaluation is emphasized in many of the activities. In general, such evaluation can be achieved qualitatively through questions such as "What do you think of your performance?" Answers to such questions should increase in depth and insight as students gain in awareness and knowledge throughout the curriculum.

Another self-evaluation method is to use a Likert scale evaluation. This provides a quantitative method for self-evaluation questions. Four examples of this type of self evaluation are included below. Educators and instructors can create their own questions and scales as needed across activities.

1) How aware are you of your own or other's _____ (e.g. beliefs, attitudes, biases)?

1	2	3	4	5
Not aware at all				Very aware

2) How much have you increased in the knowledge in _____?

1	2	3	4	5
Not much				Very much

3) How skillful are you in implementing the_____ techniques and skills with your clients?

1	2	3	4	5
Not skillful at all				Very skillful

4) How comfortable are you in integrating the new information or skills in your practice?

1	2	3	4	5
Not comfortable at all				Very comfortable

Method 4: Peer Evaluation

Evaluations from fellow students can be helpful in providing constructive feedback for the students (especially in exercises involving presentation and interactive activities). Such evaluations should be performed by peers with similar knowledge and background experiences and additionally, based on actual observations of behaviors. Peers might complete open ended questions about their observations or complete Likert type questions as described above.

Method 5: Expert Evaluations of Skills and Consistency Across Evaluations

Expert evaluation by academic or clinical educators/instructors may involve observations of specific skills such as following-through, debriefing, and identifying reasons for discrepant evaluations. Generally speaking, evaluation forms can be the Likert scale rating methods described in Method 3, or can be a specific form that is tailored for a particular activity. A comparison of the same rating forms allows inter-rater reliability in collating the degree of agreement among raters in evaluating whether students have achieved their learning objectives. Such evaluations form the basis for remedial plans to help students improve clinical interactions with clients from multicultural backgrounds.

Activities to Develop an Awareness of Clinicians' Own Beliefs and Attitudes

Definition

Curriculum development begins with increasing students' self-awareness of their own beliefs and attitudes about their racial and ethnic identity as well as that of the clients they serve. Sue and colleagues (1992) contend that "a culturally skilled counselor is one who is actively in the process of becoming aware of his or her own assumptions about human behavior, values, biases, preconceived notions, personal limitations, and so forth" (p. 481). Such self-awareness is a prelude to developing sensitivity to and respect for clients' cultural background. Note that additional activities that might be used to develop this area are listed in Appendix A of Part I of this guide.

Activities

1) Differences in Beliefs and Attitudes in Cultural Diversity

Learning Objectives: 1) To increase students' understanding of their own cultural diversity and how they are different from their peers; 2) To increase students' awareness of the differences between their own and a peer's beliefs and attitudes about cultural diversity.

Activity: Pair Discussion and Individual 3-Page Reflection Paper. Using the ADRESSING (Hays, 2001) model and its acronym: Age/generation; Disability; Religion; Ethnicity/race; Social status; Sexual orientation; Indigenous heritage; National origin; Gender, students will write one sentence or adjective that describes themselves on each characteristic. Students follow the same procedure regarding each characteristic for another classmate. Students then partner with that classmate, share their list, and compare and contrast the responses. Students should query each other regarding reasons for their beliefs. Students complete the activity by writing a three-page reflection paper that focuses on their own perception of diversity as given in the ADRESSING model and how it contrasts with their peer.

Evaluation: Methods 2 and 3.

2) Association Test

Learning Objective: To increase students' self awareness of their attitudes toward different cultural diversity phenomena when measured implicitly.

Activity: Online Activity, One-Page Reflection Paper, and Individual Discussion with Instructor. Each student takes one of the Implicit Association Tests (IAT): https://implicit.harvard.edu/implicit/. This is a research-based website that provides information and research-based tests on various implicit attitude assessments (e.g., ethnic, age, weight, skin tones, disability, sexuality, religious). Students take the test outside of class, review the results, and write a one-page reflection paper on their reaction to the result. In the paper, students should address the questions: Do you think the result is accurate? Why or why not? How does social desirability affect the discrepancy of your explicit and implicit attitudes? Students should also meet with the instructor in a debriefing session to review the results and their perceptions of them.

Evaluation: Methods 2 and 3.

3) Experiencing an Unfamiliar Environment

Learning Objective: To increase students' self awareness of what it is like to be different.

Activity: Experiential Activity and Class Presentation. Students are asked to experience an unfamiliar, cultural environment. One example is to visit a community several times where a different language is spoken (e.g. Chinatown, and Hispanic area). Students should actively engage a variety of people in the area (e.g., asking for directions, ordering in a restaurant, etc.). Students will then prepare a presentation that focuses on their experiences of entering an unfamiliar language and cultural environment. Questions that might be addressed include: What challenges did the student face? How were the challenges met? How did the student feel in the situations? How did others react to the student? What concepts can be applied to counseling from completing this activity?

Evaluation: Methods 2 and 3.

4) Reflection of Personal Values in Counseling

Learning Objective: To increase students' self awareness of various multicultural issues in relation to personal values and professional counseling.

Activity: Self-Reflection and a 4-Page Paper. A reflection workbook is provided for students to complete. G. Corey (2001) asks questions regarding students' comfort level, their attitudes, and beliefs about counseling in general as well as cultural issues (e.g. working with people of color, people with HIV/AIDS). Students then write a 4-page reflection paper on: 1) Two multicultural issues that they feel strongly about (either positive or negative), 2) How they would react personally and professionally if they faced these issues in their clinical training.

Resource: Corey, G. (2001). The Counselor: Person and Profession. In G. Corey (Ed.), *Student manual for theory and practice of counseling and psychotherapy* (pp.11-25) (6th ed.). Belmont, CA: Brooks/Coles.

Evaluation: Methods 2 and 3.

Activities to Develop Knowledge of the Clinicians' and Clients' Worldviews

Definition

The next step in curriculum development is to improve students' knowledge base about their own heritage and that of their clients. Knowledge also extends to identification of appropriate assessment and intervention techniques for working with clients from multicultural backgrounds.

Activities

1) Readings on Multiculturalism and Rehabilitation/Disability and Related Topics

Learning Objective: To increase students' knowledge of multicultural concepts.

Activity: Reading and Class Discussion of Fundamentals. Knowledge can be expanded by in depth reading of assigned professional chapters and articles. Topics and readings depend on the type of class (e.g. theory or practice focused) or the content of class (e.g. vocational counseling or personal adjustment counseling). See Appendix B: Bibliography on: 1) Readings on Multiculturalism; 2) Readings on Rehabilitation and Disability; 3) Readings on Personal Adjustment Counseling; and 4) Readings on Vocational Counseling, for possible reading lists. Students then contribute 2-3 questions for class discussion based on the readings. Questions might focus on specific content, reactions, or application to potential or real counseling situations. Instructors and educators can devise content-specific test questions such as multiple choices, short questions, matching questions, or essays that assess students' knowledge base.

Evaluation: Methods 1, 2, and 3.

2) Professional Videos on Multiculturalism and Rehabilitation/Disability

Learning Objective: To increase students' knowledge of multicultural concepts.

Activity: Video Presentation and Class Discussion. Students view one of the videos presented in Appendix B: Bibliography on the Videos on Multiculturalism list. Students each identify three new concepts they learned from the video. These serve as the basis for a class discussion on multiculturalism and implications for clinical practice.

Evaluation: Methods: 2 and 3.

3) Pop Culture and Multiculturalism and Rehabilitation/Disability

Learning Objective: To identify how various cultures are presented in popular media such as television and movies.

Activity: TV/Movie Review and Class Discussion. In small groups, students choose a decade (e.g. 40's, 50's) and review how clients from a multicultural background were portrayed in radio, television, and movies. Examples of popular movies are presented in Appendix C. Class discussion should focus on such individuals have been portrayed, stereotypes, and reasons for changes in portrayal, if any.

Evaluation: Methods 2 and 3.

4) Understanding Your Own Racial/Cultural Identify Development

Learning Objective: To increase students' self awareness and knowledge of their racial/cultural identity developmental stages.

Activity: Reading and a 4-Page Paper. After reading the assigned chapters, students write a 4-page paper analyzing the respective models of identity development outlined in the reading. Students should also describe how they fit into the model and provide examples to support why they are at a particular stage of development. The paper should discuss how their stage of development affects their worldview, their counseling approaches, and how they approach clients who are from various racial/cultural backgrounds.

For students who are White, read the Chapter: White racial identity development: Therapeutic implications (pp. 233-258). For students who are non-White, read the Chapter: Racial/cultural identity development in people of color: Therapeutic implications (pp. 259-283). In Sue, D.W., & Sue, D. (2008). (Eds.). *Counseling the Culturally Diverse. Theory and Practice* (5th ed.). Hoboken, NJ: John Wiley & Sons, Inc.

Evaluation: Methods 2 and 3.

5) Understanding Others' Racial/Cultural Identity Development

Learning Objective: To increase students' knowledge and awareness of racial/cultural identity development among those from diverse backgrounds.

Activity: Reading, Interview, and a 4-Page Paper. This can be used as a companion to the activity given above. After reading the chapters above and the one given below, students should interview a friend or classmate from a cultural background that is different from their own. The interview should focus on identifying the interviewee's stage of racial/ethnic development, according to the five-stage Racial/Cultural Minority Identity Development model (Atkinson, Moreten, & Sue, 1998; Sue & Sue, 1990, 1999). The students then write a 4-page paper that describes the results of the interview and provides examples to support the stage of development of the interviewee.

Reading:

Sue, D. W., & Sue, D. (2008). Racial/cultural identity development in people of color: therapeutic implications. In D. W. Sue, & D. Sue (Eds.). *Counseling the culturally diverse. Theory and practice* (5th ed.) pp. 233-257. Hoboken, NJ: John Wiley & Sons, Inc.

Evaluation: Methods 2 and 3.

6) Acculturation

Learning Objective: To increase students' understanding of the process of acculturation.

Activity: Research, Interview, and a 5-Page Paper. The purpose of this assignment is for students to interview and identify an individual's perception of his or her acculturation into mainstream society. Students will choose an individual from a multicultural background and

interview that individual about his or her personal acculturation experience. In addition, the student should identify an appropriate acculturation assessment tool from the references below and administer the tool to the interviewee. The paper should include an analysis of the interviewee's verbal responses and results of the assessment tool. Assurance of confidentiality of personal identity should be given.

Resources to Identify Acculturation Assessment Tools:

1) http://www.multiculturalcenter.org/test/
2) http://www.ocf.berkeley.edu/~psych/depot.html

Evaluation: Methods 2 and 3.

7) Stereotypes

Learning Objective: To increase students' self awareness and knowledge of stereotypes of a culturally diverse group.

Activity: Interview and a 4-Page Paper. Students will interview a person they know from a culturally diverse group. Prior to the interview, students should list 5-10 stereotypes they hold or believe others hold about this group. Students should assure interviewees that the questions posed are sensitive and responses do not need to be given if desired. The interview should focus on how interviewees perceive biases toward their cultural group. Other topics that might be addressed include how the students' perceptions of stereotypes match that of the interviewee, how stereotypes affect behavior, and what can be done to demystify stereotypes. The resulting paper should address these issues.

Evaluation: Methods 2 and 3.

8) Perceptions and Barriers to Vocational Rehabilitation Services and Employment

Learning Objectives: 1) To increase the knowledge of societal perceptions and barriers to vocational rehabilitation services and employment among ethnic minorities with a disability. 2) To lead a group discussion in class to brainstorm strategies in reducing such negative perceptions and barriers to enhance clients' service and employment opportunities.

Activity: Readings, Presentation and Group Discussion. Each student will choose one ethnic minority group and one disability group. Students will read the appropriate chapters from the reading list and may utilize additional readings to support their presentation if desired. Each student will give a class presentation to answer the following question: What are the negative societal perceptions and other environmental or psychosocial barriers to vocational rehabilitation services and employment among individuals from ethnic and/or disability groups? Each student will lead a discussion group to brainstorm strategies addressing the reduction of negative perceptions and barriers for minorities with a disability.

Readings:

Mackelprang, R., & Salsgiver, R. (1999). *Disability: A diversity model approach in human service practice.* Belmont, CA: Brooks/Cole Publishing Company. Chapter 1 (pp. 3-19) and Chapter 2 (pp. 20-35).

Balcazar, F. E., Suraez-Balcazar, Y., Taylor-Ritzler, & Keys, C. B (2010). *Race, culture, and disability*. Sudbury, MA: Jones and Bartlett Publishers. Chapters 5-10.

Smart, J. (2001). *Disability, society, and the individual*. Gaithersburg, MD: Aspen Publishers, Inc. Chapter 3 (pp. 71-100) and Chapter 4 (pp. 101-135).

Sandhu, D. S. (2002). *Counseling employees: A multifaceted approach.* Alexandria, VA: American Counseling Association. Chapter 8 (pp. 131-149), Chapter 9 (pp. 151-168).

Evaluation: Methods 2 and 3.

9) What Does it Mean to be "Not-Well?"

Learning Objective: To increase students' knowledge and understanding about disability from the perspective of culturally diverse groups.

Activity: Interview and a 5 to 8-Page Paper. Students will interview a person who has a disability and who is from a culturally diverse group. Assure the interviewee that all questions do not need to be answered and he or she will not be personally identifiable in the report. The interview should focus on such topics as the nature of the disability, the meaning of disability to the informant and to his/her culture, perception from others (e.g., family members, colleagues, classmates, general public), everyday experiences with the disability, types of intervention his/her culture engages in, access to home or professional rehabilitation, opinions about seeking mainstream intervention, and barriers to receiving services.

Evaluation: Methods 2 and 3.

10) The Psychology of Disability in a Different Culture

Learning Objective: To increase students' knowledge of how disabilities are viewed by various cultures.

Activity: Readings and 10-Page Paper. After completing the assigned readings, students choose a specific multicultural group and explore its perceptions of disability in general or a specific disability (e.g. How do Hispanic Americans view disability? or How do African Americans view traumatic brain injury and its sequelae?) Students write a paper that explores how the cultural group views the onset of the disability, locus of control, locus of responsibility, help seeking behaviors, and potential discrimination related to both culture and disability.

Readings:

Sue, D. W., & Sue, D. (2008). Social justice counseling/therapy. In D. W. Sue, & D. Sue (Eds.). *Counseling the culturally diverse. Theory and practice* (5th ed. pp. 287-311). Hoboken, NJ: John Wiley & Sons, Inc.

Stano, J. F. (2009). *Psychology of disability*. Linn Creek, MO: Aspen Professional Services. Chapters 5, 6, 7, and 8.

Evaluation: Methods 2 and 3.

11) Cultural Biases in Psychological and Vocational Assessment among Individuals from Diverse Cultures

Learning Objectives: 1) To increase students' knowledge about various vocational assessments; 2) To increase students' knowledge about the assessments' psychometrics and applicability to clients from multicultural backgrounds.

Activity: Readings, Research, and a 5-Page Paper. Students read the assigned readings, and choose one of the commonly used vocational assessment inventories for people with disabilities from the Zunker and Osborn (2002) text. Psychological assessment inventories can be chosen from the Bolton, B. F. (2001) text. Students should find and review at least 4 empirical studies that discuss the psychometric properties of the inventory. Write a 5-page paper that analyzes the psychometric properties of the test and its applicability to multicultural clients with disabilities. Topics include the purpose of the test, validity and reliability, norms, test interpretation for multicultural clients, existence of specific psychometrically-validated versions of the test for specific ethnic minorities, and possible ways to modify the test for such clients and their effects on validity.

Readings:

AERA, APA, NCME. (1999). *Standards for educational and psychological testing.* Washington, DC: Joint Committee on Standards for Educational and Psychological Testing of the American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education. American Educational Research: Chapters 4, 7, 9, 10, and 12.

Bolton, B. F. (2001). Multicultural issues in assessment. *Handbook of measurement and evaluation in rehabilitation* (3rd ed. pp. 449-469). Austin, TX: ProEd.

Dana, R. H. (2001). Multicultural issues in assessment. In B. F. Bolton (Ed.). *Handbook of measurement and evaluation in rehabilitation* (3rd ed. pp. 449-469). Austin, TX: ProEd.

Hernandez, B., Horin, E. V., Donoso, O. A., & Saul, A. (2010). Psychological testing and multicultural population. In F. E. Balcazar, Y. Suraez-Balcazar, T. Taylor-Ritzler, & C. B. Keys. Race, culture, and disability (pp. 55-79). Sudbury, MA: Jones and Bartlett Publishers.

Holzbauer, J. J. & Berven, N. L. (1999). Issues in vocational evaluation and testing related to the Americans with disabilities act. *Vocational Evaluation and Work Adjustment Journal, 32*(2), 83-96.

Lam, C. S., Homa, D. B., & Buser, A. (2007). Diversity issues in psychological assessment. In P. Leung, C. R. Flowers, W. B. Talley, & P. R. Sanderson (Eds.). *Multicultural issues in rehabilitation and allied health* (pp. 129-154). Linn Creek, MO: Aspen Professional Services.

Ortiz, S. O., & Dynda, A. M. (2010). Diversity, fairness, utility, and social issues. In E. Mpofu, & T. Oakland (Eds.). *Assessment in rehabilitation and health* (pp. 37-55). Upper Saddle River, NJ: Pearson Education, Inc.

Zunker, V. G., & Osborn, D. S. (2002). *Using assessment results for career development* (6th ed., pp. 219-245). Belmont, CA: Brooks/Cole.

Evaluation: Methods 2 and 3.

12) Differences in Interactive Styles in Counseling Between Generic Counseling Approach and Counseling for Minorities

Learning Objective: To increase students' understanding of the difference of the interactive approaches of clients from an ethnic background in relation to generic counseling approaches.

Activity: Readings, Small Group Discussions, and Class Presentations. This exercise is a semester long counseling technique class. Students read the assigned chapters each week on specific counseling skills (Cormier & Cormier, 2008) and the chapters on counseling of various ethnic minorities (Sue & Sue, 2008). During class, students break into small group to discuss: 1) the assumptions of generic counseling approaches; 2) the unique interactive, communication, and worldview of the various ethnic minorities; 3) focus on why a generic counseling approach may or may not work for this group. Specifically focus on: a) verbal communication style (intonation, pitch, tone and speed of speech, language); and b) nonverbal communication style (paralanguage, eye contact, proxemics, and kinesics). By the end of the semester, all basic and advanced counseling skills must be covered. In terms of the discussion and application of different ethnic minority groups, instructors will use discretion in choosing which group(s) to discuss, depending on how many students and groups are broken into for discussion.

Readings:

Specific chapters on the specific counseling skills from Cormier, S., & Nurius, P. S. (2008). *Interviewing and changing strategies for helpers. Fundamental skills and cognitive behavioral interventions* (6th ed.). Pacific Grove, CA: Brooks/Cole-Thomson Learning.

Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse. Theory and practice* (5th ed.). Hoboken, NJ: John Wiley & Sons, Inc.: Chapters 7, 14-22.

Table 3. Specific Counseling Skills and Other Pertinent Counseling Characteristics.

Basic Counseling Skills*	**Advanced Counseling Skills***	**Observations**	**Additional Observations**
Listening	Intentional Silence	Accuracy	Keep focus
Restating/Paraphrasing	Self-disclosure	Body language	Eye contact
Summary	Interpretation	Empathy	Appears confident
Reflection	Challenges	Genuineness	Appears comfortable
Open-ended Questions	Information/Advice Giving	Acceptance	Respect diversity & differences
Close-ended Questions	Guidance	Non-judgmental	
	Immediacy		

* The thirteen counseling skills are taken from Cormier and Cormier (2008)

Evaluation: Methods 2 and 3.

13) Barriers to Counseling Among Clients of Ethnic Minorities

Learning Objective: To increase students' awareness and knowledge of various types of barriers to counseling among clients of diverse cultural backgrounds.

Activity: Reading, Interview, and a 5-Page Paper. After reading the chapter given below, students will interview at least one client from a multicultural background in their practicum setting regarding the content of the text. Students should ask the client his or her opinion about the seven characteristics that might pose barriers to counseling with someone from a diverse background. The seven characteristics include: focus on individuals, ambiguity, class bound values, distinction between mental and physical functioning, patterns of communication, language barriers, and expressiveness, insight and self-disclosure. The paper should focus on those barriers from the client's perspective.

Reading:

Sue, D. W., & Sue, D. (2008). Barriers to multicultural counseling and therapy. In D. W. Sue, & D. Sue (Eds.). *Counseling the Culturally Diverse. Theory and Practice* (5th ed. pp. 133-). Hoboken, NJ: John Wiley & Sons, Inc.

Evaluation: Methods 2 and 3.

14) Barriers to Counseling Among Clients of Ethnic Minorities and Strategies to Reduce Barriers - the Therapist's Perspective

Learning Objective: To increase students' awareness and knowledge of how rehabilitation counselors reduce barriers to counseling among clients from diverse cultural backgrounds.

Activity: Reading, Interview and a 5-Page Paper. This is a companion activity to the previous one but from the perspective of therapists who work with multicultural clients. Students first read the assigned reading as a sample of three health care professionals' experiences about multicultural rehabilitation practice. Students should then ask at least two therapists their opinion about the seven characteristics that might pose barriers to counseling with someone from a

diverse background. The seven characteristics include: focus on individuals, ambiguity, class bound values, distinction between mental and physical functioning, patterns of communication, language barriers, and expressiveness, insight and self-disclosure. Students should ask the therapists about their strategies used to reduce barriers when serving ethnic minorities with a disability.

Reading:

Garate, T., Charlton, J., Luna, R., & Townsend, O. (2010). Implications for practice in rehabilitation. In F. E., Balcazar, Y., Suraez-Balcazar, T., Taylor-Ritzler, & C. B., Keys, C. B. *Race, culture, and disability* (pp. 357-369). Sudbury, MA: Jones and Bartlett Publishers.

Evaluation: Methods 2 and 3.

15) Alternative Therapies

Learning Objective: To increase students' understanding and knowledge on alternative therapies used within diverse cultures.

Activity: Reading and 8-Page Paper. After selecting and reading one chapter on a specific alternative therapy from the reference below, choose one ethnic or cultural group and investigate the literature or personal resources regarding the use of alternative therapies in that culture. Examples of alternative therapies are provided below. The paper should describe the cultural group, the alternative therapies used within the culture, their uses, and perceived effectiveness.

Selected Chapter Reading from the following book:

Singh, S., & Ernst, E. (2008). *Trick or treatment. The undeniable facts about alternative medicine.* New York: W. W. Norton & Company, Inc.

Examples of Alternative Therapies: Acupuncture, homeopathy, chiropractic therapy, herbal medicine, anthroposophic medicine, aromatherapy, ayurvedic tradition, chelation therapy, cranial osteopathy, feldenkrais methods, feng shui, food supplements, hypnotherapy, meditation, neural therapy, orthomolecular medicine, osteopathy, reflexology, reiki, shiatsu, spiritual healing, traditional Chinese medicine.

Evaluation: Methods 2 and 3.

16) Alternative Treatment Methods and Resources – Client's Perspective

Learning Objective: To increase students' beliefs/attitudes and knowledge of non-mainstream counseling interventions from a culturally diverse group.

Activity: Interview, Research, and Presentation. Identify someone who has a disability and who is from an ethnic minority group. Conduct an interview to ask about the following questions: What is your disability? What common interventions (list 2) do you and your culture seek? Why and how do those interventions work? Identify at least 2 community resources that you use for additional assistance in coping with the disability.

Evaluation: Methods 2 and 3.

17) Resource Manual on Multicultural Resources for Rehabilitation Counselors

Learning Objective: To increase students' knowledge by creating a knowledge base of available resources on multicultural issues in rehabilitation counseling.

Activity: Create a resource manual. Each student will make a three ring binder that includes educational resources on multicultural issues in rehabilitation counseling. Sections might include: relevant bibliographies and chapters; listing of professional associations that focus on multicultural issues; listing of local counseling and mental health agencies that serve clients from multicultural backgrounds; listing of conferences at local, state and national levels on relevant topics; listing of on-line courses that focus on multicultural issues relevant to rehabilitation counseling; websites with relevant materials. In addition, each student should choose a different racial/ethnic group and provide a summary that describes one particular group and a listing of resources that will help to understand the group. These materials should be shared with the other members of the class and included in the binder.

Evaluation: Methods 2 and 3.

18) Research in Multicultural Rehabilitation Counseling

Learning Objective: To increase students' knowledge of current trends and future needs in research in multicultural rehabilitation counseling research.

Activity: Readings, Research and a 5-Page Paper. Students will complete the assigned reading to develop an understanding of three research perspectives (postpositivist constructions, constructivist approaches, and transformative applications) and research trends in multiculturalism and rehabilitation counseling. Each student will select one issue of a professional rehabilitation-counseling journal (e.g. Rehabilitation Counseling Bulletin, Journal of Rehabilitation, Rehabilitation Education, Journal of Applied Rehabilitation Counseling) published in the past two years and read the articles. Students will write a 5-page paper summarizing the articles in relation to research perspectives, trends of multicultural rehabilitation counseling research, and future directions.

Reading:

Fujiura, G., & Drazen, C. (2010). "Ways of seeing" in race and disability research. In F. E., Balcazar, Y., Suraez-Balcazar, T., Taylor-Ritzler, & C. B., Keys, C. B. *Race, culture, and disability* (pp. 15-32). Sudbury, MA: Jones and Bartlett Publishers.

Evaluation: Methods 2 and 3.

Activities to Develop Clinical Skills to Work with Culturally Different Individuals

Definition

Clinical skills involve actual interaction with individuals and clients from multicultural backgrounds. They emanate from a foundation of self awareness and a broadened knowledge base of multicultural issues. This section of activities focuses on dynamic activities and ones with professional implications.

Activities

1) Cultural Immersion Activity

Learning Objective: To increase students' awareness of everyday life among a specific cultural group.

Activity: Experiential Activity, Paper, and Class Discussion. Students should participate in this activity early in the semester. Students will identify and participate in college and community programs and activities that will help them become more familiar with and immersed in a different cultural group (e.g. Native Americans). Examples of activities include living in a language centered dormitory, participating in cultural or religious programs, attending presentations, volunteering in a specific multicultural community, visiting communities and homes, or study abroad. The paper should focus on the variety of experiences they had, what they learned about the culture, and what they still would like to learn about a particular cultural group. At the end of the semester, the students' experiences should be the topic of a class discussion. Discussion might focus on similarities and differences in experiences, what can be generalized, positives and negatives encountered, and application to clinical practice.

Evaluation: Methods 2 and 3.

2) Knowledge and Skills Acquisition of Multiculturalism in Education and Counseling

Learning Objectives: 1) To increase students' knowledge/resources of multicultural education and training; 2) To encourage students to enroll in at least one or more multicultural training sessions.

Activity: Research, Training, and a 5-Page Paper. Each student creates a list of 5 multicultural training activities (e.g., workshops, conferences, short online courses) he/she would like to engage in; at least one activity must be completed by the end of the semester**.** Each student will write a 5-page reflection paper on his or her experience in the activity regarding acquisition of knowledge, belief and attitude change, and skills pertinent to counseling practice. Students are to identify multicultural training activities from one of the following resources: 1) Local rehabilitation counseling and mental health agencies; 2) National professional conferences on multiculturalism (see appendix A); or 3) On-line courses (taught by qualified professionals, and the duration of the training has to be at least one hour).

Evaluation: Methods 2 and 3.

3) Advancing Students' Racial/Ethnic Identity Development

Learning Objective: To learn strategies in experiencing and advancing students' racial/ethnic identity development.

Activity: Reflection/Consultation and a 5-Page Paper. This is a follow-up exercise to *Activity 4) Understanding Your Own Racial/Cultural Identity Development* from the Section *Activities to Develop Knowledge of the Clinicians' and Clients' Worldviews*. Reflect and provide 5 strategies that you will engage in to mobilize or maintain your stage of development. This can be done through your own reflection or through consultation with instructors or clinicians. Other topics might include how these strategies reduce barriers in counseling and the students' comfort level in integrating the strategies into clinical practice.

Evaluation: Methods 2 and 3.

4) Skills in Overcoming Personal Values that Affect Counseling

Learning Objective: To learn strategies in overcoming students' own multicultural challenges in counseling resulting from personal values.

Activity: Reflection/Consultation, and a 2-Page Write-Up. This is a follow-up exercise to *Activity: 4) Reflection of Personal Values in Counseling* from the section *Activities to Develop and Awareness of Clinicians' Own Beliefs and Attitudes*. List and discuss 4 strategies that you will engage in to overcome challenges when you encounter them in your clinical counseling with clients from a multicultural background. This can be done through your own reflection or through consultation with instructors or clinicians. How comfortable are you in integrating those strategies into your practice?

Evaluation: Methods 2 and 3.

5) Acculturation and Strategies to Work with Clients

Learning Objective: 1) To increase students' knowledge of the process of acculturation as it affects rehabilitation counseling. 2) To increase students' skills for working with individuals who are acculturating to different cultures.

Activity: Research, Interview, and a 5-Page Paper. This is a good follow up exercise to *Activity: 6 Acculturation* from the section *Activities to Develop Knowledge of the Clinicians' and Clients' Worldviews*. Student should interview two rehabilitation counselors regarding how they perceive their clients' acculturation. The interview should focus on the process of acculturation, progress, and barriers to acculturation in clients from a multicultural background. In addition, students should ask the interviewees about how they modify the counseling strategies they use with clients who are in the process of acculturation.

Evaluation: Methods 2 and 3.

6) Using Traditional and Nontraditional Assessment Methods in Rehabilitation Counseling

Learning Objectives: 1) To develop students' ability to administer traditional and nontraditional assessment techniques to a client from a multicultural background with a disability; 2) To write up a clinical report on such a client.

Activity: Readings, Test Administration, Evaluation Report, and a 5-Page Paper. After completing the reading list below, students choose one psychological or vocational assessment inventory to administer to a client from a multicultural background. The student must administer the test, score and interpret it, and write a report of results. Following this, students then choose a non-traditional assessment method outlined in the Zunker and Osborn (2002) readings to supplement the traditional assessment results. Triangulate the results from both the traditional assessment and the non-traditional assessment methods. Write a paper to address the presenting problem, traditional assessment and non-traditional assessment techniques used and results, comparison of results, and ways to modify the traditional assessment. Include the client report with the paper for evaluation.

Readings:

AERA, APA, NCME. (1999). *Standards for educational and psychological testing.* Washington, DC: Joint Committee on Standards for Educational and Psychological Testing of the American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education. American Educational Research: Chapters 4, 7, 9, 10 and 12.

Zunker, V. G., & Osborn, D. S. (2002). *Using assessment results for career development* (6th ed.). Belmont, CA: Brooks/Coles.: Chapters 12, 13, and 14.

Evaluation: Methods 2 and 3.

7) The Psychological Aspects of Disability Among Ethnic Minorities – Implications to Counseling Intervention

Learning Objective: To increase students' skills and knowledge in counseling in addressing the psychological aspect and impact of disability among ethnic minorities.

Activity: Research, Interview, and a 15-Page Paper. Students choose a disability type and an ethnic minority group**.** Students then do research on the following topics: 1) perception of the disability (causes, visibility, onset); 2) perception of coping (internal locus of control versus external locus on control, internal locus of responsibility versus external locus of responsibility; 3) professional versus non-professional help-seeking behaviors; and 4) perception and experience in discrimination related to both the disability and the personal cultural background.

Write a 15-page paper addressing each of the four topics identified above. Based on the literature, compare the perception, psychological reaction of disability, and help-seeking behaviors between the mainstream culture and this minority culture. Additionally, conduct an interview with a practicing counselor who works with this ethnic and disability group. With information you gathered from the research readings and from the interview with the clinical

expert, indicate counseling techniques and intervention strategies that help address clients' perception and behaviors of seeking counseling.

Evaluation: Methods 2 and 3.

8) Observation and Practice on Interactive Styles in Counseling Between Generic Counseling Approach and Counseling for Clients from a Multicultural Background

Learning Objective: 1) To develop students' appropriate communication counseling strategies for working with clients from a multicultural background.

Activity: Observation of Clinical Interaction and Class Discussion. This is a practical exercise following *Activity 12) Differences in Interactive Styles in Counseling Between Generic Counseling Approach and Counseling for the Minorities* from the section, Activities *to Develop Knowledge of the Clinicians' and Clients' Worldviews*. Students should each observe 3-4 rehabilitation counseling sessions for a client from a multicultural background. Such observations can be from professional videos on counseling multicultural clients or sessions demonstrated by fellow students and instructors. Observation should focus on a) the verbal and nonverbal styles used by the client and clinician, and b) the clinician's adequacy in basic and advanced counseling skills to meet the client's needs. Observations serve as the basis for class discussion of these topics and application to clinical practice. See the above exercises for the various counseling skills being covered.

Evaluation: Methods 2, 3, 4, and 5.

9) Counseling Theories and Techniques – Application to Working with Culturally Diverse Clients

Learning Objectives: 1) To increase students' ability to apply specific counseling theories and techniques in working with clients from a multicultural background; 2) To identify the strengths and weaknesses of the theories and techniques in clinical practice; 3) To identify ways to modify traditional theories and techniques in clinical practice with multicultural clients.

Activity: Class Discussion and Presentation. Each week in a Counseling Theories class, one or two theories are covered. In the last part of the lecture, students form small groups to discuss the following questions for 15 minutes. By the end of the group discussion, each group will present to the class a summary of their group discussion.

Theory or theories covered today: _____
Unique characteristics, if any, of a particular multicultural group (e.g., individuals who have autism, individuals who have hearing impairment, individuals from a race/ ethnic group):
_____

Discussion questions:
1) What are the strengths and weaknesses of the theory in conceptualizing psychopathology?
2) What specific counseling techniques of this theory would work well for this population, and why?

3) How would you modify those counseling techniques of this theory in order to better fit working with this population? Why?

Evaluation: Methods 2 and 3.

10) Role Playing Counseling Sessions

Learning Objective: To increase students' case conceptualization and multicultural counseling skills when working with clients from multicultural backgrounds.

Activity: 4 Mock-Up Counseling Sessions. A graduate student impersonates a client of a specific profile. Each student will conduct 4 sessions with the same graduate student/client, consisting of an interview, goal setting, intervention/follow-up, and termination of treatment. Each session is taped and lasts for 30-45 minutes. All session will be conducted behind a one-way mirror while the instructor (observes all 4 sessions). Students will review each tape with the instructor's input. Both students and instructor will evaluate the following counseling skills (see below).

Basic Counseling Skills
Listening
Restatement/Paraphrasing
Summary
Reflection
Open-ended Questions
Close-ended Questions

Advanced Counseling Skills
Intentional Silence
Self-disclosure
Interpretation
Challenges
Information/Advice Giving
Guidance
Immediacy

General Impression
Was your counselor accurate about the information discussed?
Did you find your counselor relaxed and approachable?

General Impression
Did you find your counselor genuine and empathetic?
Did you find your counselor accepting of you (non-judgmental)?

Did you find your counselor effective and confident in helping you?
Did you find your counselor culturally sensitive?
Note: N/A=not applicable; 0=not effective;1=somewhat effective; 2=average effective; 3=very effective; 4=highly effective

Evaluation: Methods 2, 3, 4, and 5.

11) Understanding Disability and Treatment – Evidence Based Practice

Learning Objective: To develop students' culturally appropriate skills to work with clients from diverse backgrounds.

Activity: Research/Interview and an 8-Page Paper. Students identify a disability they are interested in and research it from the perspective of a specific multicultural group (e.g. How do native Koreans view autism or Asperger's syndrome?). Students review the research from the

professional and popular literature. The content of the paper should be based on the following questions: What is the definition of the disability from the professional literature (e.g., medicine, counseling, psychology, rehabilitation specialties)? What is the definition of the disability from the popular literature of the identified culture? How are the two definitions similar and different? What is/are the evidence-based treatment(s) from the professional literature? What is/are the treatment(s) (both professional and cultural) from the popular literature? In your opinion, how are the treatments from the professional and the popular literatures complimentary or how are they in conflict of each other? Assuming you practice professional, main-stream counseling and intervention, list 5 ways you will resolve the potential conflicts if you work with a client who also wants to incorporate a particular cultural treatment.

Evaluation: Methods 2 and 3.

12) Treatment Plan in Vocational Placement for People with Various Disabilities

Learning Objective: To increase students' skills in case conceptualization and vocational counseling for various disability groups from a multicultural background.

Activity: Research and Class Presentation. Small student groups will be assigned 2-3 generally related disabilities from the reference below (e. g stroke and traumatic brain injury) and a specific racial, ethnic, or religious group, (e.g., Hispanic, Asian, Muslim). Students will research the disability and consider how their multicultural group might perceive the disability from their worldview. Students will apply and discuss how the systems' approach of vocational placement from Kundu et al. (2010) can be used in the placement process for ethnic minorities with a disability. Students then discuss how they, as rehabilitation counselors, would consider the information when planning vocational goals, resources, and placement in the community. Students then give a short 20-minute presentation on their disability and cultural group focusing particularly on vocational assessment and intervention.

Readings:

Andrew, J. D. (2008). (Ed.). *Disability handbook.* Department of Rehabilitation Education and Research, University of Arkansas. Linn Creek, MO: Aspen Professional Services.

Kundu, M. M., Dutta, A., & Chan, F. (2010). A systems approach to placement: A culturally sensitive model for people with disability. In F. E., Balcazar, Y., Suraez-Balcazar, T., Taylor-Ritzler, & C. B., Keys, C. B. *Race, culture, and disability* (pp. 325-344). Sudbury, MA: Jones and Bartlett Publishers.

Evaluation: Methods 2 and 3.

13) Personal Adjustment Counseling

Learning Objective: To increase students' skills in case conceptualization using counseling theories/interventions for multicultural clients.

Activity: Case Studies and Class Discussion. Students will be provided various case studies during classes. Case studies can be real cases from the instructors or students from practicum experiences, or fictitious cases from texts. These cases can be used in various types of

rehabilitation counseling classes, depending on the content (e.g., counseling theories, vocational counseling, or a specific intervention class). After discussing how specific theories and intervention are applied to mainstream clients, application to multicultural case studies can then be discussed. Questions for discussion include:

1. What are the unique cultural challenges of this case?
2. Applying the specific counseling theory learned today, what is the rationale for psychopathology? Are there any cultural differences and barriers that may explain other reasons for the psychopathology?
3. What are the short and long term goals you will set for this client based on this theory?
4. What are the cultural consideration in setting and prioritizing certain goals?
5. What counseling or intervention techniques will you be implementing based on this theory? Any potential cultural barriers?
6. What is the prognosis? What are the potential cultural barriers?

Evaluation: Methods 2, 3, 4 and 5.

The cases of Morticia, Mahatma, and Sam can be retrieved from the following text:

Day, S. X., & Andersen, P. (2004). *Acquiring clinical judgment to accompany theory and design in counseling and psychotherapy: A workbook/casebook*. Boston, MA: Houghton Mifflin College Division.

Another resource for true cases with case conceptualization, treatment, and discussion by professional clinicians can be found in the following text:

Spitzer, R. L., First, M. B., Williams, J. B. W., & Gibbon, M. (2006). *DSM-IV-TR Case Book Volume 2. Experts Tell How They Treated Their Own Patients*. Washington, DC: American Psychiatric Publishing Inc.

14) Case Conceptualization Using the Three Dimensional Model

Learning Objective: To increase students' knowledge, awareness and skills in case conceptualization applying a multicultural model working with ethnic minorities with disabilities.

Activity: Reading, interviews, and 10-page reflection term paper. This is a semester long activity. The chapter provides both a model (the Three-Dimensional Model) and step-by-step activity guidelines for students to integrate cultural identity, stage of development and adjustment to disability as the three underlying constructs when working with a minority with a disability. Students will write a portion of the 10-page reflection paper at different steps of the activity. 1) Students will begin by completing the assigned chapter by the first week of the semester. 2) Each student will then identify an individual, preferably a minority client that the student is actively working with in a practicum or internship. 3) Students will follow the "starting resources" section of the guidelines to reflect and write a 2-page paper on the topic of counselor characteristics. 4) Next, students will gather the necessary information, via multiple interviews, on their clients based on the "key activities" section of the guidelines, followed by a 2-page write

up. 5) Students will then write another 3-page reflection paper based on the first three goals of the "goals" section of the guidelines on a working model of case conceptualization. 6) The last two goals of the "goals" section of the guidelines ask students to meet with their clients to test their working model of case conceptualization. 7) Students complete the last 3 pages of the write-up by reflecting on how the working model of case conceptualization has helped them to understand their client, and any limitations.

Reading:

Lewis, A. N., & Shamburger, A. (2009). A three-dimensional model for multicultural rehabilitation counseling. In F. E., Balcazar, Y., Suraez-Balcazar, T., Taylor-Ritzler, & C. B., Keys, C. B. *Race, culture, and disability* (pp. 229-253). Sudbury, MA: Jones and Bartlett Publishers.

Evaluation: Methods 2 and 3.

15) Real or Factitious Case Study

Learning Objective: To develop students' skills for discussing multicultural clients with a disability.

Activity: Create a dynamic case study for class presentation. Students will create a multicultural case study for class presentation from their own clinical experiences or based on their clinical experiences in practicum or internship. Students should give pertinent personal and family history, a summary of assessments and intervention, specific needs of the client and disability, potential problems to effective service delivery, and strategies to reduce cultural barriers. Students should also include a reference list on resources to meet the needs of such a client for classmates.

Evaluation: Methods 2, 3, 4 and 5.

16) Vocational Counseling

Learning Objective: To increase students' skills in multicultural vocational counseling.
Activity: Readings, Small Group Discussion, and Presentation. Students complete the assigned readings before class. During class, students break into small groups and are given a case study for conceptualization and discussion. Specific discussion includes presenting problems, goal setting, types of counseling and treatment intervention appropriate for this client, prognosis, potential barriers and strengths the client and family bring to the vocational rehabilitation context, and possible recommendations. The following two cases are examples used in a vocational class. Instructors are encouraged to modify and use other cases that suit their class and students.

Evaluation: Methods 2, 3, 4 and 5.

Case Study 1: Ming-Yee

Referral background. Ming-Yee is referred to the Interdisciplinary Rehabilitation Unit by his case manager in the workers' compensation board. Two years ago, while he was at work, one of the oil fields had an explosion, and Ming-Yee was in critical condition. He was in a coma for two

weeks. He had multiple injuries including a moderate brain injury. The workers' compensation board was not able to clear some medical and legal issues, and Ming-Yee was not referred for rehabilitation until six months after he was discharged from the hospital. Ming-Yee was considered a "difficult" client because he was not co-operative, challenging to therapists, and always raising issues in groups. He was discharged from the rehabilitation center after four weeks due to non-compliance and lack of progress.

Personal background. Ming-Yee is a 50-year-old oil industry consultant living in Texas. Ming-Yee is an immigrant from mainland China. He and his wife came to the US 30 years ago hoping to pursue the American dream.

Educational and vocational background. Ming-Yee finished his Grade 9 equivalence in education. He learned welding informally which led him to his first job as a welder at 17 years of age. He also ran a small business with a partner where he sold construction tools for three years in China. He then entered the oil industry when his family immigrated to Texas when he was 20 years old. Ming-Yee has worked in two different oil refineries in extracting crude oil. He reported no other education or vocational training.

According to Ming-Yee, he takes tremendous pride in his achievement. He invested a great deal of his time in the oil field industry. He has been earning over $100,000 annually. Ming Yee's job involves providing technical support in checking and regulating the oil industries. His job requires him to work long hours in remote and dangerous places.

Family history. Ming-Yee has been married since he was 20 years old. He and his wife have two children, 11 and 15 both in school. Ming-Yee has been the breadwinner of the family as his wife does not work professionally. Ming-Yee indicated that he had positive relationships with his family until after the accident. Since his accident, his wife has been working part-time for six months as a cashier in a local grocery store. He indicated no other relatives or close family. Both his parents passed away, and his wife's parents reside in eastern Canada.

Psychological status. Ming-Yee reported that he was depressed and not motivated because "his future was ruined." He reported feeling "useless" because he previously earned a substantial salary to support his family, but was no longer able to do so. He reported feeling badly that his wife had to work to support the family in addition to her home and family duties. Ming-Yee's symptoms (headaches, body aches, weakness, dizziness, nausea) contribute to his anger and agitation. As a result, he has had recent conflicts and arguments with his wife. He also reported having more severe seizure symptoms, and he worries tremendously that his condition will never allow him to return to his work. Finally, Ming-Yee reported feeling somewhat apprehensive about returning to return to his former job because he is afraid that a similar accident will happen.

Current Issues. This year, Ming-Yee was readmitted to the same rehabilitation center for a minimum of 15 weeks of rehabilitation treatment after his medical and legal issues were settled.

He reports the following concerns:

- questioning the usefulness of the rehabilitation

- mistrust in staff working with him (due to the previous experience two years ago)
- questioning that his symptoms (pain, headache, dizziness, memory, recurring seizures) will ever going away
- anger and depression problems
- interpersonal problems, especially with his wife and two children at home
- self-esteem concerns
- perceiving that he will never return to the same job and earn the same salary (relates to his worries of how he would take care of his family) — he sees his career option as all or nothing
- he feels hopeless about the future, and he feels shameful and guilty for not being a good father and husband to his family

Refer to the following chapters and articles for the integration of cultural values into your case discussion.

Bedford, O., & Hwang, K. K. (2003). Guilt and shame in Chinese culture: A cross-cultural framework from the perspective of morality and identity. *Journal for Theory of Social Behaviour, 33,* 125-142.

Bond, H. M. (1991). *Beyond the Chinese face: Insights from psychology.* NY: Oxford University Press.

Kim, B. S. K., & Atkinson, D. R. (2001). Asian cultural values and the counseling process: Current knowledge and directions for future research. *The Counseling Psychologist, 29(4),* 570-603.

Leung, K. (1996). The role of beliefs in Chinese culture. In M. H. Bond (Ed.), *The handbook of Chinese psychology* (pp. 247-262). NY: Oxford University Press.

Russell, J. A., & Yik, M. S. M. (1996). Emotion among the Chinese. In M. H., Bond (Ed.), *The handbook of Chinese psychology* (pp. 294-308). NY: Oxford University Press.

Yu, A. B. (1996). Ultimate life concerns, self and Chinese achievement motivation. In M. H., Bond (Ed.), *The handbook of Chinese psychology* (pp. 280-293). NY: Oxford University Press.

Case Study 2: Amin

Referral questions. Amin was referred to the Counseling Center at the university for three major reasons: 1) mental health issues; 2) addictions; and 3) academic issues.

Basic demographic background. Amin is a single 22-year-old senior college student of Muslim descendant. He is in his third year as an Engineering major. Next semester will be his last semester in taking coursework, and he will be expected to apply for his internship after completion of coursework. Amin is an international student whose parents reside in Pakistan. He has two older siblings. One brother is a successful medical doctor in the US, and the other older sister is a lawyer in Pakistan. He reported having some friends here but mainly classmates from

his major. Otherwise, he reported that "he does not have a social life." He reportedly has no romantic relationships.

Emotional/psychological status. Amin reported that he feels "stressed about school and pressured from family." He denied having any psychological issues such as depression or anxiety. He reported that sometimes his stress level would be so high that he had difficulty going to sleep and may exhibit bodily pain. He reported that his lack of sleep could also be due to his self-expectations and values about life. For example, he was expected to respect his parents and their wishes and had to work hard in his studies. He reported that he wakes up 4 a.m. and goes to sleep at 1a.m. everyday. His daily routine follows the schedule of praying several times per day, studying, attending classes, working on campus part-time, and doing his homework. He reported that he observes the Muslim religion and prays, but the practice does not provide relief, it is only an obligation. Amin described himself with numerous self-defeating comments. For example, he stated, "I am shameful to not do well in school," "I let down my family," "I am violating my religion by drinking and becoming an alcoholic," "I feel bad that I complain," "I should complete my degree in engineering, and I should forget about other majors."

Addictions. Two years ago Amin began drinking with one of his roommates and found this a good way to relax. He reported that he was only a social drinker until one year when he found his drinking frequency increased from "once every 2-3 weeks" to "once every other day." At the same time, he reported that he was failing some of the upper level classes that were crucial for him to get a good final year internship. Since then, Amin reported finding himself drinking more, being late or not attending class, and not being able to complete his work for classes. In addition, his parents began to pressure him to get an internship and to return to Pakistan to work.

Educational/vocational status. Amin reported that he "hated" Engineering and that his parents expected him to be an engineer when he returns to Pakistan next year. While he has been forcing himself to pursue his Engineering degree, he finds the past four years of school not enjoyable at all. Amin also reported that he did not want to return to Pakistan. He would like to explore his options and explore the American culture more, perhaps exploring a graduate degree in psychology or counseling. Besides the fact that Amin does not enjoy Engineering, he reported that he took an elective in introduction to counseling and found that he enjoyed the counseling sessions and psychology. He indicated that although he does not have many friends outside his major, he usually was the one who listened and lent a shoulder to his classmates who had problems.

Family issues: As reported earlier, Amin's parents are in Pakistan. He has two siblings and reported that they are doing well. Amin reported that he does not know how and is afraid to let his parents know his current situation. He reported that his parents would be shamed by his "mischief," and they would probably disown him. His parents expect him to obtain an engineering degree and return home. Amin is afraid to let them know that he is failing classes, wants to change his major to psychology, and that he is drinking and emotionally weak.

Case conceptualization: You are a rehabilitation counselor who is trained to provide personal adjustment counseling as well as academic/vocational guidance. List 2 short term goals and 2 long goals pertaining to his academic/career issues. List 2 short term goals and 2 long goals

pertaining to his psychological issues. Consider how the client's cultural background influences your case conceptualization. What are unique cultural barriers faced by your client? Identify the unique personal, cultural, and vocational values that your client faces. What are the priorities and treatment interventions for your client?

17) Advocacy

Learning Objective: To increase students' awareness of and skills in promoting advocacy among clients from a multicultural background.

Activities: Research, Interview, and Small Group Presentation. Student pairs will decide on a multicultural group in the community and identify those individuals, groups, or agencies that frequently serve an advocacy role. Students should obtain information about each, interview key advocates, and do a 20-minute presentation on: 1) advocacy resources for their group in the community; 2) strategies and actions for clients and professionals to increase advocacy activities.

Evaluation: Methods 2, 3, 4, and 5.

18) Resources for Multicultural Clients with Various Types of Disabilities

Learning Objective: To increase students' ability to identify appropriate community resources for multicultural clients with a variety of disabilities.

Activity: Interview, Research, and Clinical Binder. Individual or student pairs should interview therapists who have caseloads with multicultural clients. The interview should focus on identifying referral and other community resources to meet the educational, medical, social, psychological and vocational needs of specific cultural groups (e.g. Chinese or Muslim clients). Students should then collect information about each resource and collate it into a clinical binder. Students should share information with classmates.

Evaluation: Methods 2, 3, and 4.

19) Multicultural Research in Rehabilitation

Learning Objective: To increase students' awareness of how multicultural issues are addressed in the rehabilitation counseling literature.

Activity: Research, Readings, and 5-Page Paper. Students will investigate the past 5 years of a research-focused journal (e.g. *Rehabilitation Counseling Bulletin, Rehabilitation Psychology, Journal of Applied Rehabilitation Counseling, Journal of Rehabilitation, Rehabilitation Education, Journal of Career Development, Journal of Career Assessment, and Journal of Vocational Behavior*) that addresses rehabilitation counseling issues. They are to review the literature in those journals and discuss how multicultural issues were or were not addressed in the published research. Students then write a short paper that addresses what multicultural groups were included in the research for their journal and time period, a synthesis of major findings for those groups, and future research needs regarding multicultural issues in rehabilitation counseling.

Evaluation: Methods 2 and 3.

Appendix A: National Conferences on Multiculturalism and Rehabilitation Counseling, Psychology and Education

1. National Association of Multicultural Concerns – annual conference held by the National Rehabilitation Association.
   http://www.namrc.org/about/index.html

2. National Multicultural Conference and Summit – conference held every two years by the following divisions of the American Psychological Association (Divisions 17, 35, 39, 42, 44 and 45).
   http://www.multiculturalsummit.org/

3. Diversity Challenges – annual conference held by the Institute for the Study and Promotion of Race and Culture - Boston College, Lynch School of Education.
   http://www.bc.edu/schools/lsoe/isprc/home.html

4. The Winter Roundtable on Cultural Psychology and Education. Incorporating Multicultural Models in Psychology and Education – annual conference held by Teachers College, Columbia University.
   http://www.tc.columbia.edu/roundtable/

Appendix B: Bibliography

Readings on Multiculturalism

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Abreu, J. M., Gim Chung, R. H., & Atkinson, D. R. (2000). Multicultural counseling training: Past, present, and future directions. *The Counseling Psychologist, 28*(5), 641-656.

Arredondo, P., Toporek, M. S., Brown, S., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). *Operationalization of the multicultural counseling competencies*. Alexandria, VA: AMCD.

Association of Multicultural Counseling and Development (2009). The AMCD multicultural counseling competencies. Retrieved July 24, 2009, from http://www.amcdaca.org/amcd/competencies.pdf

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Professional Videos on Multiculturalism

Selected list of videos is from the Microtraining and Multicultural Development: (www.emicrotraining.com). Microtraining and Multicultural Development, 141 Walnut Street, Hanover, MA 02339.

Social Justice

- Competence: Awareness, knowledge & skills.
- Cultural Psychology: Fostering agency for human change.
- Delivering psychological services in the midst of social injustices.
- Empowerment and social justice: Values, theory and action.
- Overcoming personal racism: What can I do?
- The psychology of racism: Where have we gone wrong?
- Surviving racism: A message to people of color.
- Social justice in action: Examples of practice and visions of the future.
- What does it mean to be White? The invisible Whiteness of being.

Professional Videos on Disability

- Culturally diverse individuals with disabilities: Therapeutic needs.
- Disability – affirmative therapy: A beginner's guide.
- What psychotherapists should know about disability.

Counseling Specific Diverse Population

- Counseling and therapy with Native American Indians
- Counseling Latina/o children and adolescences: Cross cultural issues
- Cultural competency in the treatment of African-American couples
- Innovative approaches to counseling African descent people

- Innovative approaches to counseling Asian-American people.
- Innovative approaches to counseling Latina/o people.

Multicultural Groups Counseling

- Group microskills: Encountering diversity.

General Multicultural Counseling

- Cross-Cultural counseling: Clinical case examples.
- Counseling the multiracial population: Couples, individuals, & families
- Pedersen's triad training model: Five vignettes of culturally different counselors interviewing a single client.
- Vignettes of culturally different counseling: Working with clients different than you.

Multicultural Assessment

- Culture and standardized tests: Native American issues and examples.
- Race and assessment: Measurement and legal implications.
- Solving the mystery of racial bias in testing: How much does it cost to think about being blank?

The following selected videos are from the American Psychological Association. American Psychological Association, 750 First Street, NE, Washington, DC 20002.

Counseling Specific Diverse Population

- Counseling Asian-American clients.
- Counseling Latina/Latino clients.
- Working with African American clients.
- Working with Asian American clients.
- Working with Native Americans.

Group Counseling

- Afrocentric approaches to group work: I am because we are.

Multiracial Counseling

- Working with immigrants.
- Mixed-race identities.

Vocational Counseling

- Career counseling skills for contextual decision making.
- Career counseling skills for guided discovery and career assessment.
- Culturally oriented career counseling.

Appendix C: Popular Videos

- Bend it Like Beckham (cultural and family adjustment)
- The Birdcage (Lesbian, Gay, Bisexual and Transgender [LGBT])
- Boyz N the Hood (African American culture)
- Breakfast Club (school age students)
- Children of a Lesser God (people with disabilities)
- The Color Purple (African American culture)
- Crash (various scenes of ethnic groups)
- Dead Poets Society (adolescents dealing with adjustment issues)
- Fight Club (Adults with adjustment life issues and psychiatric issues)
- Girl, Interrupted (adolescents with adjustment and psychiatric issues)
- The Good Son (grief and loss, adjustment issues)
- Hoop Dreams (Native American culture)
- I Am Not Stupid (Asian culture)
- Igby Goes Down (school and family issues)
- The Joy Luck Club (Asian culture)
- Mi Familia (Latina/Latino culture)
- The Milagro Beanfield War (Latina/Latino culture)
- The Mission (Native American culture)
- My Left Foot (people with disabilities)
- Napoleon Dynamite (people with disabilities)
- Queen of the Nile (LGBT)
- Stand By Me (grief and loss)
- The Wedding Banquet (An Asian who is gay)
- What's Eating Gilbert Grape (family issues)