Recognizing Ableism and Practicing Disability Humility: Conceptualizing Disability Across the Lifespan

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Abstract

Disability culture is often misunderstood by counselors who lack extensive training in working with individuals with disabilities (IWDs) (Stuntzner & Hartley, 2014). This quantitative study used the Counseling Clients with Disability Survey (CCDS) to explore the beliefs and perceived knowledge of counselors-in-training (CITs), counselors, and counselor educators regarding preparation to counsel IWDs, which is particularly important as disability status can change across the lifespan, and given that the Council for Accreditation of Counseling and Related Educational Programs (CACREP) Standards Review Committee provided a guide to the draft standards incorporating the infusion of disability concepts. Results indicate that counselors were competent regarding disability awareness and use of microskills but lacked specific knowledge regarding disabilities. Findings suggest that faculty members need to intentionally infuse cultural humility and assess for readiness when working with IWDs. The manuscript concludes with specific suggestions of integrating disability content into varied coursework.

KEYWORDS:
disabilities, humility, lifespan, counseling, identity development

Recognizing Ableism and Practicing Disability Humility: Conceptualizing Disability Across the Lifespan

More than 61 million, or 1 in 4, adults in the US are living with a disability as defined by the Americans with Disabilities Act (ADA; Centers for Disease Control and Prevention, 2019). Additionally, the U. S. Census Bureau (2021) estimated that individuals with disabilities (IWDs) comprise nearly 13% of the overall population in the US, making up less than 1% of people under 5 years old, nearly 6% of people ages 5 to 17 years old, 6.6% of people 18–34 years old, 12.5% of people ages 35-64 years old, 24.4% of people ages 65-74 years old, and over 48% of people 65 or older. Consequently, as adults develop and age, counselors need to be informed of issues that can affect individuals throughout young, middle, and older adulthood. Additionally, as global populations become increasingly diverse, counselors need to be trained to use best practices to provide culturally competent services to people of all ages with disabilities.

Although cultural competence, or the ability to display knowledge and provide effective treatment, is important for counselors, it can inadvertently reduce clients to one facet of their identity. Therefore, counselors have shifted their focus to practicing cultural humility, which values the self-first and calls on counselors to examine and unpack any implicit biases. The need for counselors to practice cultural humility is imperative. Thus, counselor educators and supervisors (CESs) play a vital role in implementing learning activities that cultivate increased self-awareness and self-reflection. Additionally, CESs monitor the willingness of counselors-in-training (CITs) to learn through interpersonal interactions (Ratts et al., 2016). Further, the merger of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and the Council of Rehabilitation Education (CORE) in July 2017 (two of the largest counseling accrediting bodies) provided an opportunity for CACREP to address a major gap in the standards: the lack of training counselors receives in meeting the needs of IWDs. The CACREP Standards Review Committee incorporated disability concepts into the draft standards, which calls on counselors to not only be aware of disability concepts, but also to understand the effects that power and privilege have on the therapeutic alliance, as well as factors that affect human development and functioning (CACREP, 2016). However, to date, among the eight core areas, only human growth and development indicates that curriculum should include "a general framework for understanding differing abilities and strategies for differentiated interventions" (Section II: F.3.h.). Although this standard ensures that training programs provide counselor students with curriculum that addresses the needs of IWDs, it remains vague and undefined. Therefore, we aimed to examine the perceived knowledge, skills, and awareness of CITs, licensed counselors, and counselor educators in a CACREP-accredited program.

This article provides current data on the disability population in the United States, along with empirical findings related to counselors' perceived knowledge, skills, and awareness when counseling IWDs. In this study, we use the person-first language and approach to disability (e.g., person with a disability) to emphasize the individual over the disability, which is commonly used in formal writing (Employer Assistance and Resource Network on Disability Inclusion, n.d.). However, others in the field might employ an approach that emphasizes the disability as a valued identity (e.g., disabled person) and an integral part of one's cultural context. Both approaches are represented in the literature and should be selected to honor individuals' preferences (American Psychological Association, 2020). Given how integral language is in the lives of IWDs, counselor awareness of intersectional language when working with this population is essential to understanding lifespan and development and delivering culturally responsive care. Additionally, cultural humility can also advance counseling practice as a developmental approach. To highlight a developmental approach, we discuss potential andragogical methods within counseling curricula to promote recognizing, addressing, and practicing cultural humility when working with IWDs across their lifespan.

A Developmental Perspective

Information about disabilities can be incorporated into courses across the counseling curriculum. However, we believe it is crucial to connect all master's-level counseling courses to a lifespan or whole-person perspective, which is integral to the counseling profession. Additionally, human growth and development is central to the American Counseling Association (ACA) Code of Ethics, which requires counselors to communicate information in a manner that is developmentally and culturally appropriate (ACA, 2014). Therefore, human growth and development is the foundation of counselor identity, providing a conceptual framework for understanding clients and their worldviews. Specifically, this perspective allows patterns of change to be observed from conception to death. These patterns reflect the biopsychosocial integration of clients and the maturation of biological and

physical processes in the body. In addition to these factors, counselors can assess their clients' psychological, emotional, and cognitive changes, and the interplay of these elements with social and cultural contexts.

Introduction to Disabilities

The ADA (1990) defines disability as a physical or mental impairment that substantially limits one or more major life activities (e.g., hearing, seeing, speaking, walking, thinking, learning, working, etc.). This definition is the most used for individuals over 18. However, a more current, globally accepted view of disability is the friction between an individual's personal condition and any negative, inaccessible, or antagonistic environmental factors that impede the person's participation in society (Kelly, 2014). Additionally, Cieza et al. (2018) described disability as a human experience and stressed the importance of viewing disability on a continuum of functioning. This perspective acknowledges that individuals may be currently experiencing or are susceptible to experiencing disabilities throughout their lifespan.

A Sociopolitical Perspective

Ableism occurs when individuals stereotype, display prejudicial attitudes, exhibit discriminatory behavior, or exercise social oppression against IWDs. These actions compromise the general wellbeing of IWDs, especially as IWDs constitute the largest minority group in the U.S., unique in that it is a group anyone can become a member of at any point across their lifespan (Forber-Pratt & Zape, 2017; Huff, 2021). Further, the population of IWDs has been increasing due to the COVID-19 pandemic. The U.S. Department of Health & Human Services (2021) recently categorized "Long COVID," the prolonged effects of the SARS-CoV-2 virus that causes COVID-19, as a disability under existing federal disability law. More than half of the 236 million people diagnosed with COVID-19 worldwide since December 2019 will experience "Long COVID" for 6 months or longer after recovering from the acute infection stage. These long-term effects include mental health disorders (Mosheva et al., 2021). Consequently, the percentage of individuals acquiring a disability will increase, as will the likelihood of counselors encountering IWDs in their clinical practice.

Counseling IWDs

Clinical mental health counselors (CMHCs), marriage, couple, and family counselors (MCFCs), and school counselors (SCs) provide services to IWDs and their families. However, they have reported lower levels of preparation and receptivity to individuals with physical disabilities due to counselors' primary area of expertise being mental health rather than physical disabilities (Bell et al., 2022; Strike et al., 2004; Thomas et al., 2011). Overall, counselors have felt underprepared to provide services to IWDs (Bell et al., 2022), expressing a desire for more training to support IWDs effectively. One strategy for addressing IWDs in the curriculum is to make time for students to explore potential biases and prejudices they might have and how those biases can affect their work with IWDs. Therefore, counselors need specialized training to serve IWDs; however, the inclusion of people affected by disability culture has seldom been incorporated or explicitly articulated in the counseling curriculum. Given this absence, counselors must become well-versed in disability language, intervention, and practice.

Intersectional Cultural Humility

Intersectionality (Crenshaw, 1997; Nash, 2008) is a term that captures the concept that individuals possess multiple, interconnected identities that cannot be rightly understood in isolation. Intersectionality demands that counselors commit to social justice and the liberation of oppressed populations (Buchanan et al., 2020; Ratts et al., 2016), a commitment essential for understanding individuals' experience within cultural contexts and the multiple and distinct oppressions they might face (Crenshaw, 1989). Intersectionality has moved beyond race and ethnicity to include gender, sexual orientation, age, and disability. Therefore, to grasp clients as intersectional beings, counselors must display cultural humility in their professional interactions with all individuals (Ratts et al., 2016).

Cultural humility embodies a lifelong practice of self-reflection that one must actively engage in to respect and accept the various cultural identities of others (Hook et al., 2013). Cultural humility requires counselors to engage in conversations about stereotypes, privilege, and oppression, specifically considering instances when one can engage in activities where their identities are present. Singh (2019) encouraged the consideration of various identities (e.g., age, physical ability, religion, race, socioeconomic status, gender, unique physical characteristics, etc.) and identifying biases that have been acquired through socialization.

It is essential to understand how those biases might affect work with diverse clients. Essentially, counselors can develop more openness to others' identities and develop cultural humility (Ratts et al., 2016) by engaging in intersectional cultural humility. This approach elicits ongoing learning, accounting for individuals' subjective experiences shaped by their social, sociopolitical, and historical contexts (Buchanan et al., 2020).

Andragogical Application

Eight core CACREP curriculum areas serve as entry points for foundational knowledge (CACREP, 2016). Recently, Feather and Carlson (2019) examined instructors' perceived ability to integrate disability-related content into their courses. Instructors reported that they did incorporate disability-related content into their curriculum. They incorporated and discussed disability in multicultural, school counseling, human development, assessment, and introduction to counseling courses. However, offering disability-focused experiential activities where CITs can learn by doing is more likely to increase their competence (Feather & Carlson, 2019).

Counselors can increase intersectional cultural humility by participating in self-reflection, scrutinizing their privilege, and recognizing their biases and how systemic and social oppression impact IWDs and the therapeutic alliance (Davis et al., 2016). This self-examination process supports counselors' own cultural identity development, increasing cultural humility, which is essential in understanding IWDs. Assignments and discussions can be infused into core courses (e.g., counseling skills, group dynamics, assessment, career, and social and cultural foundations) to bridge the gap between counselors' perceived skills and their ability to work competently with IWDs. Completing personal and social identity wheels, values assessments, and understanding family of origin concepts can aid counselors in conceptualizing IWDs and counseling relationships. It is vital that counselors understand how IWDs experience their disability identity across their lifespan and strive to alleviate mental health concerns that clients experience due to systemic oppression (Ratts et al., 2016).

Despite the calls from professional organizations and legislation for increased professional competencies, no one to date has offered specific suggestions on integrating disability-related content (Hall, 2015). Furthermore, counselors have reported their programs were ineffective in addressing counseling for IWDs. Feather and Carlson (Feather & Carlson, 2019) noted that CESs might be depending on practicum and internship sites to provide opportunities for CITs to work with IWDs. Consequently, a gap persists between curriculum content and what students perceive as necessary to work effectively with IWDs. Given these concerns, disability concepts will be included in the 2023 CACREP Standards (CACREP, 2016), and CESs will need to evaluate ways to intentionally infuse disability-related experiences into their programs. However, without a standardized model for implementation, it could be difficult to determine how to best implement content and monitor for mastery among CITs (Glance et al., 2018).

Strike et al. (2004) used multicultural counseling competencies in their research, which require counselors to have an awareness of their own worldview, biases, and beliefs related to racial and ethnic minorities, understand clients' worldviews, and acquire and apply culturally responsive interventions when working with clients (Sue et al., 1992). Additionally, Strike et al. (2004) referenced disability and counseling literature to create the Counseling Clients with Disability Survey (CCDS). The CCDS assesses the self-reported disability competency of mental health professionals (Strike et al., 2004). Strike (2001) discovered significant differences between experienced and inexperienced counselors among all three subscales: self-awareness, perceived knowledge, and perceived skills. More recently, the American Rehabilitation Counseling Association published Disability-Related Counseling Competencies (DRCCs) (Chapin et al., 2020). The development of these competencies marked an important step toward improving disability awareness in the counseling profession. CESs can use the DRCCs (Chapin et al., 2020) to infuse counseling for IWDs into the curriculum, aiming to increase CIT competency and address the disparity between awareness and perceived skills and abilities. Given the complexity of intersectionality, particularly concerning IWDs, it is imperative for counselors to practice cultural humility. Therefore, our study aimed to describe counselors' (CMHC, MCFC, SC, doctoral students, and CES faculty) self-reported competence when working with IWDs. Additionally, we examined whether CCDS responses would suggest a need for CESs to employ andragogical methods in counseling curricula, thereby helping counselors recognize, address, and engage in cultural humility when working with IWDs. We defined competence with the following areas: (a) self-awareness, beliefs, and attitudes towards disabilities; (b) perceived knowledge of disability and disability-related issues; and (c) perceived skills and behaviors when working with IWDs. These competencies were measured using the CCDS (Strike, 2001). Therefore, we investigated the following research questions:

1. How do CITs and CES faculty self-report their disability competency on the CCDS?

2. Are there any differences in levels of perceived competency exist between CITs and faculty?

3. What, if any, differences in levels of perceived competency exist between CMHC, SC, and MCFC CITs?

Method

Author Positionality

The authors identify as counselors and counselor educators situated in various regions across the U.S. The first author self-identifies as a White, cisgender, non-disabled woman who specialized in school and clinical mental health counseling. She has over 10 years of experience counseling children, adolescents, and families, many of whom struggled to understand legal concepts and rights associated with civil laws, as the identified clients were protected by the ADA, Section 504, and the Individuals with Disabilities Education Act (IDEA). The second author identifies as a Black, cisgender, non-disabled woman whose areas of interest center around disability competency among mental health professionals, intersectionality, and research and assessment in program evaluation. The third author immigrated to the U.S. and identifies as a BIPOC (Black, Indigenous, and People of Color), non-disabled woman who is passionate about promoting equity and access for marginalized and racialized beings. The fourth author identifies as a White, cisgender, multiply disabled and neurodivergent person whose areas of interest include disability justice, disability rights, climate justice, accessibility, technology, and intersectionality.

Therefore, to conduct our study, we initially contacted each student enrolled in the master's counseling program (e.g., SC, CMHC, and MCFC students) and the counselor education and supervision program, as well as counseling program faculty (including core, visiting professors, and lecturers) via email. However, due to slow responses using this method, we shifted and emailed program faculty directly, asking them to consider participating in the survey and to announce the call for participants in their classes.

Participants

We collected survey data from CITs, doctoral students, and CESs at a CACREP-accredited state university in the Midwest. Out of the enrolled students and faculty, a total of 109 participants, or 52% of those contacted, responded to the survey. Out of these, 95 participants indicated their specialty: 22 were either working toward or already possessed a doctorate in CES; 35 were CMHC students; 20 were MCFC students; and 18 were SC students. Over 92% of the participants identified as female, with 6.4% male, and .9% preferred not to disclose their gender. Participants ranged in age from 22–65. Regarding ethnicity, 50% percent of participants identified as White, 39.4% African American/Black, 5.8% Hispanic/Latinx, 3.8% Asian/Pacific Islander, and 1% identified as biracial or multiracial, which was representative of overall enrollment in these programs.

Procedures

The university's Institutional Review Board reviewed and approved the study, and the invitation sent to participants informed them that the researchers were seeking information addressing perceived competence in counseling IWDs. Potential participants were assured of confidentiality, the voluntary nature of the study, and their right to withdraw without penalty. Participants were asked to complete a questionnaire and a demographic form, which solicited data about their race, gender, years of counseling experience, and area of specialization (e.g., CMHC, MCFC, or SC). We distributed surveys to the entire student body and to CES faculty via email, which contained a cover letter and a Google Forms link containing the informed consent, the CCDS, and an extra question eliciting feedback. Approximately 1 month after the initial invitation, we sent students and faculty a second request to complete the survey, followed by a third and final reminder the following semester. All data collected was in electronic form.

Measures

Counseling Clients with Disabilities Survey (CCDS)

The CCDS (Strike, 2001), a 60-item scale, uses a 6-point Likert scale to measure mental health professionals' disability competence (e.g., self-awareness, perceived knowledge, and perceived skills). The CCDS also includes seven demographic questions. The survey refers to several types of disabilities, encompassing both universal experiences (e.g., minority group experience) as well as individual differences (e.g., the relative importance of disability in identity). The CCDS, informed by disability, counseling, and multicultural literature, is divided into three subscales that measure self-awareness, perceived knowledge, and perceived skills. The Self-Awareness Scale examines respondents' understanding of the effects of being disabled or nondisabled, evaluating their perceptions of being disabled, and incorporates statements that establish self-awareness, beliefs, and attitudes toward disability in general (Strike et al., 2004). The Perceived Knowledge Scale measures factual knowledge about disability and related issues, assessing previous exposure and training related to disabilities (Strike et al., 2004). Finally, the Perceived Skills Scale assesses and evaluates skills and behaviors deemed necessary when working with IWDs (Strike, 2001; Strike et al., 2004).

The CCDS is widely acknowledged as a valid and reliable assessment (Deroche et al., 2020; Feather & Carlson, 2019; Maturen, 2021; Strike, 2001; Strike et al., 2004). Researchers established its validity using expert reviewers' comments, thoughts, and opinions to design the content of the scale and ensure the validity of the items. This process included obtaining results that differentiated between mental health providers who had experience working with IWDs and those who did not. Further, the use of CCDS in previous studies as a trusted measure demonstrates its construct validity as an effective measure of disability competence (Strike, 2001). Cronbach's coefficient alpha yielded an overall high internal consistency reliability (.94) and displayed reliability within the subscales: self-awareness (.67), perceived knowledge (.87), and perceived skills (.90). Thus, a positive relationship is evident among awareness, knowledge, and skills (Strike et al., 2004). Further confirming this correlation, analysis revealed correlations between the Self-Awareness and Perceived Knowledge scales (.72), Self-Awareness and Perceived Skills scales (.69), and the Perceived Knowledge and Perceived Skills scales (.81). As expected, a positive relationship appears among awareness, knowledge, and skills.

Subscales

Each of the subscales is comprised of 20 statements, wherein respondents indicate their agreement or disagreement with the given statements on a 6-point Likert scale (*1 = Strongly Disagree, 2 = Disagree, 3 = Slightly Disagree, 4 = Slightly Agree, 5 = Agree, and 6 = Strongly Agree*). Each subscale could potentially yield a score of 20–120, with higher scores representing greater perceived disability competence. We reverse-scored 35% of the 60 items.

Results

We used the Statistical Package for Social Sciences (SPSS-25) to analyze the results from the CCDS database. To answer the first research question, How do CITs and CES faculty self-report their disability competency on the CCDS?, we computed descriptive statistics. The mean score for participants was 230.41, indicating a moderate to high level of overall perceived disability competency (Table 1).

Table 1
Descriptive Statistics

	N	Mean	SD	SE	95% CI for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
CMHC	35	226.06	34.889	5.897	214.07	238.04	167	320
MCFC	20	215.05	30.939	6.918	200.57	229.53	176	273
SC	18	233.61	36.340	8.565	215.54	251.68	156	277
CES	22	248.68	36.400	7.761	232.54	264.82	173	333
Total	95	230.41	36.138	3.708	223.05	237.77	156	333

For the second research question, *What, if any, differences in levels of perceived competency exist between CITs and faculty?* We computed a one-way ANOVA. Despite some differences in group sizes (CES n=22, SC n=18, CMHC n=35, MCFC n= 20), the assumption of equality of variances was met. The one-way ANOVA was statistically significant, $F(3, 91) = 3.565$, $p < .05$, indicating a statistically significant difference between how CITs and CES participant reported their perceived disability competency (Table 2).

Table 2
ANOVA: CCDS_ total

Source of Variation	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	12911.103	3	4303.701	3.565	.017
Within Groups	109847.886	91	1207.120		
Total	122758.990	94			

We performed further analysis to determine where the differences occurred between CITs and CES concerning the total CCDS score. A statistically significant group mean difference occurred between the CES and MCFC groups, $p < .05$ (Table 3).

Table 3
Multiple Comparisons Bonferroni: CCDS_total

Program of Study (I)	Program of Study (J)	Mean Difference (I-J)	Std. Error	Sig.	95% CI Lower Bound	95% CI Upper Bound
CMHC	MCFC	11.007	9.739	1.000	-15.26	37.27
	SC	-7.554	11.288	1.000	-34.73	19.63
	CES	-22.625	10.734	.112	-48.12	2.87
MCFC	CMHC	-11.007	9.739	1.000	-37.27	15.26
	SC	-18.561	11.288	.621	-49.01	11.88
	CES	-33.632*	10.734	.014	-62.58	-4.68
SC	CMHC	7.554	10.077	1.000	-19.63	34.73
	MCFC	18.561	11.288	.621	-11.88	49.01
	CES	-15.071	11.042	1.000	-44.85	14.71
CES	CMHC	22.625	9.453	.112	-2.878	48.12
	MCFC	33.632*	10.734	.014	4.68	62.58
	SC	15.071	11.042	1.000	-14.71	44.85

* The mean difference is significant at the 0.05 level.

To answer the third research question, What, if any, differences in levels of perceived competency exist between CMHC, SC, and MCFC CITs?, we used a one-way ANOVA to determine whether there was a statistical difference among CMHC, MCFC, and SC on the three subscales of the CDDS (Table 2). The one-way ANOVA revealed significant differences by group for self-awareness, $F(3, 91) = 4.331$, $p < .05$, and perceived skills, $F(3, 91) = 3.133$, $p < .05$. However, post-hoc tests using the Bonferroni method (Table 4) showed no statistically significant difference between the groups across the three subscales.

Table 4
ANOVA: Group Differences

		SS	df	MS	F	sig
Self_aware	Between groups	982.401	3	327.467	4.331	.007
	Within groups	6880.925	91	75.615		
	Total	7863.326	94			
Perc_know	Between groups	1300.689	3	433.563	2.369	.076
	Within groups	16653.458	91	183.005		
	Total	17954.147	94			
Perc_skills	Between groups	2826.413	3	942.138	3.133	.029
	Within groups	27365.587	91	300.721		
	Total	30192.000	94			

Table 5
Multiple Comparisons: Bonferroni

						95% CI	
Dependent Variable	Program of Study (I)	Program of Study (J)	Mean Diff. (I-J)	SE	Sig.	Lower Bound	Upper Bound
Self_aware	CMHC	MCFC	5.136	2.437	.227	-1.44	11.71
		SC	2.397	2.522	1.000	-4.41	9.20
	MCFC	CMHC	-5.136	2.437	.227	-11.71	1.44
		SC	-2.739	2.825	1.000	-10.36	4.88
	SC	CMHC	-2.397	2.522	1.000	-9.20	4.41
		MCFC	2.739	2.825	1.000	-4.88	10.36
Perc_know	CMHC	MCFC	3.850	3.792	1.000	-6.38	14.08
		SC	-4.744	3.924	1.000	-15.33	5.84
	MCFC	CMHC	-3.850	3.792	1.000	-14.08	6.38
		SC	-8.594	4.395	.322	-20.45	3.26
	SC	CMHC	4.744	3.924	1.000	-5.84	15.33
		MCFC	8.594	4.395	.322	-3.26	20.45
Perc_Skills	CMHC	MCFC	2.021	4.861	1.000	-11.09	15.13
		SC	-5.206	5.031	1.000	-18.77	8.36
	MCFC	CMHC	-2.021	4.861	1.000	-15.13	11.09
		SC	-7.228	5.634	1.000	-22.42	7.97
	SC	CMHC	5.206	5.030	1.000	-8.36	18.77
		MCFC	7.228	5.634	1.000	-7.97	22.42

* The mean difference is significant at the 0.05 level.

Discussion and Training Implications

This study's aim was to gather the perceived disability competence and level of comfort of CITs and CESs in counseling IWDs. Additionally, we were curious to determine whether CCDS responses would suggest the need for CESs to employ andragogical methods in counseling curricula to help counselors recognize, address, and engage in cultural humility when working with IWDs. The following research questions guided our study:

1. How do CITs and CES faculty self-report their disability competency on the CCDS?

2. What, if any, differences in levels of perceived competency exist between CITs and faculty?

3. What, if any, differences in levels of perceived competency exist between CMHC, SC, and MCFC CITs?

Participants reported an overall moderate level of disability competence, which aligns with previous research (Bell et al., 2022; Feather Carlson, 2019; Rivas Hill, 2018), and supports the belief that CITs, doctoral students, and CESs generally report positive beliefs and moderate levels of knowledge regarding counseling IWDs.

When reviewing group differences among CITs and CES on the CCDS, a statistically significant difference emerged, specifically between the CES and MCFC groups on the CCDS. This finding could suggest a trend toward expanding cultural competence to include cultural humility. Although counselors have emphasized the importance of cultural competence, recent distinctions made by professional organizations suggest that the practice of cultural humility diverges from cultural competence. Cultural competence is difficult to achieve; thus, calling on counselors to practice humility requires CESs to create opportunities for self-reflection and exploration of CITs personal beliefs.

Upon reviewing group differences on the CCDS subscales among CITs (CMHC, SC, MCFC), we found no statistical significance, which was an interesting finding in that there is an assumption that SCs would report statistically significant higher scores on the CCDS subscales due to their roles in secondary education settings (American School Counselor Association, 2022). We recommend incorporating additional readings and experiential activities in the graduate program curriculum related to counseling IWDs, as this could serve to increase CITs' awareness. We offer the subsequent recommendations based on the findings, analysis, and conclusions of this study.

Integrating Curricula

Study results indicated a need to integrate disability culture throughout counseling curricula to increase awareness, knowledge, skills, and overall disability competency. Additionally, as the proposed 2024 CACREP standards highlight the infusion of disability concepts across counseling curricula, CESs will undoubtedly seek ways to incorporate this content into current coursework. We included methods for infusing disability concepts into the various content areas below.

Ethics

Counselor training often commences in a professional orientation or ethics course where CITs are acquainted with the ACA (2014) Code of Ethics. The DRCCs (Chapin et al., 2020) mention respecting clients' rights to privacy and stresses that counselors take extra steps to ensure these rights (Section A.10). Moreover, it calls for understanding legal concepts and associated civil laws that protect IWDs (Section E.4). Consequently, CESs could infuse the ADA, Section 504, and IDEA for CITs to analyze and assess the multifaceted roles and functions of helping relationships. They could also incorporate research on how counselors can become part of interdisciplinary teams that represent IWDs (CACREP, 2016). CESs can also implement case studies and guide CITs through ethical decision-making models to determine ethical and legal considerations when counseling IWDs.

Assessment and Testing

The DRCCs (Chapin et al., 2020) state that counselors must demonstrate sensitivity regarding tests and assessments that are products of an ableist culture. These tools might inadvertently reflect or reinforce stereotypes about the abilities and characteristics of IWDs (Section D). Best practices advocate for the use of tests standardized with the disability reference groups of interest; however, few of these tests exist or match the needs of different ability statuses (American Psychological Association, 2022). CESs can meet this standard by asking CITs to critique the language and development of tests and assessments, present their pros and cons, or compare two assessments that purport to measure the same construct, and then require CITs to select the most suitable assessment. Furthermore, the DRCCs (Chapin et al., 2020) assert that prior to diagnosis, when counselors administer assessments, they must ensure that the client's clinical impression reflects an enduring psychological state rather than an adaptation to the disability (Section D). Therefore, CESs can lead discussions to assess CITs' comprehension of basic concepts and how to apply assessments to diagnose developmental, behavioral, and mental disorders (CACREP, 2016; Chapin et al., 2020) in IWDs.

Human Growth and Development

CITs are called to understand human growth and development across the lifespan, encompassing biological, neurological, and physiological factors influencing development and functioning (CACREP, 2016). The DRCCs (Chapin et al., 2020) focus on understanding disability experiences, indicating counselors must understand that IWDs can live full and productive lives and deserve opportunities to develop and express themselves throughout their lifespan (Standard A.1). Accordingly, CESs can assign CITs to study specific diagnoses relevant to IWDs and their families, promoting a shared learning environment about differing abilities and how interventions are implemented throughout the therapeutic process. Additionally, CESs might ask CITs to engage in critical thinking about disability identity development models and how identity development is formed across the lifespan of IWDs.

Helping Relationships

The DRCCs (Chapin et al., 2020) focus on the counseling relationship and process, aligned with standards in Section C that ensure communication and documentation are available in alternate formats and prohibit counselors from assuming that disability is the sole reason for counseling services. CESs can require CITs to record mock sessions to demonstrate the consultation process and identify characteristics and behaviors that influence the counseling process with IWDs. For example, suicide risk is one area where IWDs lack support. CESs can help CITs identify essential interviewing and assessment skills so they can appropriately screen for and respond to suicidal thoughts and behaviors (Marlow et al., 2022). Unfortunately, substantial barriers persist in effectively screening IWDs, as there are currently no widely accepted screening tools adapted for individuals with cognitive disabilities (Marlow et al., 2022). CESs should inform CITs that IWDs frequently report recurring mental distress and experience heightened suicidal ideation when subjected to discrimination or systemic or social oppression (Cree et al., 2020). Furthermore, CESs can also advise CITs on how to organize their first sessions, ensuring appropriate paperwork is available in various formats, and assessing the physical space to ensure it is accessible to diverse ability requirements, noting the potential need for office rearrangement to accommodate IWDs.

Social and Cultural Foundations

CACREP (2016) standards indicate that programs are tasked with ensuring CITs understand the effects of beliefs and acculturative experiences and help-seeking behaviors of marginalized populations. This includes the elimination of barriers and identifying oppression and discrimination. Similarly, the DRCCs (Chapin et al., 2020) report that counselors should be conscious of their biases, prejudices, and assumptions regarding disability culture, while increasing their knowledge, skills, and advocacy efforts in working with IWDs (Sections A.9, B.4). To meet these guidelines, CESs can implement guest speakers, such as professionals with disabilities, IWDs, and persons who work with IWDs, to share first-hand perspectives and experiences. Additionally, CESs can improve CIT competency in this area by implementing activities such as personal or social identity wheels, values inventories or surveys, a Disability Implicit Association Test, or readings. CESs can further build on this learning and facilitate discussions around thoughts, feelings, or ideas that were generated after completing the identity wheels.

Group Counseling

The DRCCs (Chapin et al., 2020) state that counselors should consider factors such as time elapsed since diagnosis and cognitive capacity when screening IWDs for group appropriateness and participation (Section C). CESs can ask CITs to research existing groups for IWDs in their surrounding communities and conduct interviews to learn about approaches to group formation, screening, and member selection, and any variations for IWDs. Moreover, CESs can also encourage CITs to create a group proposal for IWDs where they are asked to include culturally relevant strategies (CACREP, 2016).

Career Development

The DRCCs (Chapin et al., 2020) underscore the importance of understanding discriminatory systems that IWDs might experience and how their employment or underemployment could affect IWDs' ability to function in other life spheres (Section E). In this regard, CESs can assist CITs in conceptualizing the interrelationships among and between the life roles of IWDs and discuss the use of technology and how it might help or hinder those with disabilities. Furthermore, CESs can involve CITs

in service-learning projects where they visit various workplaces and assess the work environment for its suitability for IWDs. This could also encompass providing strategies to advocate for diverse populations and ways to address career development (CACREP, 2016). Another activity could require CITs to visit workplaces to assess and discuss the practices these firms use to ensure inclusivity.

Research and Program Evaluation

The Association for Assessment and Research in Counseling (2012) has developed Standards for Multicultural Research that ensure cultural inclusivity and sensitivity toward IWDs. CESs and counselors can modify training and teaching to enhance the quality of care for IWDs; however, this cannot be executed without sufficient awareness. Consequently, in alignment with service-learning projects, CESs can require CITs to conduct program evaluations for companies where they can gather data and analyze information to suggest culturally relevant strategies for IWDs and advocate for appropriate accommodations. Additionally, CITs might appreciate the opportunity to conduct and interpret the results of small research projects or identify evidence-based practices currently employed in the field (CACREP, 2016).

Limitations

This study's findings must be considered in light of several limitations. First, the survey was extensive, comprising 67 items and seven demographic items. Second, as Hays (2008) reported, relying exclusively on self-reported responses about cultural competence warrants additional exploration due to potential lack of clarity of constructs and the overestimation of knowledge, skills, and disability awareness. Additional appraisals could be implemented to examine how participants conceptualize the experience of disability (Smart & Smart, 2006). Furthermore, the assessment of oppressive attitudes and their potential to interfere with culturally responsive practice is needed (Hays, 2008). Another significant limitation is that the study was conducted within a single CACREP-accredited state university counseling program in the Midwest. Therefore, the recruitment of participants was confined to the students and faculty members housed in that counseling program. A further limitation is the methodological concern of self-selection bias in the decision to participate in this study, which could reflect inherent bias or impact generalizability (Costigan & Cox, 2001). Despite these limitations, the findings support the need for integration of disability concepts throughout coursework.

Future Research

As statistical significance was found between MCFC and CES on the CCDS, we suggest future research studies focus on MCFC training and education, which would aid in deepening MCFC's understanding of their disability competence. Additionally, programs could review MCFC syllabi to determine if and where disability-related content is included in the curriculum. Qualitative research could be conducted to gain an in-depth understanding of MCFC students' competency in working with IWDs, or it could concentrate on counselors' knowledge related to IWDs. Quasi-experimental design studies could be conducted using the CCDS as a pre- and post-test for a course or workshop series intervention. The intervention could focus on disability-related concerns using various textbooks that spotlight lifespan concerns related to changes in disability status, definitions, diagnoses, and practice implications. Additionally, we discovered a statistically significant difference between CITs and CES; however, there was no statistically significant distinction between CMHC, MCFC, and SCs. Thus, future qualitative research could inform the field about students' perceived knowledge, skills, and self-awareness related to working with IWDs, which could be achieved by incorporating the DRCCs (Chapin et al., 2020) into the study. These suggestions would supply empirical data regarding how counselors benefit from additional knowledge when serving IWDs.

Conclusion

In summation, we assessed counselors' beliefs and perceived knowledge regarding their preparedness to provide services to IWDs. Participants reported some competency in working with IWDs and a need for additional preparation in multicultural and skills techniques. Multiculturalism encompasses identities that contribute to shaping the collective identities of people and affects how they experience privilege and systemic oppression. Counselors can intentionally focus on multiculturalism to uncover clients' collective identities and self-aspects that might require further exploration due to the discrimination associated with marginalized collective identities. More specifically, counselors will need to consider clients' developmental context as

well as the ways multiculturalism has affected their growth and development, since disability status can place IWDs at a higher risk for both physical and mental health problems (Bramesfeld et al., 2019). Given that disability status can change across the lifespan (Cieza et al., 2018) and that the percentages of IWDs have been increasing, it is imperative that counselors expand their knowledge of IWDs. Counselors must be prepared to handle the range of issues IWDs bring to counseling and must provide culturally responsive care. Therefore, counseling programs could benefit from beta testing to align disability to current curriculum and revisiting andragogical methods paramount for expanding CITs' multicultural and social justice lenses.

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