9 Marginalized Racial and Ethnic Adults with Disabilities in Rural Communities: The Role of Cultural Competence and Social Justice

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Overview

Historically marginalized groups (hereafter, marginalized groups) – Hispanic/Latino, Black/African American, and American Indian – make up about a quarter of the people living in rural America. While rural Asian Americans/Pacific Islanders are the exception and are not geographically concentrated on the mainland, over half reside in Hawaii, California, New York, Oregon, and Wisconsin; other marginalized groups, particularly those who are poor, are geographically concentrated in different regions:

- Seventy percent of African Americans reside in rural Southern states of Mississippi, Georgia, North Carolina, Louisiana, Alabama, and South Carolina.
- Seventy-three percent of Hispanic/Latino Americans reside in rural Southwestern states of Texas, New Mexico, California, Arizona, and Colorado.
- Fifty-seven percent American Indian/Alaskan Natives reside in rural Western states of Arizona, New Mexico, Oklahoma, South Dakota, and Montana (Probst et al., 2002, p. 2).

As more marginalized groups, particularly Hispanic/Latino Americans, have moved out of large urban areas into rural communities and smaller cities, rural areas continue to become even more diverse. The immigration rates of Hispanic/Latino Americans have increased their numbers in rural areas, in part because of the shift from seasonal workers who came to the United States to work on farms and left after harvest time to immigrants who remain. Subsequently, rural marginalized groups lag behind rural European Americans and urban groups on many crucial economic, health, educational, and social measures (Bahls, 2011; Bennett, Bellinger, & Probst, 2010; Probst, Bellinger, Walsemann, Hardin, & Glover, 2011). The diversification of rural areas further emphasizes the need to understand differing cultural belief systems and the importance of cultural competency of rehabilitation counselors and other human/social service providers.

Studies over the past four to five decades show minimal progress for marginalized groups as measured by changes in occupation, income, and poverty rates (Leung & Wright, 1993; Probst et al., 2002; Swanson, 1996). Individually and collectively, marginalized groups in rural areas have disproportionately higher poverty rates.

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Over two decades ago, Leung and Wright (1993) reported that marginalized group members with disabilities "are more at-risk, have fewer personal and family resources, have less knowledge and understanding of externally available resources, and fare less well socioeconomically than do marginalized groups without disabilities" (p. 17). More recently, in a study of self-rated health status among adults with disabilities, Blacks/African Americans and Hispanic/Latino Americans were more likely to report fair to poor health status compared to European American adults (Mead et al., 2008). In addition, the prevalence of disability was reported to be higher among Blacks/African Americans, American Indians, and Alaskan Natives with persistent disparities in their quality of healthcare (Centers for Disease Control and Prevention [CDC], 2006; Fiscella & Sanders, 2016). Asian Americans/Pacific Islanders with disabilities have not been studied as extensively as other marginalized groups.

A further common complication among members of rural marginalized groups is that they are more likely to have lower hourly wages and higher unemployment and subsequently face disparities in the availability of quality of care and access to healthcare resources, services, and providers, especially among Hispanic/Latino Americans and poor people (Bahls, 2011; National Advisory Committee on Rural Health and Human Services [NACRHHS], 2004; The 2010 National Healthcare Quality and Disparities Reports) (see Table 9.1). Although implementation of the Affordable Care Act (ACA) has helped to reduce the gap of uninsured individuals, marginalized groups still remain uninsured at a higher rate than European Americans (Agency for Healthcare Research and Quality, 2014). Disparities continue to persist (U.S. Census Bureau, 2006) and are predicted to continue into the foreseeable future (CDC, 2006; U.S. Census Bureau, 2013; U.S. Census Bureau, 2014).

Rural marginalized group members with disabilities are considered to have a triple marginal group status – racially/ethnically, disability, and geographically. In addition, these groups have higher rates of disability and more health disparities than their European American counterparts. There is consensus in studies that examined the provision of VR services to individuals with disabilities in conjunction with their marginal racial background that some disparity exists based on racial status of VR applicants, services provided, closure types, and employment outcome status (Atkins & Wright, 1980; Capella, 2002; da Silva Cardoso, Romero, Chan, Dutta, & Rahimi, 2007; Jones, 2008; Kim-Rupnow, Park & Starbuck, 2005; Martin, 2010; Rosenthal, Ferrin, Wilson, & Frain, 2005; Wheaton, & Hertzfeld, 2002; Wilkerson, & Penn, 1938; Wilson, 2004; Wilson, Harley, & Alston, 2001; Wilson, Turner, & Jackson, 2002). Furthermore, agreement in the literature is that marginalized groups have been underserved in the public vocational rehabilitation service system for decades (Chan, Wong, Rosenthal, Kundu, & Dutta, 2005; Kim-Rupnow, et al.; Mwachofi, 2008).

Table 9.1 Racial and ethnic minorities' healthcare disparities

Quality:
Blacks and American Indians and Alaskan Natives received worse care than Whites for about 40% of measures.
Asians received worse care than European Americans for about 20% of measures.
Hispanics received worse care than non-Hispanic Whites for about 60% of core measures.
Poor people received worse care than high-income people for about 80% of core measures.
Access:
Blacks had worse access to care than Whites for one third of core measures.
Asians, American Indians, and Alaskan Natives had worse access to care than Whites for one of five core measures.
Hispanics had worse access to care than non-Hispanic Whites for five of six core measures.
Poor people had worse access to care than high-income people for all six core measures.
Outlook:
Fewer than 20% of disparities faced by Blacks, American Indians, Alaskan Natives, Hispanics, and poor people showed evidence of narrowing.
The Asian-White gap was narrowing for about 30% of core measures, the largest proportion of any group, but most disparities were not changing.

Adapted from The 2010 National Healthcare Quality and Disparities Reports

Learning Objectives

By the end of the chapter, the reader should be able to:

1. Identify disability, health, and healthcare disparities for marginalized groups.
2. Distinguish areas of concern between rural and urban marginalized groups.
3. Understand why cultural competence is important, particularly in rural areas.
4. Incorporate multicultural and social justice competencies into professional practice, adopting culturally sensitive practices and interventions to address the needs of rural clients from marginalized groups to enhance employment outcomes.

Introduction

"While rural Americans are predominately White, there is significant diversity in many rural areas" (NACRHHS, 2004, p. 10). Data from the 2010 Census of Population and Housing report that approximately one quarter of the people living in rural America are members of marginalized groups. Hispanic/Latino Americans make up about 9.3% of rural populations, followed by Black/African Americans at 8.2% and American Indians at 1.5%. More than half of the residents of the rural population live in counties with marginalized populations that will become majorities by mid-century (U.S. Census, 2013).

Rural areas have been plagued by higher rates of chronic illnesses and limitations in activities of daily living. The rate of disability varies among marginalized adults. In 2015, Blacks/African Americans had a higher prevalence of disability than Hispanic/Latino Americans and Asian Americans (Bureau of Labor Statistics, 2016). Blacks/African Americans have higher than average rates of disabilities, in part, because of the types of occupations they have. Marginalized groups are concentrated in jobs with high physical demands. Some rural areas have a higher percentage of farming and manufacturing jobs, while others might have more recreation and tourism jobs, subsequent to the availability of lakes, mountains, and forests. Farming remains a major industry in rural areas and has one of the highest levels of occupational stress, both physical and economic (Glasscock, Rasmussen, Carstensen, & Hansen, 2006). Farming is a hazardous profession with high rates of job-related illnesses, injuries, and disabilities from machinery, livestock, tools, and work surfaces and exposure to long hours in the sun, deafening noise, toxic chemicals, gases, and fuels, and dust from animal feeds and hay. In addition, farmers are exposed to zoonotic and respiratory illnesses because they work in animal enclosures, silos, and manure pits (National Institute for Occupational Safety and Health, 2004; Smith, 2011). Marginalized farmers experience higher incidences of injury than European American farmers. These high injury rates are exacerbated by the difficulty to access services in rural areas.

Attitudes Toward Disability

Meanings of health, illness, and disability vary greatly across cultures and time. This is particularly significant since beliefs about the cause of illness appear to be important determinants of health-related behaviors, including strategies for self-care, health seeking, and decision-making about what treatments to use and what outcomes to expect (Bryan, 2007; Cartwright, 2010; Groce & Zola, n.d.). Those who share a culture have their own explanations for illness and disability, which may differ from or include biomedical explanations. In fact research in health psychology, anthropology, and sociology over the last several decades indicate that:

> individuals subscribing to the Western biomedical system perceive health and illness from a scientific point of view focused on what can be observed and measured. Persons holding this view tend to attribute illness to natural factors, including poor diet, smoking, alcohol use, lack of exercise, stress, weight, and heredity. On the other hand, individuals subscribing to Eastern medical systems hold a holistic view about health and illness that considers mind, body, and spirit as an integral whole. In addition to natural causes, many of these individuals tend to attribute illness to supernatural factors, including God's punishment, destiny and karma, as

> well as sinful thoughts, witchcraft, the Evil Eye, and voodoo. (Cartwright, Zhang, & Jin, 2014, p. 969)

Many marginalized populations do not define or address disability and chronic illness in the same manner as European Americans or "mainstream" American culture (Bennett, Zhang, & Tarnow, 2000; Groce & Zola, n.d.; Sue & Sue, 2015). In some languages, for example, Spanish, the word disability does not exist. Attitudes toward disability may vary depending on the type of disability (e.g., physical vs. psychological). The extent to which a group engages in traditional and indigenous practices also influences their views and attitudes toward disability (Burnhill, Park, & Yeh, 2009; Harley, 2005). Indigenous practices or healing refers to culturally bound explanations of behaviors and physical conditions and the cultural-specific ways of dealing with human problems and distress (Burnhill et al.; Yeh, Hunter, Maden-Bahel, Chiang & Arora, 2004). From the beginning of time, cultures have developed strategies (i.e., worldview and prevailing philosophy of life) of dealing with psychological distress, behavioral aberration, and physical ailments. Generational differences also may dictate attitudes and perceptions about disability. For example, older adults may hold closer to traditional cultural beliefs and practices than younger adults and adolescents. Other dimensions such as religion, geography, and gender contribute to attitudes, beliefs, and perceptions about disability and help seeking.

Considering the intra- and intercultural diversity of marginalized groups, the attitudes and perceptions toward disability that are presented here is to provide the reader with an overview rather than a prescriptive view. In light of the increasing diversity of the United States, Balcazar (2010) contends that the topics of race, culture, and disability have rarely been examined together. First and foremost, it is important to recognize that there is no one culture that fits any group of people; rather, there are numerous cultures associated with any ethnic group (Bryan, 2007). For example, a Latino reared in rural Alabama will have some similarities to a Latino reared in Los Angeles; however, the two will have many different experiences, which will mean their cultural backgrounds will be different. Bryan suggests there may be more cultural similarities between a Latino reared in rural Alabama and a Caucasian reared in rural Alabama than between a Latino Los Angeles native and the Latino Alabama native. A point of caution is that as human service professionals, counselors must avoid falling into the trap of generalizing specific cultural characteristics to all members of that group. Bearing that in mind, this section presents commonly held attitudes and perceptions toward disability that may be shared among and between marginalized groups.

Attitudes about disability also differ based on the type of disability. For example, society in general has negative attitudes about mental illness and tends to stigmatize people with such diagnoses. The *Attitudes Toward Mental Illness: Results from the Behavioral Risk Factor Surveillance System* found that most adults agreed that treatment can help people living with mental illness lead "normal" lives, yet respondents believed that people are generally not caring and sympathetic to people with mental illness (Centers for Disease Control and Prevention et al., 2012). In studies that specifically examined marginalized group members' attitudes toward mental illness, African American men and women were not very open to acknowledging psychological problems, were very concerned about stigma associated with mental illness, and were somewhat open to seeking mental health services, but they prefer religious coping. Overall, significant gender and age differences were evident in attitudes and preferred coping, with young women having more positive attitudes and openness to seeking help than younger men. Middle-aged and older men and women had a higher propensity for seeking help overall compared to other groups (Ward, Wiltshire, Detry, & Brown, 2013). While African American adults have similar rates of depression as European Americans, they are significantly less likely to seek help. Conner et al. (2010) suggested that cultural differences in the way depression symptoms are manifested, defined, interpreted, and labeled, in part, explain some of the racial differences in help-seeking behaviors.

Asian Americans as an ethnic group are reported to underutilize mental health services. The reason for this is the commonly held belief that Asian Americans' cultural values conflict with the counseling process, when often the plausible explanation for early termination is the inadequacy of the service provided. In an earlier study, Atkinson and Gim (1989) examined the relationship between cultural identity and attitudes toward mental health of Asian American (i.e., Chinese, Japanese, and Korean) college students and found, regardless of ethnicity and gender, most acculturated students were (a) most likely to recognize personal need for professional, psychological help, (b) most tolerant of the stigma associated with psychological help, and (c) most open to discussing their problems with a psychologist. Forty-three percent of Asian American women in a recent study reported that they either suffered from current moderate to severe depression symptoms or a lifetime history of suicidal ideation or suicide attempt. Mental health risk groups were created based on participants' current depression symptoms and history of suicide behaviors: Group 1, low risk; Group 2, medium risk; and Group 3, high risk. Although the high-risk group demonstrated statistically significant higher mental health utilization compared to the low- and medium-risk groups, more than 60% of the high-risk group did not access any mental healthcare, and more than 80% did not receive minimally adequate care. Three underutilization factors were identified: (1) Asian family contributions to mental health stigma, (2) Asian community contributions to mental health stigma, and (3) a mismatch between cultural needs and available services (Augsberger, Yeung, Dougher, & Hahm, 2015).

While some Hispanic/Latino Americans have a negative attitude toward mental healthcare, and lower rates of access than non-Hispanic/Latino European Americans, research is sparse examining this issue or supporting this view. According to Shim, Compton, Rust, Druss, and Kaslow (2009), Hispanic/Latino Americans may have more positive attitudes than non-Hispanic European Americans and have treatment barriers, not because of attitudes but because of socioeconomic factors, language barriers, and other structural barriers to care. In addition to language barriers, Hispanic/Latino Americans have cultural values that create barriers. Moreover, bilingual clients are evaluated differently when evaluated in English versus Spanish, and Hispanic/Latino Americans are more frequently undertreated than European Americans (Dingfelder, 2005). Focusing on the misconceptions and personal beliefs associated with depression, Jang, Chirboga, Herrera, Tyson, and Schonfeld (2009) explored predictors of attitudes toward mental health services of older Hispanic/Latino adults and found that negative attitudes toward mental health services were predicted by advanced age, belief that having depression would make family members disappointed, and belief that counseling brings too many bad feelings such as anger and sadness. Clearly, generational differences exist with regard to attitudes and perceptions about mental health among Hispanic/Latino populations.

The attitudes of Hispanic/Latino populations toward mental illness might also be influenced by *culture-bound syndromes* (Diagnostic and Statistical Manual, DSM, 2013). Culture-bound syndrome is "a cluster or group of co-occurring, relatively invariant symptoms found in a specific cultural group, community, or context" (DSM, 2013, p. 14). The *DSM* names three culture-bound syndromes sometimes found in Hispanic/Latino populations. The first is *ataque de nervios* – intense emotional upset, often with shouting, screaming, and crying; feelings of heat, verbal, or physical aggression; sometimes dissociative experiences, seizures, or fainting; and sometimes suicidal gestures. This is often a response to a stressful event related to family. The second syndrome is *nervios* – a state of vulnerability to stress, often with multiple somatic and emotional symptoms. The final syndrome is *susto* – varying symptoms that are attributed to a frightening event that causes the soul to leave the body. Yet, other Hispanic/Latino Americans might function under the belief of *mal de ojo* (evil eye), in which sickness is believed as sent or caused by others. It is important to note several disadvantages of the term culture-bound

syndrome are that it (a) "ignores the fact that clinically important cultural differences often involves explanations or experience of distress, rather than culturally distinctive configuration or symptoms" and (b) "overemphasizes the local particularity and limited distribution of cultural concepts of distress" (DSM, p. 758).

The role of culture not only influences how we view disability in general but how we view people with disabilities. Pfeiffer et al. (2003) argued that beyond looking at a specific person with a disability, in the helping professions (e.g., rehabilitation, nursing, social work, psychology), people with disabilities and the disability cannot be separated because the concept of a person with a disability embodies the phenomenon of disability. In some ways, this argument is the opposite of the pro-person-first language that promotes the identification of the person, not the disability (e.g., person who is deaf). Yet, deaf culture promotes identification of their disability as part of their identity, thereby referring to themselves as deaf people. Deaf culture's conception of disability is more in line with that of Pfeiffer (see Chap. 15 for discussion of deafness).

Palmer, Redinuis, and Tervo (2000) examined attitudes toward disabilities among rural and urban college students and found they both had positive attitudes. However, rural students exhibited more negative attitudes toward the personality of people with disabilities (e.g., factors labeled "derogatory personality stereotypes" and "behavioral misconceptions"). A more recent study examining implicit and explicit attitudes toward persons with disabilities among Chinese college students indicated that students tended to hold negative attitudes implicitly and positive attitudes explicitly toward persons with disabilities. In particular, students from rural areas exhibited more negative implicit attitudes than those from urban areas; males demonstrated more negative explicit attitudes than females (Chen, Ma, & Zhang, 2011). Another recent study investigating two groups (i.e., those who viewed Paralympic-level ID sport footage and information and those who viewed Olympic footage and information) and determining whether stimuli depicting people with intellectual disabilities (ID) performing at Paralympic level of competition was effective in changing attitudes toward ID. The results suggested that implicit attitudes significantly changed in a positive direction for both groups. The findings provide evidence that both Paralympic (ID) and Olympic media coverage may have at least a short-term effect on attitudes toward people with disabilities (Ferrara, Burns, & Mills, 2015).

The cultural views of marginalized groups, as well as their rural culture, can impact how they view helping professionals. In a study of attitudes of persons with physical disabilities and Black Americans toward counseling professionals, Hansen and Bryant (1991) found that both groups may not seek professional counseling because of the perception that the counselor is just one more authority figure who makes their decisions and controls their lives. Considering that recruitment and participation in clinical trials by minorities, particularly African Americans and rural underserved populations, were low, a cross-sectional design was used to survey adults residing in Maryland, including urban Baltimore City, the rural regions of Western Maryland, and the Eastern Shore. Findings revealed that Black and middle-income respondents were significantly less likely to actually participate in clinical trials, whereas respondents who received information about clinical trials from their healthcare provider, who were knowledgeable about clinical trials, and those who had the time commitment were significantly more likely to participate in clinical trials. These results suggest continued gaps in efforts to recruit racial/ethnic minorities and residents of rural regions into clinical trials (Baquet, Commiskey, Mullins, & Mishra, 2006).

Another study examined the perceptions, attitudes, and experiences of African American male students with school counselors and their school counseling services. Despite being Black, male, poor, and enrolled in special education, most planned to pursue postsecondary education after high school graduation. Participants had both positive and negative perceptions and comfort levels with school counselors. The findings also indicated that the students had many expectations and experiences with their school counselors, but

they were oftentimes not fulfilled. It is interesting that the participants did not perceive career issues as one of the roles of school counselors. Analysis of results revealed that those who did seek the assistance of school counselors seemed to have benefited; however, such assistance tended to focus on scheduling and academic planning. Similar to what was found in the research literature on African American males and counseling, the African American male participants illustrated comfort-level issues with their school counselor. Some of the comfort-level issues were related to past school counselor experiences, family-school boundaries, school counselor time availability, and school counselor bias, as evidenced by the following quote offered by one of the participants: "They [school counselors] worry about certain people for so much, but they don't worry about all of them" (Moore, Henfield, & Owens, 2008).

Marginalized Client Access to VR Services and Quality of Services

Wilkerson and Penn (1938) conducted a large-scale study reporting the disparities in the federally funded civilian vocational rehabilitation (VR) system. Similar results were found in studies on African Americans receiving vocational rehabilitation services (Atkins & Wright, 1980; Herbert & Cheatham, 1988; Wilson, Harley, & Alston, 2001; Wilson, Turner, & Jackson, 2002). Mwachofi (2008) examined African Americans' access to vocational rehabilitation services before the antidiscrimination legislation in 1937 and after the legislation in 2004 using RSA 911. The study found widening gaps between European American and African American consumers in education, employment, earnings, and per capita VR expenditures for services rendered.

Disparities in vocational rehabilitation services and outcomes for Hispanic clients revealed that European Americans were more likely to obtain employment than were Hispanics. In addition, Hispanics with work disincentives had lower odds of returning to work and had more unmet basic needs (e.g., food, shelter, transportation) that need to be addressed in the rehabilitation process. Although job placement and on-the-job support services were found to significantly improve employment outcomes, on-the-job support services were more likely to be provided to European Americans than to Hispanics (da Silva Cardoso et al., 2007).

American Indians have the highest rate of disability among marginalized groups and have the lowest opportunity for access to culturally sensitive programs and services of all races (NEA, 2003) (see Chap. 13 for discussion on American Indians). The US Census projects that Asians and Pacific Islanders will grow proportionately more than any other marginalized group in the country and estimates that 13% have some type of disability. Asian and Pacific Islanders have not been studied extensively, in part, because of the wide range of ethnicities that comprise the population and the differing economic and social histories of each (Probst et al., 2002). However, one study conducted by Park, Kim-Rupnow, Stodden, and Starbuck (2005) demonstrated that Asian Americans and Pacific Islanders (21%) were less likely to be accepted than European Americans (17%), and of those accepted, Asians and Pacific Islanders (35%) had less successful closures than European Americans (43%).

In contrast, research on consumers with sensory disabilities reported mixed or conflicting findings with regard to racial disparities. For example, Giesen, Cavenaugh, and Sansing (2004) reported that African Americans who were legally blind or had visual impairments accessed the state-federal VR system at a higher percentage rate than their percentage in the general population of those who were legally blind or had visual impairments, while those who were European Americans and legally blind or had visual impairments accessed VR at a lower rate than their percentage in the general population of persons who were legally blind or had visual impairments. They attributed these results, were in part, due to increased outreach to marginalized groups with visualized impairments. These researchers also suggested that the results might have been associated with preexisting socioeconomic disadvantages, higher unemployment,

lack of health insurance, higher numbers of single-parent families, and greater receipt of public support. Another study examining the VR outcomes among European Americans and Latino consumers with hearing losses found that consumer ethnicity was not significantly associated with successful VR outcome (Bradley, Ebener & Geyer, 2013). These researchers suggested that one plausible reason for this insignificance of ethnicity among consumers in this study only involved Latinos who identified themselves as European American.

Rehabilitated closure is a strong indicator of successful VR service outcomes. Extant studies have found disparities in the employment outcomes among specific disability groups. For example, Catalano, Pereira, Wu, Ho, and Chan (2006) found that European Americans (53%) with traumatic brain injuries (TBI) had appreciably higher competitive employment rates than American Indians (50%), Asian Americans (44%), African Americans (42%), and Hispanic/Latino Americans (41%). However, Johnstone, Mount, Goldfader, Bound, and Pitts (2003) found no significant difference in the number of successfully employed African American rehabilitation clients with traumatic brain injury (23%) versus European Americans (18%) in a midwestern State Vocational Rehabilitation Agency. Interestingly in that study, African Americans (92%) were more likely than European Americans (58%) to live in urban areas. Among young adults with specific learning disabilities, transitioning from school to work, European Americans had higher competitive employment rates (64%) than African Americans (20%), Hispanic/Latino Americans (13%), Asian Americans (1.5%), and American Indians (1.2%) (Gonzalez, Rosenthal & Kim, 2011). In another study examining the employment outcomes of individuals with spinal cord injuries over a period of 3 years, the majority of the individuals whose cases were closed successfully employed were European Americans (82%), followed by African Americans (16%), Hispanic/Latino Americans (8%), American Indians, and Asian Americans (1%), respectively (Inge, Cimera, Revell, Wehman, & Seward, 2015). Cinnamond's recent dissertation study (2016) examining the rehabilitation and employment outcomes of Hispanic/Latino Americans over a 17-year period (i.e., 1997–2013) shows promise for increased employment outcomes in the new immigration destination (i.e., Southeast) versus the traditional settlement (i.e., Southwest) for Hispanic/Latino Americans; however, the employment rates in comparison to European Americans in both areas remain disparate. With few exceptions, research documents the fact that the employment outcomes for members of marginalized groups continue to lag behind those of European Americans in the State VR system.

Counselor-Client Working Alliance with Marginalized Clients

The working alliance (Bordin, 1979) is defined as a collaboration between the client and the counselor based on the development of a bond and shared commitment to the goals and tasks of counseling. The foundation for development of the working alliance is a counselor with a good attitude and a good rapport with the client. The ingredients of a working alliance are a collaborative effort, equal contributions from the client and counselor, and active participation between the counselor and client. These ingredients of care combine to meet the goals (agreed upon objectives), tasks (agreed upon behaviors), and bonds (level of empathy) (Lustig, Strauser, Rice, & Rucker, 2002). The working alliance consists of both the quality and strength of the reciprocal relationship (Bedi, Davis, & Arvay, 2005). Generally, the working alliance influences client outcomes and is a salient counseling component across cultures (Asnaani & Hofmann, 2012; Vasquez, 2007).

Building trust and collaboration with marginalized clients and their communities is paramount in achieving positive outcomes. The counselor or service provider must be cognizant of the historical-social-political context of marginalized groups in the United States. It is not uncommon for the counselor, especially one from outside of the client's membership status and especially European American counselors,

initially to be met with suspicion, distrust, and, to a certain extent, historical hostility. Thus, the counselor needs to have a working knowledge of cultural attributes of marginalized clients in rural areas, as well as how these clients define themselves within the context of community. The fact that RFT residents generally interact and live in a geographically defined place, those interactions shape the structures and institutions of the locality, and those structures and institutions in turn shape the activities of the people with whom they interact (Beckley & Weathersby, 2005). For racial and ethnic marginalized groups in rural areas, the "density of acquaintanceship" is one of the bases by which the community builds a sense of solidarity and ultimately how they build a sense of solidarity through interactions with one another (Flora et al., 1992, p. 68). Expanding on Flora et al.'s assumption, counselors should consider that frequent interaction with marginalized clients might form the basis for acquaintanceship and potentially a better working alliance.

Chang and Yoon's study (2011) indicated that the majority of marginalized clients believed that European American therapists could not understand key aspects of their experiences and subsequently avoided broaching racial/cultural issues in therapy. However, many felt that racial differences were minimized if the therapist was compassionate, accepting, and comfortable discussing racial, ethnic, and/or cultural issues. These results support recommendations that therapists acquire and expand their expertise to deliver culturally appropriate services to address the needs of marginalized clients.

One key aspect of improving the working alliance between the counselor and a marginalized client is for the counselor to be aware of the influence of microaggressions in the counseling process. The term *racial microaggressions* was originally coined by Chester Pierce to describe the subtle and automatic put-downs that African Americans face (Pierce, Carew, Pierce-Gonzales, & Willis, 1978). Microaggressions are defined as brief, everyday exchanges that send denigrating messages to a target group, such as people of color, people with disabilities, LGBTQ individuals, and religious minorities (Sue et al., 2007). Expressions of racism and discrimination have evolved over time into more subtle and ambiguous forms and in some ways have become more disguised and covert (Sue & Sue, 2015). However, this is not to say that overt and blatant acts of racism and discrimination do not exist.

Sue and Sue (2015) indicate microaggressions can also be delivered environmentally through the physical surroundings of target groups. Although rural areas are becoming more racially diverse, they are predominately European. For racial and ethnic marginalized groups living in these rural areas, the display of historical artifacts (e.g., pictures) in prominent buildings (e.g., courthouse, post office, city hall) sends a message that "your kind does not belong here." A similar message is sent to persons with physical disabilities when there is limited or lack of access to buildings. The occurrence of such microaggressions can (a) be subtle, unintentional, and indirect, (b) occur in situations where there are alternative explanations, (c) represent unconscious and ingrained biased beliefs and attitudes, and (d) more likely occur when people pretend not to notice differences (Sue et al., 2007). The result of microaggressions is that ethnic and racial marginalized groups can often feel like aliens or second-class citizens in their own land. It is important to understand how marginalized groups understand their environment. In addition, the fact that counselors possess unconscious biases and prejudices is problematic, especially when they sincerely believe they are capable of preventing them from entering the working alliance (Sue & Sue, 2015). Unintentional stereotypes and biases can undermine service providers' efforts to deliver quality services. Denial of unconscious biases by counselors is only one part of the challenges of service delivery to ethnic and racial marginalized groups residing in rural areas; the other is counselors and other human service workers may be inadequately prepared to address the needs of these populations (Hancock, 2005) (see Research Box 9.1 for perspective of registered nurses' cultural competence in a rural state).

Research Box 9.1

See Seright (2007).

Objective: The article is the second in a two-article series. The first article provides the readers a conceptual definition of cultural competence, a review of literature, and a description of the relevance of culturally competent care in a rural state. The purpose of this article was to determine the relationship between cultural competence and educational preparation.

Method: A voluntary sample of registered nurses from urban and rural hospitals in the state of North Dakota were surveyed using the Inventory for Assessing the Process of Cultural Competence-Revised version (IAPCC-R) and a demographic survey tool. It was hypothesized that nurses who reported participation in cultural competency educational programs would rank themselves higher on the IAPCC-R than those who had not reported participation in such programs. The data was analyzed using correlational statistics.

Results: A majority (>80%) of the participants did not consider themselves culturally competent. While higher self-rating scores did correlate to participation in educational activities, the quality and frequency of those activities vary.

Conclusion: Ongoing education, or cultural diversity training, at the workplace, positively impacted IAPCC-R scores more than any other variable. Although there were no significant correlations made between higher IAPCC-R scores and participation in a cultural diversity course within the respondents' nursing program, the survey participants did express a need and desire to learn more about those from other cultures.

Questions:

1. How can replication of this study be conducted across other disciplines and employment settings?
2. How can this study be conducted in other ethnically homogenous states and comparisons run between states?
3. How can the IAPCC-R be used as a benchmark and evaluation tool within facilities and human service agencies when they are evaluating their cultural diversity training programs?

Counselor Cultural Competence

The increased demographic shifts described earlier compel rehabilitation counselors to incorporate cultural competence into their practice when working with individuals from traditionally underserved marginalized groups, particularly those residing in rural America. Approximately three decades ago, Sue et al. (1982) identified minimal competencies for counselors to skillfully and knowledgeably serve clients from culturally diverse backgrounds, based on three domains: *awareness*, which involves becoming aware of one's own values, biases, assumptions about human behavior, preconceived notions, personal limitations, as well as the sociopolitical relevance of cultural group membership; *knowledge*, namely, about the ways in which cultural processes affect different groups (e.g., the effects of social stratification, acculturation, immigration, historical factors, institutional structures, individual meaning making); and *skills*, which includes the ability to effectively integrate the impact of cultural factors when actively practicing appropriate, relevant, and sensitive intervention strategies and techniques.

The newly adopted multicultural and social justice competencies (MSJCCs) add an additional domain, *action*, emphasizing the need to

create maximum influence of counseling interventions (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016). Thus, culturally competent counselors are defined as those who have internal awareness of values and biases, extend this awareness to understand clients' worldviews, and subsequently determine, in collaboration with clients, interventions and strategies that are culturally responsive and that promote social justice through advocacy (Ratts, Singh, Nassar-McMillan, Butler, & McCullough). The MSJCCs encourage understanding of the context relevant to the lives of marginalized group members. Therefore, recognition of the following important aspects of counseling practice for both marginalized counselors and clients is vital:

(a) Understanding the complexities of diversity and multiculturalism on the counseling relationship
(b) Recognizing the negative influence of oppression on mental health and well-being
(c) Understanding individuals in the context of their social environment
(d) Integrating social justice advocacy into the various modalities of counseling (e.g., individual, family, partners, group) (Ratts et al., 2016, pp. 30–31)

This inclusive and broad understanding of culture and diversity requires that counselors acknowledge the existence of multiple identities and intersecting privileged and marginalized statuses, recognize that the social construction of identities cannot be understood in isolation, and realize that a client's environment influences which aspect of his/her identity is significant at that moment in time. Therefore, an understanding of intersectionality and the influence of oppression and discrimination on mental health and well-being, particularly among clients of color residing in rural areas, are critical components of cultural competency.

The MSJCCs are the catalyst that rehabilitation counselors may use as leverage toward quality and equitable services for all clients. We recognize that cultural competence is an active, developmental, and ongoing process. Rehabilitation counselors are encouraged to expand their knowledge and expertise by understanding the impact that culture has on behavior, attitudes, and values, the help-seeking behaviors of clients who are members of marginalized groups, the specific cultural customs, the role of language, speech patterns, communication styles of the varied client groups in the communities served, and the informal helping networks that may be used. To that end, a case study follows demonstrating Shauna's interactions with a client to illustrate the value of cultural competency awareness in working with this client.

The Case of Mahealani

Mahealani is a 19-year-old young woman who was diagnosed with spina bifida, hydrocephalus, hypertension, and obesity. Mahealani uses a wheelchair and sometimes her crutches; she has no limitations with her upper body. While in high school as a transition student, she was referred to Shauna. Mahealani presented with a career decision-making dilemma and also shared that she was having difficulty adjusting to her move from Hawaii to the mainland in the rural south. In reference to her career issues, she realized that she now has to give up her childhood dream of becoming a massage therapist. The closest training program is located 6 h away, farther away from her family and social support system, with fewer housing accommodations, less transportation options, and less accessible healthcare resources. Mahealani then confided that prior to her move to the south, her identity as a Nativve Hawaiian was never questioned. Here, only her African American heritage was acknowledged, forcing her to always explain. To fit in with her friends who are also bisexual, she is considering multiple body tattoos. However, she wonders how this may affect her future career choices.

Shauna is a rehabilitation counselor who self-identifies as an American Indian/African American working in a rural Southern State VR agency. The following culturally sensitive prac-

tices are gleaned from Shauna's experience as a service provider. First, the key consideration was the counselor-client match; both were members of marginalized groups. Shauna was able to build trust with Mahealani by sharing obstacles she too faced as a biracial person. This supports the results from Bellini's (2003) study which demonstrated significant main effects as well as complex interaction effects among client race, counselor race, and counselor multicultural competency in relation to rehabilitation rate and vocational training rate. Thus, clients from different racial groups experience different outcomes in the VR process in this agency as a function of the counselors' race and cultural competency. Second, Shauna respected Mahealani's worldviews without imposing negative judgments or invalidating her feelings in regard to fitting in with her peers. And third, Shauna had no problem extending her role beyond the traditional office setting to collaborate with community allies to assist Mahealani to pursue her new goal as a medical coder at the local community college.

Implications and Recommendations for Rural Rehabilitation Service Delivery

The MSJCCs compel counselors to move beyond self-reflection and awareness by adopting a professional commitment to action and collaborating at social, community, and institutional levels to ensure social change. In a study to identify the best method of building trust and collaboration with rural marginalized farmer in the Mississippi Delta, Mwachofi (2012) found that trust and collaboration building took several steps: (a) communicating individually with key community members, (b) getting insider involvement in the project administration, (c) gathering more background information about the focus population, (d) meeting farmers on their turf and on their terms, (e) gaining acceptance by officers of farmers and organizations, (f) recruiting interviewers and focus group facilitators from among the farmers, and (g) convening follow-up meetings with farmer interviewers. Each of these steps emphasizes the importance of involving the target party and community in the process. Counselors and other human service providers can learn from Mwachofi's steps in the delivery of services. Often, human service providers have procedures and policies to follow in the delivery of services. It would be prudent for them to look for ways to modify the protocol and to seek input from their clients about effective approaches to use in rural areas. Doing so does not promote violations of agency policies and procedures; rather, it promotes elements and advantages of empowerment and community-based action.

Lee, Carlson, and Senften (2014) examined the relationships between families' perceptions of cultural competence, therapeutic alliance, and practice outcomes in rural practice settings of social workers and found provider competence in rural culture was positively associated with practice outcomes (i.e., consumer satisfaction and hopefulness). Lee et al. recommended:

1. To achieve cultural competence, service providers need to receive, understand, and interpret information from clients in a culturally competent and sensitive manner (e.g., "think, feel, and act in ways that acknowledge, respect, and build upon ethnic, sociocultural, and linguistic diversity") (Lynch & Hansen, 1993, as discussed in Cox, Sullivan, Reiman, & Vang, 2009).
2. Practitioners need to ensure that the presenting problems and issues are understood as the consumer understands them and process them in culturally appropriate and relevant ways.
3. Service plans must also be conceptualized and organized with identified cultural values (Simmons, Diaz, Jackson, & Takahashi, 2008).
4. Because consumers need services from other agencies, in rural communities there are fewer formal resources, and other agencies are likely to be informal and may not be listed in a directory of social services. For better practice outcomes, providers need to identify and use informal as well as formal resources in order to provide culturally competent services from community collaboration.

Culturally competent providers are able to match services that support clients' cultural values and then incorporate the appropriate interventions (Lum, 2011). For example, ethnic and racial marginalized populations may rely on their church for services beyond religious and spiritual support. Culturally competent providers should consider strategies to incorporate this important informal support into delivery of services to the client as a means of overcoming resource barriers.

Finally, addressing the service needs of ethnic and racial marginalized populations in rural areas, service providers will need to understand how disparities in the provision of services disproportionately affect outcomes. Thus, the one-size-fits-all approach to services is not necessarily an effective approach to working with these groups. Furthermore, the intersectionality of identities (e.g., gender age, race) should be weighed in understanding how ethnic and racial marginalized groups interact with their rural environment and its influence on their receptiveness to services (e.g., independence, mistrust of the system). This process of introspection is at the core of the helping professions.

Summary

Racial and ethnic marginalized groups living in RFT communities represent distinctive groups and present with unique concerns for service delivery. Culturally competent counselors must be knowledgeable about the remnants of discrimination and microaggressions that have resulted in disparities in access, eligibility, quality, and types of services provided, types of closures, and employment outcomes of members of marginalized groups living in rural areas who need VR services. They must also commit to delivering services that embrace beliefs, customs, traditions, and history of members of marginalized groups living in rural areas. Insensitivity to these areas will continue to result with underserved clients from these groups and others who terminate services prematurely or under use services.

Resources

National Black Disability Coalition: http://www.disability.gov/resource/national-black-disability-coalition

Disability Justice: http://www.disabilityresources.org/HISPANICS.html

Understanding Prejudice: http://www.understandingprejudice.org/demos/

Positive Propaganda Advocacy & Empowerment: http://www.positivepropaganda.com

Project RACE: Reclassifying All Children Equally: http://www.projectrace.com

National Congress of American Indians: http://www.ncai.org/

Consortia of Administrators for Native American Rehabilitation: http://www.canar.org/

Initiative on Asian Americans & Pacific Islanders: https://www.whitehouse.gov/aapi

Center for Multilingual Multicultural Research: Asian-Pacific Island Resources: http://www.bcf.usc.edu/%7Ecmmr/Asian.html

Alaska Native Heritage Center: http://www.alaskanative.net/

The African Americans: Many Rivers to Cross: http://www.pbslearningmedia.org/collection/the-african-americans-many-rivers-to-cross/

Alaska Native Communities on Harriman's Route: http://www.pbs.org/harriman/1899/native.html

PBS Learning Media: Latino Americans: http://www.pbslearningmedia.org/collection/latino-americans/

Asian Americans: A Model Minority: http://www.pbs.org/video/1l512028463/

Pacific Heartbeat: A Place to Call Home: http://pbshawaii.org/tag/pacific-islanders/

Learning Exercises

Self-Check Questions

1. Explain what is meant by rural marginalized individuals with disabilities are considered to have a triple minority status.

2. What issues must be considered in determining how racial and ethnic marginalized groups define disability and chronic illness?
3. What are some things you can do to ensure that microaggressions do not occur in your counseling process with clients who are members of marginalized groups?

Experiential Activities

1. Interview an individual with a disability who is a member of a marginalized group residing in a rural area to (1) assess barriers in accessing healthcare and rehabilitation services, (2) identify their perceptions of the quality of services in the State VR agency, and (3) then compare and contrast your findings with those in the Eide et al. (2015) study found at DOI:10.1371/journal.pone.0125915.
2. Interview five individuals with disabilities who are members of marginalized group residing in a rural area to assess the barriers to voting in the general election.

Attend a church with a majority membership from a marginalized group. Interview a prominent member of that community (e.g., religious leader) to learn about the services provided to the congregation.

Multiple-Choice Questions

1. Microaggressions are defined as ____.
   (a) Positive statements about a targeted group
   (b) Denigrating messages to a targeted group
   (c) Historical messages about a targeted group
   (d) Culturally specific characteristics of a targeted group
2. Which of the following statements is generally true of racial and ethnic marginalized groups?
   (a) They seek mental health services at the same rates as European American populations.
   (b) They are very open about acknowledging psychological problems.
   (c) They are significantly less likely to seek mental health services.
   (d) They are less likely to have mental health in comparison to European Americans.
3. Which of the following explain some of the differences in help-seeking behaviors of racial and ethnic marginalized groups for depression?
   (a) The way symptoms are manifested
   (b) The way depression is defined
   (c) The way symptoms are interpreted and labeled
   (d) All of the above
   (e) None of the above
4. Which of the following has been added to multicultural competencies by the multicultural and social justice competencies?
   (a) Awareness
   (b) Knowledge
   (c) Skills
   (d) Action
5. Which of the following most influences how we view people with disabilities?
   (a) Age
   (b) Gender
   (c) Culture
   (d) Religion
6. What are typical complicating factors impacting the well-being of marginalized groups residing in rural areas?
   (a) Lowered unemployment rates
   (b) Increased on-the-job support
   (c) Greater disparities in access to healthcare resources and availability of quality healthcare
   (d) Increased VR outreach
7. Which marginalized group has research reported mixed or conflicting findings with regard to racial disparities in employment outcomes?
   (a) Hispanic/Latino Americans with hearing losses
   (b) American Indians with traumatic brain injuries
   (c) African Americans with spinal cord injuries

(d) Asian American/Pacific Islander young adults with specific learning disabilities

8. Which of the following is a key component in a counselor's understanding of the existence of the intersectionality of multiple statuses impacting the well-being of an African American gay male?
   (a) Client worldview
   (b) Cultural competency
   (c) Counselor self-awareness
   (d) Advocacy intervention
9. What components are paramount in achieving positive outcomes in a working alliance?
   (a) Building trust and collaboration with marginalized clients and their communities
   (b) Developing a thorough knowledge of cultural characteristics of marginalized clients
   (c) Reducing early termination
   (d) Avoiding racial/cultural issues
10. Which of the following areas does research not demonstrate that disparities exist in VR service provision to marginalized group members?
   (a) Closure types
   (b) Employment outcomes
   (c) Eligibility
   (d) Work disincentives

Key

1 – B
2 – C
3 – D
4 – D
5 – C
6 – C
7 – A
8 – B
9 – A
10 – D

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