Exploring cultural competencies of certified therapeutic recreation specialists: Implications for education and training

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Abstract:

The purpose of this investigation was to explore the influence of demographic and educational variables on self-reported multicultural competencies of Certified Therapeutic Recreation Specialists(TM) (CTRSs(R)). A sample of 277 therapeutic recreation specialists currently certified with the National Council for Therapeutic Recreation Certification participated in this investigation. Multicultural course work, seminars and workshops, and perception of level of cultural competence among CTRSs(R) were found to be statistically significant with self-reported multicultural competencies, such as multicultural awareness, knowledge and skills. These findings are discussed in terms of pre-service education and continued professional in-service training for CTRSs(R).
Key Words: Minorities, Cultural Competence, Multiculturalism, Therapeutic Recreation

Article:

The United States is becoming more culturally diverse each day. According to the U.S. Census Bureau (2000), of the over 284 million people in our total population, almost 20% are ethnic minorities. Additionally, about 1 in 5 Americans has a disability, and 1 in 10 has a severe disability (U.S. Census Brief, 1997). By the year 2030, it is approximated that 20% of the population will be over age 65 (Kramarrow, Lentzner, Rooks, Weeks, & Sayday, 1999). This increasing diversity presents a challenge to Certified Therapeutic Recreation Specialists (CTRSs) to consider the future consumers of therapeutic recreation (TR) services and how well their practices meet the multicultural needs of clients (Arthur, 2000; Austin, 1999).

Multicultural Competencies

Holland (1997) described multiculturalism as a concept which implies that appropriate consideration be given to physical and emotional disabilities, ethnic and racial cultural diversity, as well as poverty and native languages. The concept of multiculturalism includes issues such as racism, sexism, ableism, anti-Semitism, classism, and homophobia. Multicultural competence is a unique category of awareness, knowledge, and skills that enables a system, agency, or professional to work effectively in cross-cultural situations (Cross, Barzon, Dennis, & Isaac, 1989; Harris & Haughton, 2000). Multiculturalism and the need for a multicultural approach toward patient care has been supported by theory and research in other fields, such as counseling and psychology, and is quickly becoming established as a major theoretical perspective (Pope-Davis, Prieto, Whitaker, & Pope-Davis, 1993). Pope-Davis et al. (1993) viewed a multicultural approach as appropriate for all consumer activities, as opposed to a special type of intervention or treatment. Lee and Skalko (1996) suggested an approach where consideration of diverse health and illness values and beliefs in a cultural context is needed in order to provide enlightened, relevant TR services. Thus, a multicultural approach appears appropriate for use in the provision of TR services due to the nature of the therapeutic relationship between provider and consumer.

Sue et al. (1982) pioneered efforts to identify cross-cultural competencies necessary for culturally skilled individuals. Those efforts were specific to those people who have moved from being culturally unaware to being sensitive to their own cultural issues and to how their values and biases affect diverse clients. Pope-Davis et al. (1993) indicated that individuals who are multiculturally competent "consider and evaluate factors such as the effect that the sociopolitical system has on people of color in the United States, have a knowledge base

concerning cultural and racial groups, and are able to implement a wide range of appropriate responses to patient needs" (p. 839).

Sue et al. (1982) categorized multicultural competencies into three areas: Beliefs and Attitudes, Knowledge, and Skills. Sodowsky and Taffe (1991) added a fourth competency area called Relationship. The Beliefs and Attitudes area, also referred to as Awareness, is defined as the awareness of one's own cultural heritage, values, and biases, and of the ways these affect one's relation with persons of color. The Knowledge area consists of appreciation and respect for differences in other cultures. The goal is to acquire information about specific cultures. Skills are defined as behaviors demonstrated during interaction with culturally diverse populations, such as communication skills appropriate to the client's particular culture and being sensitive to behaviors unique to different groups (Sue & Sue, 1990). Sodowsky and Taffe (1991) identified Relationship as a competency area that deals with an individual's ability to integrate awareness, knowledge and skills and use these to develop effective and appropriate therapeutic relationships with culturally diverse populations.

Service Inequities for Minorities

Historically, minorities have not received the same level of care in health, social, and human services comparable to the majority population. These minority groups include people of color (Williams & Dickerson, 1995; Williams, 2001), people with disabilities (Lecca, Quervalu, Nunes, & Gonzales, 1998; Narrow, Regier, Norquist, Rae, Kennedy, & Arons, 2000), women (Sharpe, 1995; Williams, 2002), and older adults (Auchincloss, Nostrand, & Ronsaville, 2001; Bazargan, Bazargan, & Baker, 1998). Minorities tend to visit their physicians and utilize ambulatory and acute services less often than non-minorities (Husaini et al., 2002). Previous research also suggests minority groups have relatively low mental health service usage rates (Black, Rabins, German, McGuire, & Roca, 1997; Padgett, Patrick, Burns, & Schlesinger, 1994). Predisposing characteristics associated with utilization of mental health services included sex, age, and ethnicity.

Many researchers argue that cultural, attitudinal or service system barriers may prevent minorities from utilizing mental health services (Padgett et al., 1994). Underutilization of services among minorities may also be associated with stigmas attached to mental illness and with acceptance of physical and mental health problems occurring due to age, age discrimination, or access barriers to services (Husaini et al., 2002). Minorities may also be reluctant to use a health delivery system that is dominated by English-speaking Whites or they may prefer other informal sources for mental health (e.g., friends, families or ministers) that they believe are more attuned to their own individual culture (Black et al., 1997; Padgett et al.). Similarly, researchers have argued that minority ethnic groups do not utilize mental health services because of certain sociocultural factors, such as geographic location (Auchincloss, Nostrand, & Ronsaville, 2001), language barriers (Sharpe, 1995), and cultural differences in attitudes toward or preferences for health care (Krakauer, Crenner, & Fox, 2002). Uba (1994) indicated that clients who do access these medical services have disorders that are more severe than those of other clients, or they must be hospitalized as a consequence of not receiving culturally appropriate services earlier.

Researchers have used the term "culturally encapsulated" to refer to therapists who stereotype individuals from minority groups rather than consider their cultural differences (Lecca el al., 1998; Sylvester, Voelkl, & Ellis, 2001). CTRSs run the same risk of culturally encapsulating their clients by categorizing cultural differences observed during the therapeutic recreation (TR) process as a form of resistance by the clients. For example, a client might refuse to participate in a card game a CTRS is utilizing to improve the client's fine motor skills. The client's refusal could be viewed as a form of resistance by the CTRS, when in fact the refusal may be based on the client's religious beliefs and values. Hence, due to the therapist's ignorance of various beliefs the client could potentially not receive adequate TR services.

CTRSs have the potential to utilize culturally competent treatment services in order to prevent the underutilization and premature termination of services by minority clients. Without these cultural competencies, CTRSs risk negative consequences occurring during TR service delivery. For example, because most ethnic and cultural groups have strong familial orientations (Boyd-Franklin, 1989), it would be useful for therapists to

understand the value of the family presence in the rehabilitation process. Additionally, minorities often have different views about illness and culturally based approaches to their treatment (Lecca et al., 1998). For example, researchers have found that African Americans prefer to seek emergency service over scheduled clinic visits secondary to limited resources, cultural differences in illness management, and social reaction to illness and race (Black et al., 1998; Husaini et al., 2002). Williams (2001) indicated that clients may not make use of services if they do not perceive a need, or if the assistance offered runs counter to deeply held cultural beliefs about how illnesses or problems are solved. Therefore, it would be helpful for the CTRS to be knowledgeable of different expectations of their clients and of themselves.

Minimal research has been reported in the health care arena regarding the examination of multicultural competencies, with the exception of counseling (Arthur, 2000; Granello, Wheaton, & Miranda, 1998), occupational therapy (Pope-Davis et al., 1993), and nutrition (Harris-Davis & Haughton, 2000). Arthur (2000) examined self-reported multicultural competencies and demographic and professional practice factors associated with higher and lower level of multicultural counseling competencies of a national sample of Canadian counselors. The results indicated multicultural course work and professional development seminars as well as experience with a caseload comprised of culturally diverse clients had a positive impact on multicultural counseling competencies. Similarly, Pope-Davis et al. (1993) explored the influence of demographic and educational variables on self-reported multicultural competencies of occupational therapists. They found multicultural course work, seminars and workshops, percentage of minority patients worked with, and highest degree held to correlate significantly with self-reported multicultural competencies.

Within the field of TR, cultural competence has been encouraged in terms of education and/or training and practice. For example, Henderson (1997) discussed the need for all recreation professionals, board members, staff, and volunteers to be trained about diversity. She indicated that much of that training should begin with higher education, but that it should be "an ongoing endeavor since each community is different" (p. 30). Sheldon and Dattilo (1997) stated that it can be beneficial for CTRSs to scrutinize personal beliefs about and attitudes toward people, to identify people specifically and sensitively, and to seek ways to accommodate individual preferences by providing alternatives or adaptations as needed. Lee and Skalko (1996) suggested that TR personnel must be equipped with an innovative mind-set and "assume more proactive roles in removing cultural barriers in order to maximize our rehabilitative efforts" (p. 53).

As part of the systematic 4-step TR process of client assessment, development of a plan of action, implementation of the action plan, and evaluation of the intervention effects, CTRSs provide purposeful interventions designed to help clients grow and to assist them to prevent or relieve problems through activities, recreation, and leisure (Austin, 1999). More than ever, CTRSs will be expected to work with, and have a significant understanding and knowledge of, individuals from many racial, ethnic, and cultural backgrounds, including an awareness of socioculturel factors (e.g., ethnic, racial, and cultural backgrounds), biological factors (e.g., anatomical and physiological underpinnings), and psychological factors (e.g., personality, family, and group psychodynamics) (Ho, 1992).

Unfortunately, CTRS have limited exposure and training in areas needed to provide them with this body of knowledge (Aguilar & Washington, 1990; Lee & Skalko, 1996; Peregoy & Dieser, 1997). Sheldon and Dattilo (1997), for example, reviewed recent professional journals and textbooks in TR and found a limited number of references to ethnic, racial, religious, or other dimensions of cultural diversity. They further stated that references that did occur often assumed that the reader understood multicultural diversity language, which may not be the case for many professionals. Dieser and Peregoy (1998) indicated more than one-half of all graduate-level park and recreation programs do not have multicultural program requirements.

Conceptual Framework

A theoretical model that is commonly used for cultural diversity training is Wheeler's (1994) Education and Training Model. According to Wheeler, diversity training is approached with the knowledge that people often are not aware of their behavior and personal biases, nor are they culturally aware or naturally sensitive to the

differences of others. Wheeler's hierarchical model of cultural diversity suggests four sequential levels of cognizance of diversity issues. These levels range from being "unconsciously incompetent" to "unconsciously competent" about diversity issues. The first level is the assumption that people are unconsciously incompetent, or they do not know what they do not know. CTRSs who are unconsciously incompetent are unaware of their reactions toward minority groups and/or stereotypes and preconceived notions they hold toward culturally different clients. They also have limited knowledge, if any, of their clients' cultures, such as communication patterns, cultural heritage, and historical backgrounds. At the second level, individual awareness is enhanced to the point where the individual becomes consciously incompetent, or she knows that she does not know. CTRSs who are consciously incompetent have a new awareness and understanding of their own cultural values and biases and are willing to improve their understanding and effectiveness in working with culturally diverse populations. The third level assumes that a person becomes consciously competent, or she has a new awareness and understanding of cultural differences. The consciously competent CTRS develops and implements TR programs with cultural awareness and understanding. Finally, at the fourth level, the person is unconsciously competent, or she knows how to deliver culturally competent TR services but does not think about it.

This literature review provides a strong rationale for examining the multicultural competencies of CTRSs and demonstrates concern within the field for ensuring the provision of effective TR services to culturally diverse populations. However, no empirical research is available that has examined the multicultural competencies of CTRSs, or the influence that various demographic and educational variables have on these competencies. The purpose of this study, therefore, was to address the following questions: (a) How culturally competent did CTRSs perceive themselves to be? (b) Were the multicultural competency scores of CTRSs influenced by demographic variables, such as age, sex, gender, and educational level? (c) Was there a difference between perceived cultural competence of CTRSs and the self-reported multicultural competency scores? (d) Was the amount of multicultural training received by CTRSs related to their multicultural competence scores?

Methods

Participants

The sample consisted of 500 currently Certified Therapeutic Recreation Specialists from the U.S. and Canada. The CTRSs were systematically and randomly selected from the National Council for Therapeutic Recreation Certification's mailing list. At the time of data collection, there were approximately 17,000 nationally certified therapeutic recreation specialists.

Instruments

The CTRSs were asked to complete the Multicultural Counseling Inventory (Sodowsky, Taffe, Gutkin, & Wise, 1994) and a demographic questionnaire that included items such as age, sex, race/ethnicity, level of education, number of courses and workshops/seminars attended on multiculturalism, and personal perceptions of the cultural competence of CTRSs.

Multicultural Counseling Inventory (MCI) (Sodowsky et al., 1994)

The MCI consists of 43 self-report items that assesses multicultural competencies on a 4-point Likert scale (1 = very inaccurate; 4 = very accurate) asking the respondent to indicate the degree to which the scale items describe their work as counselors/trainers. Scale scores are obtained by adding the items specific to each subscale. Higher subscale scores indicate greater multicultural competence in the respective subscale areas. A large midwestern sample of counseling, school and clinical psychology graduate students and counseling professionals were surveyed to develop the MCI. This analysis resulted in four subscales, namely Multicultural Awareness, Knowledge, Relationship, and Skills-with internal consistency reliabilities of .83, .79, .71, and .83 respectively. There were low to moderate intersubscale correlations ranging from r = .23 to r = -.52.

Alpha coefficients for the MCI subscales for the current sample produced internal consistency estimates of .76 (Awareness), .70 (Knowledge), .62 (Relationship), and .82 (Skills). These estimates closely approximate the reliabilities reported by Sodowsky et al. (1994). Subscale intercorrelations of the four MCI subscales showed a reasonable level of internal consistency for use with this national sample of CTRSs. Low to moderate

correlations were found between the four subscales ranging from r = .14 to r = .51. These correlations also approximate MCI subscale correlations found during instrument development and suggest that the inventory is measuring related but different constructs.

The MCI is based on a conceptual framework from Sue et al. (1982) on multicultural counseling competencies on the following four subscales:

Awareness. Ten items measure multicultural sensitivity, interactions, and advocacy in general life experiences and professional activities. Sample items include "My professional and collegial interactions with minority individuals are extensive" and "My life experiences with minority individuals are extensive (e.g., via ethnically integrated neighborhoods, marriage, and friendship)."

Knowledge. Eleven items measure treatment planning, case conceptualization, and multicultural research. Sample items include "When working with minority clients, I examine my own cultural biases" and "When working with minority clients, I consider the range of behaviors, values, and individual differences within a minority group."

Skills. Fourteen items measure general and specific multicultural skills. Sample items include "When working with minority clients, I am able to quickly recognize and recover from cultural mistakes or misunderstanding" and "When working with minority clients, I use varied counseling techniques and skills."

Relationship. Eight items measure the interaction process with the minority patient (e.g., comfort level, world view, and trustworthiness). Sample items include "When working with minority clients, I tend to compare client behavior with those of majority group members" and "When working with minority clients, I experience discomfort because of the clients' different physical appearance, color, dress, or socioeconomic status."

Data Collection

The instruments were mailed to a random sample of CTRSs in the U.S. and Canada. Participants were asked to complete the MCI and a demographic questionnaire and return them when completed. Packets included a cover letter with specific directions for completing the instruments and a return date. Follow-up postcards were mailed twice to increase the response rate.

Data Analysis

The data were analyzed using descriptive statistics to summarize characteristics of data, including frequencies and measures of central tendencies. Comparative analyses included independent t tests to measure differences between age, sex, level of education, and race/ethnicity on the MCI subscales. Further comparative data analysis included univariate analyses of variance (ANOVA), multivariate analyses of variance (MANOVA), and Tukey post-hoc tests. The ANOVA was utilized to test the differences among two or more groups, and the MANOVA was used to detect the effects of multiple variables on multiple groups. The post-hoc comparisons were used to determine where the differences existed between groups.

Results

Participant Profile

Of 500 surveys mailed, 294 (58.8%) were returned and 277 (55.4%) were usable. The unusable surveys were returned incomplete or the participants indicated they were no longer practicing in the TR field. The participants ranged in age from under 30 to over 50 years. Greater than three-fourths of the sample were females and European American/White, while just over one-tenth were African-American, Latin American/Hispanic, Asian American, Pacific Islander, and American Indian. Approximately three-fourths of the participants held undergraduate degrees, and one-fourth held graduate level degrees. See Table 1 for demographic characteristics of the sample.

Multicultural Training

Regarding multicultural training, over one-third of the participants had not completed multicultural course work, one-half had completed one or two courses, while only one-tenth had completed three or more courses. Similarly, less than one-third of the participants had not attended any multicultural seminars or workshops, less than one-half attended two workshops, and less than one-fourth attended three or more workshops (see Table 2 for multicultural training profile of the sample).

Perceptions of Multicultural Competence

Less than one-fourth (20%) of the respondents indicated that CTRSs demonstrated high levels of cultural competence, less than three-fourths (70%) indicated moderate levels of cultural competence, and one-tenth (10%) indicated low levels of cultural competence.

Descriptive Statistics

Averages were computed so that scores could be interpreted with reference to the original 4-point Likert scale. Higher mean scores indicate more self-reported multicultural competency in the respective subscale. MCI subscale means and standard deviations for CTRSs were Awareness (M = 2.70, SD = .52), Knowledge (M = 3.06; SD = .38), Skills (M = 3.32; SD = .42), and Relationship (M = 3.30; SD = .42). Because the scale mid-point is 2.0, it is evident that the participants reported moderate levels of multicultural competencies, particularly in the areas of multicultural skills and counseling relationships.

Comparative Analyses

Age, sex, level of education, and race/ethnicity. Independent t-tests were run to determine whether a difference existed between age, sex, level of education, and race/ethnicity on the MCI subscales. While no significant differences were found when age and level of education were examined across MCI subscale scores, there was a significant difference in sex on the Relationship subscale (females M = 3.34; males M = 3.17) ($t = 2.50$; $p = .013$). However, due to the low number of males in the sample, the results must be interpreted cautiously. Due to the lack of ethnic diversity in the field of TR (only 12%), a comparison could not be made between ethnic groups and their MCI subscale scores.

Perceptions of cultural competence. The initial MANOVA that assessed differences between CTRSs' perceptions of cultural competency and their MCI subscale scores found no significant differences in the areas of Multicultural Knowledge, Multicultural Counseling Skills, and Multicultural Relationships. However, the initial MANOVA of CTRSs' perceptions of the cultural competency of CTRSs in general and their MCI subscale scores found statistically significant differences among the groups in the area of Multicultural Awareness ($F = 1.67$; $p = .035$).

Based on this initial finding, ANOVAs with a post-hoc test were examined to determine where the differences existed in the area of Awareness. Table 3 illustrates these differences. Significant differences were found in 6 of 10 items. CTRSs who perceived other CTRSs to have high levels of cultural competence indicated having a working understanding of certain cultures, understanding the importance of the legalities of visa, passport, green card, and naturalization, having extensive professional or collegial interactions with minority individuals, enjoying multicultural interactions as much as interactions with people of their own culture, and having extensive experiences with minority individuals than did CTRSs who perceived other CTRSs to have low levels of cultural competence. Similarly, respondents who perceived CTRSs to have high levels of cultural competence indicated having experience at solving problems in unfamiliar settings, having extensive professional or collegial interactions with minority individuals, and enjoying multicultural interactions as much as interactions with people of their own culture than did CTRSs who perceived other CTRSs to have low levels of cultural competence.

Multicultural course work. The initial MANOVA that assessed for differences between the number of multicultural courses taken and Multicultural Counseling Knowledge, Skills, and Relationship found no significant differences. Therefore, subsequent ANOVAs were unnecessary. However, initial MANOVA of

Multicultural Awareness and the number of multicultural courses taken revealed a significant difference among the groups ($F = 2.03$; $p = .001$).

Based on these initial findings, ANOVAs with a post-hoc test were examined to determine where the differences existed. Table 4 illustrates these differences; significant differences were found in 8 of 10 items. Differences were predominantly found among those who had taken three or more courses and those who had not taken any courses or those who had taken one course only. CTRSs who had taken 3 or more multicultural courses self-reported significantly higher mean scores in having experience solving problems in unfamiliar settings, having a working understanding of certain cultures, understanding the importance of the legalities of visa, passport, green card, and naturalization, having extensive professional or collegial interactions with minority individuals, having had a 50% increase in multicultural caseload in the past year, being involved in advocacy efforts against institutional barriers for minority clients, having extensive life experience with minority individuals, and frequently seeking consultation with multicultural experts and attending multicultural workshops or training sessions in order to be able to work with minority clients.

Multicultural workshops/seminars attended. The MANOVA that looked for differences among the number of multicultural workshops/seminars attended and Multicultural Relationship found no significant differences. Therefore, subsequent ANOVAs were unnecessary. However, the MANOVA found a significant difference among the groups in the areas of Multicultural Awareness ($F = 2.67$; $p = .000$), Knowledge ($F = 1.65$; $p = .01$) and Skills ($F = 1.58$; $p = .02$) and the number of multicultural workshops/seminars attended.

Based on these initial findings, ANOVAs with a post-hoc test were examined to determine where the differences existed. Table 5 illustrates these differences relative to Multicultural Awareness; significant differences were found in 4 of 10 items. Differences were predominantly found among those who had attended two or more workshops and those who had not attended any workshops or those who had only attended one workshop. CTRSs who had attended two or more multicultural workshops self-reported significantly higher mean scores in having experience solving problems in unfamiliar settings, being involved in advocacy efforts against institutional barriers for minority clients, having extensive life experience with minority individuals, and frequently seeking consultation with multicultural experts and attending multicultural workshops or training sessions in order to be able to work with minority clients.

Similar post-hoc results were found when examining differences between Multicultural Counseling Knowledge subscale mean scores and the number of multicultural workshops or seminars attended. Table 6 illustrates these differences relative to Multicultural Counseling Knowledge; significant differences were found in 4 of 11 items. Differences were predominately found among those who had attended two or more workshops and those who had not attended any workshops or those who had only attended one workshop. CTRSs who had attended two or more multicultural workshops self-reported significantly higher mean scores in using innovative concepts and treatment methods, examining own cultural biases, keeping in mind research findings about minority clients' preferences in counseling, and considering the range of behaviors, values, and individual differences within a minority group.

Similar post-hoc results were found when examining differences between Multicultural Counseling Skills subscale mean scores and the number of multicultural workshops or seminars attended. Table 7 illustrates these differences; significant differences were found in 5 of 11 items. Differences were predominately found among those who had attended 2 or more workshops and those who had not attended any workshops or those who had only attended 1 workshop. CTRSs who had attended 2 or more multicultural workshops self-reported significantly higher mean scores in being effective at crisis interventions, using varied counseling techniques and skills, being comfortable with exploring sexual issues, being skilled at getting a client to be specific in defining and clarifying problems, and making nonverbal and verbal responses congruent.

Discussion

The purpose of this study was to explore the self-reported multicultural competencies of CTRSs in the U.S. and Canada. In addition, the influences of demographic and educational variables were examined to determine their contributions to self-reported multicultural competencies. Results suggested that clear differences exist in perceived multicultural competency and self-reported multicultural competencies as well as exposure to multicultural course work among CTRSs in the area of multicultural awareness. Further, results suggested that exposure to seminars or workshops addressing multicultural issues appear to have a strong effect on the perceived acquisition of multicultural awareness, knowledge, and skills.

The findings indicated that CTRSs reported moderate levels of multicultural competencies, particularly in the areas of skills and relationships. They also perceived other CTRSs to have moderate to high levels of cultural competence. However, results suggested there is a clear difference in their self-reported cultural competencies and perceived levels of multicultural competence in the area of multicultural awareness. CTRSs who perceived other CTRSs to have high levels of cultural competence indicated having a working understanding of certain cultures and enjoying multicultural interactions as much as interactions with people of their own culture than did CTRSs who perceived other CTRSs to have low levels of cultural competence.

These results provide support for Wheeler's (1994) hierarchical model of cultural diversity that suggests four sequential levels of cognizance of diversity issues. The current findings suggest that even though CTRSs self-reported moderate levels of multicultural competence, they may be in the unconsciously incompetent level, especially in the area of multicultural awareness. A CTRS who is unconsciously incompetent is unaware of different groups' cultural expressions and/or leisure behaviors, whereas one who is unconsciously competent knows how to develop and implement TR programs with cultural awareness and understanding but does not think about it. One is compelled to question the level of multicultural awareness of CTRSs based on the results of this study. For example, CTRSs differed significantly in the multicultural awareness domain in the majority of variables under investigation, namely perception of multicultural competence of CTRSs, the amount of multicultural course work received, and the number of multicultural workshops or seminars attended. This appears to suggest that CTRSs are unconsciously incompetent, or they do not know what they do not know, or they believe themselves and other CTRSs to be more culturally competent than they actually are.

Limitations

In interpreting these results, the limitations of this study warrant discussion. First, the major limitation of this investigation relates to using a self-report measure. The participants may have assessed anticipated rather than actual behaviors or attitudes. The participants may have selected responses they believed to be socially acceptable, and they may have interpreted the items on the inventory differently than was intended. Additionally, while these data provide important information regarding self-perceived competence, they do not speak to whether these CTRSs are actually competent to work with diverse minority groups, or what level of competence is adequate for the provision of effective therapeutic recreation services. Another limitation is the lack of diversity within the sample itself. The majority of the sample was White females, which made it difficult to conduct comparative analyses, related to race/ethnicity and sex. Despite these limitations, the results of this study demonstrate the impact that multicultural training can have on cultural competence.

Recommendations for Practice

This study identified variables associated with high and low levels of multicultural competencies. In particular, the study highlighted the importance of personal, professional and collegial interactions and experiences with minorities, the need for multicultural course work and professional development workshops or seminars, as well as the importance of consultations with multicultural experts.

Personal, professional and collegial interactions with minorities. It is important to have direct interactions with people from diverse cultural backgrounds in order to learn more about their value systems and cultural norms, how they live in society, why they hold certain beliefs, and the relationship of those beliefs to recreation and leisure. CTRSs could use culturally diverse guest speakers from both the academic and professional

community to introduce students or practitioners to issues and concerns facing particular underrepresented groups (e.g., racial/ethnic, disability, gender, etc.). Washington (1996) encouraged the use of outside guests, noting that they provide an opportunity for students to learn about personal experiences of people who are different from them. Outside guests could assist CTRSs to become more knowledgeable about disabilities on a practical level, gain first-hand knowledge of the service delivery system, and develop an experiential understanding of challenges faced by underrepresented populations. Lee and Skalko (1996) recommended discussion groups composed of personnel experienced in multicultural service delivery to complement professional training as well as inviting various local groups from different cultural backgrounds to foster an understanding of cultural health and illness beliefs and values.

In terms of collegial interactions, the number of people from underrepresented groups practicing in the field of TR specifically is appallingly low. Data from this study showed that a little over 10% of a random sample of CTRSs were from a non-white (underrepresented) group, and less than 20% were male. This lack of diversity, in essence, denies TR consumers opportunities for role models and CTRSs with whom they can relate. This suggests a need to boost efforts to recruit and train additional minorities to enter the field of TR. Multicultural pre-service and in-service training. Sharpe (1995) stressed the need for a multifaceted approach to address the problem of ageism and sexism within the health care system, including both patient and professional education and changes in organizations and policies. She suggested "training of health professionals that incorporates attention to communication skills, cultural sensitivity, and challenge to ageist and sexist stereotypes" (pg. 17). Pre-service TR training programs should be developed that will require students to become actively involved with minority individuals outside the helping setting so their perspective of minorities is more than an academic exercise. Peregoy, Schliebner, and Dieser (1997) developed a training model with multicultural knowledge infused throughout the TR curriculum with an emphasis on awareness, knowledge and skills.

Training programs or employers who encourage and support their staff to take advantage of seminars and workshops concerning multiculturalism will probably increase their staff members' perception of themselves as multiculturally competent and subsequently will increase the likelihood of their ability to deliver effective services to minorities. Dieser and Peregoy (1998) stated that practitioners who receive multicultural awareness education as part of their program of study have a much higher potential for success than do those who have not taken relevant courses. Therefore, once TR students have begun to develop a foundation of cultural competencies through course work within pre-service training, exposure to further in-service training through multicultural workshops and/or seminars may enhance knowledge and skill competency areas, such as the ability to design innovative treatment methods, use a variety of techniques and skills, and solve problems in unfamiliar settings. Peregoy and Dieser (1997) stressed that multicultural competencies can be infused in TR pre-service and in-service training programs, citing as an example an introduction class on TR where the instructor introduces topics such as cultural self-awareness and sensitivity to one's own cultural heritage.

Consultations with multicultural experts. It is also important to enlist the assistance of qualified multicultural experts to serve as consultants and/or diversity trainers. Many administrators do not feel they have the internal expertise or resources necessary to conduct diversity training (Wheeler, 1994). However, Schneider and Allison (2000) cautioned against leaving diversity initiatives to one "diversity expert" (p. 282). They suggest that doing so has the potential of minimizing the importance of diversity efforts and defers the group responsibility. Washington (1996) recommended hiring a consultant(s) who differ in race, gender, and/or ability to challenge traditional beliefs and assist CTRSs and TR students to gain an understanding of how different TR approaches may or may not be appropriate for a specific culture.

Recommendations for Future Research

By documenting the ability of multicultural training to enhance multicultural awareness, knowledge, and skills, these findings highlight the potentially facultative role of such education in TR pre-service and in-service training programs. The implications of these changes, however, remain largely unexplored. Further effects might be directed, for example, at determining relevant experiences that will increase a CTRS' competency to effectively serve diverse populations. This study might also be replicated with emphasis on the number of

minority clients and/or amount of contact with minority clients to determine whether direct contact with minority clients influences cultural competence.

Another possibility is to replicate the study using a stratified random sample to ensure proportionate representation in terms of sex and race/ethnicity. This is needed because of the small percentage of men and ethnic minorities in the field of TR. Future research might also measure cultural competence of CTRSs from the perspectives of their clients as opposed to self-reported multicultural competencies. It is important to ask consumers of TR services if we are identifying and meeting their culturally related needs. Finally, additional research is needed to explore the nature and content of multicultural course work and workshops/seminars. For example, it is important to develop exemplary multicultural preservice and in-service training programs to ensure future and current TR professionals are culturally competent.

Conclusions

The conclusions reached in this study are tentative and need to be confirmed with other groups of recreation and park professionals and investigated in more detail. However, the study emphasizes the importance of personal, collegial and professional interactions with individuals from diverse groups, educational experiences such as multicultural course work and participation in multicultural workshops or seminars in the development of multicultural awareness, skills, and knowledge. Cultural competence requires the continuous seeking of knowledge, skills and attitudes that will enable CTRSs to transform interventions into positive client outcomes and levels of satisfaction. Given the reality of an emerging diverse society within the 21st century, practicing CTRSs or those in training must increase their cultural competencies in order to provide culturally appropriate services.

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