Chapter One

Rehabilitation Counseling: Concepts and Paradigms

1. 1 Concepts and definition of rehabilitation and rehabilitation counseling

Rehabilitation is a robust concept that is widely used in different parts of the world. It is used in diverse contexts with reference to the rehabilitation of **person**, **places**, and even **things**. In each of these contexts, there is an implied connotation of **restoration** to the state of **health** or useful and **constructive** activity. It can be used to refer to **profession**, and a **scope of practice** within **health care** and **human services delivery system**. It is therefore, critical to begin with definitions in order to provide a language through which the concepts and paradigms of rehabilitation and rehabilitation counseling may be presented. From this foundation, rehabilitation counseling may be articulates more clearly as both a **profession** and a **practice**.

The following definitions have been proposed for the terms '**rehabilitation**' &'**rehabilitation counseling**'

Rehabilitation

Rehabilitation is defined as " a holistic and integrated program of medical, physical, psychological, and vocational interventions that empowers a person with disability to achieve a personally fulfilling, socially meaningful, and functionally effective interaction with the world"(Banja, 1990).

Rehabilitation within the context of rehabilitation counseling process, it is "a **comprehensive** sequence of **services**, mutually planned by the rehabilitation counselor and the consumer, to **maximize** employability, independence, integration, and participation of persons with disabilities in the work place and the community.

Rehabilitation according to encyclopedia of special educatio*n* (2007) refers to **any *process***, ***procedure***, or ***program*** that ***enables*** an individual with disability to ***function*** at a more independent and personally satisfying level. This functioning should include all aspects—physical, mental, emotional, social, educational, and vocational—of the individual's life. A person with disability may be defined as one who has any chronic mental or physical incapacity caused by injury, disease, or congenital defect that interferes with his or her independence, productivity, or goal attainment. The range of disabilities is wide and varied, including such

conditions as autism, mental retardation, muscular dystrophy, and a variety of neurological and orthopedic disorders. These disparate conditions may appear singly or in concert. Clearly, the process that is designed to assist persons in obtaining an optimal level of functioning is a complex one. The **complexity** of the rehabilitation process necessitates a **team approach** that involves a range of professionals almost as broad and varied as the types of conditions being addressed. Goldenson, Dunham, and Dunham (1978) discuss no fewer than 39 rehabilitation specialists in their handbook. Their list includes such diverse professions as orientation and mobility training, genetic counseling, biomedical engineering, and orthotics and prosthetics, in addition to numerous medical, mental health, therapeutic, and special education fields. In view of the potential involvement of such an array of professionals, it becomes particularly important to remember that the rehabilitation process is **not one that is done to** or **for PWDs,** but rather one that is **done with PWDs** and often their *families* as well. It is necessary for the professionals involved in the rehabilitation process to function as a team rather than as separate individuals. McInerney and Karan (1981) have pointed out that without information sharing and cooperative integration, the rehabilitation process will not fit the needs of the client. The client should not be expected to fit the needs of the service delivery system. As rehabilitation is a process, not an isolated treatment, a continuum of services must be provided to give the person with disability assistance in all aspects of life. A program that is cohesive in approach, regardless of the number of professionals involved, is essential. In addition, these services must alter to meet the client's changing needs.

Rehabilitation counseling

Rehabilitation counseling is viewed as "a profession that ***assists*** persons with disabilities in ***adapting*** to the environment, assist environment in ***accommodating*** the ***needs*** of the individual and works towards ***full participation*** of persons with disabilities in all aspects of the society, especially work" (Szymanski, 1985, p. 3).

Rehabilitation counseling as a scope of practice

Is defined as "a ***systematic process*** which assists person with mental, physical, developmental, cognitive and emotional disabilities to achieve their **personal**, **career**, and **independent living goals** through in most integrated setting possible through the application of rehabilitation counseling process.

The counseling process involves communication, goal setting, and beneficial growth and change through self advocacy, psychological, vocational, social and behavioral interventions" [commission on rehabilitation counselor certification (CRCC,) 1994, P.1]

The field of rehabilitation counseling is thus defined as a specialty within the rehabilitation profession with counseling as its core, and is differentiated from other related counseling fields. It is also a practice that has evolved within the context of changing legislative mandates, societal perspectives, as well as technological and medical advances.

Rehabilitation philosophy

The philosophy of rehabilitation is premised in a belief of in **the dignity and worth of all people**. It values are independence, integration, and the inclusion of people with and without disabilities in employments and in their communities. Rehabilitation represents the philosophy that whenever possible people with disabilities should be integrated in the least restrictive environment. Inherent in this philosophy is a commitment to equalize the opportunities to participate in all right and privileges available to all people and to provide a sense of equal justice based on a model of accommodation. In addition, there is a commitment to support people with disabilities in advocacy activities in order to enable them to achieve this status and thus further empower themselves.

Simultaneously, within this philosophy there is a commitment to models of the services delivery that emphasize integrated, comprehensive services that are mutually planned by the consumer and the rehabilitation counselor. Throughout rehabilitation emphasis is given to **choice** of and the **holistic nature** of the people.

Individuals are conceptualized as interacting within multiple context of life especially those of their family and cultural systems. The philosophy is **solution focused** and **stresses the asset of the person** and **the resources of the environment**. The focus is on adaptation and accommodation from an ecological perspective that is directed toward achieving a meaningful quality of life for the person with disability. Contemporary rehabilitation philosophy is reflected in several paradigm shifts. These shifts include a movement from an individual problem solving approach to an ecological solution-focused approach, from institutionalization to community participation; from charity to civil right, from segregated vocation training models to community

integrated or community supported employment and independent living models, and from a medical model within an illness and pathology to social model focusing on development and life stages. The philosophy of rehabilitation is advocacy for consumer choice and empowerment. The philosophy of rehabilitation embraces as a person's right to choose his or her relationships and goals both personal and vocational.

1.2 History of rehabilitation and rehabilitation counseling

Rehabilitation Counseling is focused on helping people who have ***disabilities*** achieve their personal, career, and independent living goals through a ***counseling*** process. Rehabilitation counselors can be found in private practices, in ***rehabilitation*** facilities, universities, schools, government agencies, insurance companies and other organizations where people are being treated for congenital or acquired disabilities with the goal of going to or returning to work.

In United States, initially, rehabilitation professionals were recruited from a variety of human service disciplines, including public health nursing, social work, and school counseling. Although educational programs began to appear in the 1940s, it was not until the availability of federal funding for rehabilitation counseling programs in 1954 that the profession began to grow and establish its own identity.

Historically, rehabilitation counselors primarily served working-age adults with disabilities. Today, the need for rehabilitation counseling services extends to persons of all age groups who have disabilities. Rehabilitation counselors also may provide general and specialized counseling to people with disabilities in public human service programs and private practice settings.

The rehabilitation counseling profession has a rich history, with philosophical and legislative underpinnings (Jenkins, Patterson & Szymanski, 1998). The profession emerged from society's view of disability and its subsequent impact on individuals. Society had reasons to provide and/ or offer rehabilitative services and resources, aimed at assisting individuals with disabilities in achieving independence, integration, and security. These reasons were philosophical and economical, as it can be said that society not only desired to provide assistance, but needed to do so for reasons of economy. The profession's development can be credited to three philosophical tenets of rehabilitation, defined by Maki & Riggar (1985) as: (1) recognizing the impact of

disability on individuals (2) a declaration of individual rights and (3) strategies to achieve the goals of rehabilitation. With the emergence of the profession, counselors essentially came into the business of delivering one or more types of rehabilitation services. Rehabilitation counselors are uniquely skilled to provide a wide variety of services to individuals with disabilities and are grounded with commendable values and beliefs which mediate the profession. The profession has traditionally provided counseling and consulting services, and although the roles and functions assumed by individual counselors will vary dependent on the area and/ or industry in which the service is delivered. They share common competencies in core knowledge domains, and have responsibilities to practice in an ethical manner of the highest standard. The profession fully developed from legislation passed in the early 1900's, all of which was aimed in some form or fashion to authorize support to individuals with disabilities, in the form of rehabilitation services, to include but not limited to; medical treatment and intervention, financial aid, education, and training benefits. This legislation as a whole served to promote equality and civil rights for people with disabilities. One of the most notable pieces of legislation worth mention is the Rehabilitation Act of 1973 and its subsequent amendments, as its content clearly structured the system in which rehabilitation counselors practice. The act's core mandates were to (a) serve individuals with disabilities (b) promote consumer involvement (c) stress program evaluation (d) provide support for research and (e) advance civil rights of persons with disabilities (Rubin & Roessler, 2001). The Rehabilitation Act Amendments of 1998 are also worth mention as they are central to the theme developed in this discussion, as they proactively sought to affect the quality of the roles and functions of a rehabilitation counselor. The amendments repeat the need for increased consumer control over the rehabilitation process and then call for the provision of rehabilitation services to be provided by qualified vocational rehabilitation counselors.

Education, Training & Certification

Rehabilitation counselors are primarily trained at the graduate level. Entry level positions at this current time primarily require a Masters degree. The Council on Rehabilitation Education (CORE) accredits qualifying institutions, however, not all programs are CORE accredited. Rehabilitation counselors are trained in the following core areas:

- Counseling theory, skills, and techniques;

- Individual, group, and environmental assessment;
- Psychosocial and medical aspects of disability, including human Growth and development;
- Principles of psychiatric rehabilitation;
- Case management and rehabilitation planning;
- Issues and ethics in rehabilitation service delivery;
- Technological adaptation;
- Vocational evaluation and work adjustment;
- Career counseling;
- Job development and placement

1.3 Persons with disabilities

1.3.1 Definition of disability

Before define disability we should have tried to answer the following question in advance.

Does anyone know what "normal" is? Why is it necessary to define disability?

The questions that heads this section is an important question because the answer has a great impact on the self concepts of individuals, on how people treat each other, and on the allocation of public resources for services and benefits. Other questions followed. Is it always positive to be labeled "normal"? Where can we see pictures of "normal" people? Is "abnormal "always a negative label, indicating someone inferior, deviant, or deficient? Is there one fixed correct pattern of human development?

Over and over again, normal is defined solely as the absence of deviance, illness, or disability, so the definition becomes a definition of exclusion. In other words, if deviance, illness, or disabilities are not present, the person is judged to be normal. No definition of exclusion is very helpful. After all, only eliminations are made, usually of those factors considered to be undesirable; there are no further guidelines or clarifications given. Diagnosis of exclusion, including the determination of normalcy, is frequently given due to the ambiguity and lack of specificity of these types of diagnoses. Consequently, there are more clear-cut, standardized, measurable, and objective guidelines for the definition of abnormal than there are for the definition of normal.

Conceptualizing normalcy as the idea, as the standard against which everything is measured, is another invalid assumption. For many, normal means perfect. Assumptions, accurate or not, can remain intact throughout centuries of human history. Those who subscribe this assumption believe that anything, or anyone, that does not meet all the prescribed criteria, guidelines, and standards is judged to be abnormal.

The determination of normalcy would depend upon the combination of three elements:

⇒ The characteristics to be judged
⇒ The environment in which the characteristics appears
⇒ The individual who are making judgment

Defining power is the authority to determine who or what is normal.

In the original sense of the word "normal" carries no value judgment; normal is neither good nor bad. Normal simply means typical, prevalent, customary, routine, commonplace, and to be expected. Abnormal, therefore, can also be bad or good. For example, "it is normal for 500 murders to be committed each year in the City of Oz." accordingly, the determination of normalcy or abnormity is not an evaluation, because these concepts have no inherent value, but is rather a simple determination based on how typical an event, a characteristic, or a behavior is. Normalcy, then, is more of a statistical concept, which includes the ideas of "most commonly occurring and most likely to happen."

American psychological Association (1994, pp. 59-60) guidelines suggest the following rules with regard reference to disabilities:

- Put people first, not their disability, preferred expressions avoid the implication that the person as a whole is disabled.
- Do not label people by their disability or overextend its severity because the person is not the disability, the two concepts should be separate.
- Use emotionally neutral expressions.

Terms such as victim, afflicted, suffering, and confined are examples of problematic expressions which have excessive, negative overtones and suggest continued helplessness. It is important to

reiterate that the term of professional reference, be it client or consumer, as well as the language used to describe a person involved in our service is a critical consideration. The language chosen communicates a philosophical and attitudinal orientation as both a personal and professional level. Remember, it is preferable to put the person before the disability. Person first language is the generally accepted rule therefore, "person with _____," "person living with _____," and person who has_____," are neutral and preferred language. Referring the client as retarded is inappropriate in contemporary rehabilitation practice.

1.3.2 Models of disabilities

A model is a framework for understanding information. It is commonly accepted that there are two contrasting "models" or "views" of disability currently present within modern day society. These are described as the Social and Medical Models of Disability and form part of the way we all conduct our actions, views and feelings towards people with disabilities. Most of us are in fact more familiar with the Medical Model as this has been operating longer in society and is the one we invariably grew up with. The movement in society over the last sixty years from segregation to inclusion has been through and in many cases is still working itself through, these two models.

I. The Medical Model of Disability

This model thinks that the person is the problem. Through the medical model, disability is understood as an ***individual*** problem. If somebody has an impairment– a visual, mobility or hearing impairment, for example– their inability to see, walk or hear is understood as their disability.

Here the person with disability is seen as being ill or having a condition (referred to as the disability) and is in need of some form of treatment. In this model, or view, of disability the illness or condition is said to be seen first and the person second.

The emphasis here is on a culture of dependency backed up by views of disability brought about in part by a history of segregation in our society. The method of bringing about change for the person with disability is seen to lie within the medical and associated professions. Increasing numbers of people now regard the Medical Model as one that creates a negative approach and tends to offer a somewhat limiting and outdated view of disability. However the mainstream of

our society still tends to take this view. Much of present day law, as it affects people with disabilities, is still based on the Medical Model.

The medical model is also sometimes known as the '***personal tragedy model'*** because it regards the difficulties that people with impairments experience as being caused by the way in which their bodies are shaped and experienced.

It was clear to PWDs that, in the absence of any cure for their physical condition, the impairment must be regarded as *given*: a constant factor in the relationship between themselves and the society with which they attempt to interact.

It follows from this that any failure in the interaction must be overcome through a restructuring of the social and physical environment. What were required were definitions which took account of the many individuals with their particular impairments and dealt with the effect on such individuals of their social and physical environment.

When people such as policy-makers and managers think about disability in this individual way they tend to concentrate their efforts on 'compensating' people with impairments for what is 'wrong' with their bodies. Examples of this are the targeting of 'special' welfare benefits at them and providing segregated 'special' services for them.

The medical model of disability also affects the way PWDs think about themselves. Many PWDs internalize the negative message that all problems of PWDs stem from not having 'normal' bodies. PWDs can also be led to believe that their impairments automatically prevent them from taking part in social activities. This internalized oppression can make PWDs less likely to challenge their exclusion from mainstream society.

II. The Social Model of Disability

- This model thinks that society is the problem
- Using the Social Model all PWDs have a right to be a part of society.
- Society needs to be changed, not PWDs.

This model concentrates on the person as a valued member of a very diverse society. It suggests that the person with disability is a unique individual who has the right to the same opportunities in housing, education, transport and facilities as anyone else. It recognizes that a person's impairment does not make them less of a human being. In this model the "disability" is seen as the common oppression brought about by the non-disabled world. This suggests that a person can acquire disability by society. It is fair to say that much of the oppression is not deliberate but

comes about because the non-disabled world has been taught consistently over a period of time that PWDs are different and somehow not normal. Any segregated provision, such as in the work place, in education or leisure, while very likely being offered at the highest level could prolong the movement to the often expressed goal of a more inclusive society. It could also maintain and even add to the negative reactions some of us have towards PWDs.

The solution according to this model is to bring about attitudinal, environmental and organizational changes within present day society. The move towards inclusive education, although in its early stages, is an example of this new thinking. As well as this it is felt that PWDs need to be encouraged to play an equal part in decision making processes, particularly when the decisions affect them personally.

The social model was created by PWDs themselves. It was primarily a result of society's response to them but also of their experience of the health and welfare system which made them feel socially isolated and oppressed. The denial of opportunities, the restriction of choice and self-determination and the lack of control over the support systems in their lives led them to question the assumptions underlying the traditional dominance of the medical model.

Through the social model, disability is understood as an unequal relationship within a society in which the needs of people with impairments are often given little or no consideration. People with impairments acquired disability by the fact that they are excluded from participation within the mainstream of society as a result of physical, organizational and attitudinal barriers.

These barriers prevent them from gaining equal access to information, education, employment, public transport, housing and social/recreational opportunities. However, recent developments promote inclusion. Anti-discrimination legislation, equal-opportunity policies and programs of positive action have arisen because it is now more widely recognized that PWDs are unnecessarily and unjustly restricted in or prevented from taking part in a whole range of social activities which people without disability access and take for granted.

III. Environmental model of disability

The environmental model posits that the individual's environment- both social and physical can cause, define or exaggerate disability. It is easy to see the relationship between disability and the physical environment. "Disability is viewed as …a product of a disabling, unresponsive or insensitive environment" (Hursh, 1995, p. 322). Essentially, environment can limit physical access and opportunities for work, education, and social participation.

Today, there are many environmental changes that have transformed the definition of disability. For example, introduction of psychotropic medications, supporting employment and supported living have affected the definition of disability. Prejudice, discrimination and stigma are not an inherent part of a disability, but rather are part of the environment. These attitudes needlessly handicap PWDs. Society has created many barriers, both physical attitudinal, for PWDs.

IV. Functional model of disability

The functional model of disability theorizes that the function of the individual influence the definition of disability. The relationship between functioning and disability is very specific to the individual. The example most often used to illustrate the functional model of disability is that of professional pianist who has one finger amputation would be a life changing disability. Two peoples can have the same type and degree of disability, but because of their functions and environments, have very different disability experiences. Most functional models, at present include only work activities and activities of daily living, which assist PWDs in getting to jobs. The functional model of disability, of course, is closely related to the availability of adaptive technology and the capability of such technology to assist in role functioning.

1.4 Paradigms of rehabilitation practice

The ***individual*** is considered to be the primary focus of the ***medical model*** of the ***rehabilitation process***. Each individual has a ***unique personality*** and ***life*** before disability; this has a significant impact on the process of rehabilitation. In addition, the human service and health care environments, as well as society as a whole affect the person and the rehabilitation process. A conceptual model proposed by Hershenson (1990), provide a rational for distinguishing rehabilitation counseling from such other helping disciplines as medicine or psychotherapy. This system of categories involves primary, secondary, and tertiary prevention.

A- ***Primary prevention*** is characterized by activities directed toward preventing the onset of disease or disability. This has been traditionally the mission of such fields as public health and occupational health and safety.

B- ***Secondary prevention*** is characterized by activities directed toward preventing or, when that is not possible, limiting the effect of the disease or disability in case in which primary prevention has failed. This has been traditionally the mission of medicine, psychotherapy, and similar curative fields.

C- ***Tertiary prevention*** is characterized by activities directed toward preventing long- term residual conditions from having any greater disabling effects, once the secondary prevention field has done all they can do to cure or limit the disease or disabling process. This has traditionally been the mission of rehabilitation counseling and allied rehabilitation fields.

Hershenson (1990) described how the relative attention given to the individual and to the environment differs at each level, for example, primary prevention is heavily weighted toward the environment (e.g. drinking water supply, worksite safety, automobile seat belts).

Secondary prevention is heavily weighted toward the individual (e.g. curing or limiting the pathology that exists within the individual) and examines the environment only insofar as it facilitates or impedes the curative process within the individual.

Tertiary prevention differs from both of the other categories of prevention in that it requires equally balanced focus on both the environment and the individual. This dual focus is necessary because disability may stem as much from environmental barriers as from internal limitations. Thus, at each level the discipline of public health, medicine, and rehabilitation counseling differ from each other in their basic science, focus, strategy, for intervention, and goals.

For ***intentional***, ***systematic*** practice to occur, it is critical that rehabilitation counselors have a ***conceptual model*** or ***paradigm*** to guide their work. It has been argued that rehabilitation counselors have at least three orientations to conceptualize their teaching, research, and practice. According to (Cottone & Emener, 1990) these paradigms include:

- The Psychomedical model
- The system model
- The ecological model

Each of these orientations has merit and distinguishes themselves by the relative emphasis they place on the person, the environment, and the relationship between them.

1.4.1 The Psycho-medical model

The psycho-medical model looks within the ***individual for a diagnosis of the problem***, placing the ***patient*** in a "one-down position" relative to the expert, typically a medical doctor or psychiatrist. From this perspective, the person with disability is ***examined and treated relative to the extent*** and prognosis of his or her pathophysiology, impairment, and potentially his or her functional limitations. The Psycho-medical model represents a **biomedical** orientation toward the scientific representation of the **person's condition** and uses diagnostic categories to administratively classify and subsequently treat the underlying cause of a person's disability. This approach is valuable to understanding the medical and allied health profession's contributions to the rehabilitation team. It underlies the restorative services offered in rehabilitation and it is related to the secondary prevention model.

1.4.2 The system model

Cottone and Cottone (1986) provided yet another perspective to conceptualizing rehabilitation counseling practice, that is, the system approach. This perspective suggests that it is neither the person nor the environment that it is the unit of analysis but ***the relationship between the two***, specifically defined within ***interpersonal interaction*** style. This perspective suggest that to focus on either the individual (psycho-medical) or the individual- environment transaction (ecological) is incomplete as the ***inherent nature of person is systemic and the impact of disability affects all persons with relation to the person and in the varied environments involved***. This perspective argues for the ***inclusion of family counseling*** in the curriculum and competency of rehabilitation counselor.

1.4.3 The ecological model

An ecological model reflects the tertiary prevention model and has been proposed by Cotton E and Emener (1990) as an alternative to the psycho-medical and systems perspectives. Historically, this perspective of rehabilitation has emerged from a ***trait-factor*** tradition, which measures traits within the individual and parallel factors within environmental contexts and further seeks to describe the extent of congruence between them. The Minnesota theory of work adjustment (Lofqueist & Dawis, 1969) has provided an empirically valid version of trait- factor model for vocational rehabilitation practice, specifically for persons with disabilities. This model

gives equal consideration to the **person** and the **environment**. The tradition of the personnel management model in business and industry is reflected in this approach as it seeks selectively to match a person to a job for which he or she is qualified and would find satisfaction. Maki, McCracken, Pape, and Scofied (1979) suggested that an ecological perspective with a developmental orientation transformed a trait factor approach in to a viable theoretical framework for vocational rehabilitation. Kosciulek (1993) supported the continuing validity of this approach to a contemporary practice. Basically, this ecological model of individual difference provides a conceptual infrastructure for the profession of rehabilitation counseling and its model of practice.

Trait refers to the ***underlying characteristics*** that exist in people. They account for the observed behavioral consistencies within people and for the stable and enduring difference among people in response to the similar stimuli. All people are assumed to possess the same traits, but in different amounts. In the process of measuring and evaluating the trait configuration of an individual, one must infer their presence from samples of behavior; as trait cannot be measured directly or in their pure form. **The particular traits the rehabilitation counselor decides to evaluate depend on the purpose of the assessment**. The professional must **identify those traits most relevant to the client's objectives**. The assessment techniques that have been demonstrated to provide the most valid and reliable evaluation of the individual's physical, as well as cognitive capacities in terms of his or her aptitudes and achievements are then selected for use.

These individual traits are paralleled by factors describing the essential and marginal functioning of an environmental context.

1.5 The role and function of rehabilitation counselor

Regardless of the area in which a counselor practices, their core competencies remain the same, and although their roles and functions may differ, depending on the type of service delivered, they will likely share many more common characteristics, than differing ones. The roles and functions have been described as multifaceted, requiring a variety of professional competencies, to include **counseling**, **consulting** and **coordinating**, all accompanied by **effective communication** skills (Rubin & Roessler, 2001). It should be stressed that rehabilitation

counselors work with the **person as a whole** and should be disciplined in a wide variety of areas, with the **skills** of a **therapist**, **guidance counselor**, **vocational evaluator**, **case manager**, and **social** and **family** relater (Whitehouse, 1975). They should be able to assume the role of a **mediator**, in managing the case of an individual within a dynamic environment that often influences the direction of the activities that would take place to maximize the quality of life for a person with disability (Chubon, 1992). These viewpoints lend themselves to the concept that the profession should produce and require the practitioners to demonstrate, (a) counseling skills, directly related to client interaction, (b) coordinating skills, to effectively manage all variables related to an individual's case, and (c) consulting skills, utilized to offer guidance and promote the development of an environment suited to achieving the goals of rehabilitation (Hershenson, 1998). Rehabilitation counselors will be confronted with roles subjected to a wide variety of factors central to their clients, and need to be able to identify the most appropriate function at any given point in time. It is understandable that counselors practicing in the public sector may assume different roles than those practicing in the private sector, or workers' compensation industry. It is most certain that the characteristics of clients served will differ between sectors. Furthermore, the counselor will encounter different laws, regulations, and procedures applied to their practice. These differences may manifest themselves in differing responsibilities, rehabilitation timetables, and/or constraints which may be placed on the rehabilitation process. Nonetheless, it is to be expected that the counselor will utilize the same base of knowledge and employ the same fundamental techniques to achieve a desired outcome for their clients, or in performing the responsibilities assumed in their position. The acquisition of knowledge in areas central to the roles and functions of the rehabilitation counseling profession may include but are categorically not limited to: (a) case management (b) services coordination (c) vocational counseling (d) consultative services (e) the medical and psychological aspects of disability (f) assessment and (g) environmental and attitudinal barriers. Core competencies common in most all work settings include but are not limited to performing assessment, intake, eligibility determination, plan development, job analysis, job development and placement, and follow up once the agreed upon plan is implemented (Koch & Rumrill, 1997). Other notable competencies include an understanding and familiarization with ethics, ethical practice, counseling, career development theories, organizational theory, business practice, rehabilitation delivery systems, and an awareness of governing laws and regulations central to practice.

The Scope of Practice Statement identifies knowledge and skills required for the provision of effective rehabilitation counseling services to persons with physical, mental, developmental, cognitive, and emotional disabilities as embodied in the standards of the profession's credentialing organizations.

Several rehabilitation disciplines and related processes (e.g., vocational evaluation, job development and job placement, work adjustment, case management) are tied to the central field of rehabilitation counseling. The field of rehabilitation counseling is a specialty within the rehabilitation profession with counseling at its core, and is differentiated from other related counseling fields.

The professional scope of rehabilitation counseling practice is also differentiated from an individual scope of practice, which may overlap, but is more specialized than the professional scope. An individual scope of practice is based on one's own knowledge of the abilities and skills that have been gained through a program of education and professional experience.

Underlying Values

- Facilitation of independence, integration, and inclusion of people with disabilities in employment and the community.
- Belief in the dignity and worth of all people.
- Commitment to a sense of equal justice based on a model of accommodation to provide and equalize the opportunities to participate in all rights and privileges available to all people; and a commitment to supporting persons with disabilities in advocacy activities to achieve this status and empower themselves.
- Emphasis on the holistic nature of human function which is procedurally facilitated by the utilization of such techniques as:
    - ✓ Interdisciplinary teamwork.
    - ✓ Counseling to assist in maintaining a holistic perspective.
    - ✓ A commitment to considering individuals within the context of their family systems and communities.
- Recognition of the importance of focusing on the assets of the person.

- Commitment to models of service delivery that emphasize integrated, comprehensive services which are mutually planned by the consumer and the rehabilitation counselor

Scope of Practice Statement

The specific techniques and modalities utilized within this rehabilitation counseling process may include, but are not limited to:

- assessment and appraisal;
- diagnosis and treatment planning;
- career (vocational) counseling;
- individual and group counseling treatment interventions focused on facilitating adjustments to the medical and psychosocial impact of disability;
- case management, referral, and service coordination;
- program evaluation and research;
- interventions to remove environmental, employment, and attitudinal barriers;
- consultation services among multiple parties and regulatory systems;
- job analysis, job development, and placement services, including assistance with employment and job accommodations; and
- the provision of consultation about and access to rehabilitation technology.

1.6 The rehabilitation concept and process

1.6.1 The rehabilitation concept

Ones the rehabilitation counselor has a clear respect for and understanding of the philosophy of rehabilitation, the concept of disability, his or her own role and scope of practice, as well as a systematic paradigm to guide that practice, it is possible to revisit the rehabilitation concept. Maki (1986) operationalized the rehabilitation philosophy by defining the rehabilitation concept in terms of comprehensive, individualized process, prescriptive in nature, and directed toward the development or restoration of functional independence and a quality of life. Vocational rehabilitation traditionally defines functional independence in terms of economic self-sufficiency; where as independent living rehabilitation defines this in terms of community integrity and autonomous living. Both vocational and independent living rehabilitation programs increasingly include quality of life indices in their definitions of successful outcome.

The following represent the key elements in understanding the concept of rehabilitation.

1- It is comprehensive in scope and holistic in nature
2- It is an individualized process
3- It is prescriptive in nature
4- It function to develop or restore
5- Its goal is functional independence and a quality of life

1- It is comprehensive in scope and holistic in nature

The rehabilitation process is an orderly sequenced of activities related to the total needs of the individual. Though comprehensive services will differ from client to client, there are certain basic dimensions relevant to understanding the total person. The most significant dimensions include the ***medical, psychological, personal-social, cultural, educational, vocational, as well as spiritual*** considerations. To understand the client or provide services relating to only one aspect of the person's life functioning, without considering the other aspects and their interdependency, would be ineffective and may result in the ultimate failure of the rehabilitation effort. Effective rehabilitation thus usually demands the coordinated effort of a multidisciplinary or interdisciplinary team.

2- It is an individualized process

Each person is **unique** in terms of **skills**, **residual capacity**, **functional limitations**, **recourses**, and **personality**. The manifestations of disability present themselves differently to each individual, with varying meanings and implications depending on the **environmental context**. ***Rehabilitation*** is thus a process based on the **needs** and **asset** of a particular client. Rehabilitation counselor must continually be aware of the drawback of labeling and stereotyping. Various authors (Feist-Price, 1995; Nathanson, 1979) have noted that the counseling professionals are not immune to bias or prejudice regarding disability and must be aware of their own attitudes and expectations. Successful rehabilitation is based on **individualized written rehabilitation plan (IWRP) developed with clients based on valid meaningful data.**

3- It is prescriptive in nature

That is to say, a prescriptive course of action is developed with each individual. The type and amount of service provided are based on the **needs** and **characteristics** of the individual.

Services are selected that will remove, reduce, or compensate for the functional and social limitations of the individual in achieving the goals established in the individualized plan. Environmental accommodations and modifications must be considered, as well as client development and change through restoration or education program.

4- It function to develop or restore

Habilitation is the term that denotes the development or acquisition of skill and functions previously not attained. This term is used commonly in reference to serving persons with developmental disabilities who, due to lack of training or experience, are initially developing their functional independence. Habilitation refers to an initial learning of skills and roles that allows an individual to function in society. Rehabilitation refers to the restoration or reacquisition of skills and function lost through injury, disease, or trauma. The term rehabilitation is used here as well as throughout the text to generically describe either process resulting in functional independence.

5- *Its goal is functional independence and a quality of life*

Functional independence is the capacity to take care of one's own affairs to the extent that one is capable. This is a broad goal; subsumed under the goal are economic self- sufficiency as well as personal, social, and community living skills (Morris, 1973). It also reflects the individualized orientation in defining success and functioning. Functional independence considers the total individual in his or her environments.

A quality of life is perspective on rehabilitation counseling integrates counseling program goals such as clients independence or employment into a higher-order, multidimensional rehabilitation outcome. Counselors committed to a quality of life orientation work from a wellness and holistic position that addresses both development of the individual and the environment in which the individual lives. QOL is directly applicable to the long-standing criterion problem in rehabilitation.

Rehabilitation professional continue to disagree as to whether the primary goal of rehabilitation is promoting client independence or vocational placement. Quality of life offers a higher-order that subsumes both independence and employment as legitimate outcomes (Roessler, 1990).

1.6.2 The rehabilitation process

Historically persons with disabilities have received services through a delivery system that contains the following ordered components:

1-Intake 2-Assessment 3- Services 4-Outcome

This is a generic model that accommodates the interdisciplinary nature of rehabilitation. The client's entry into the service delivery system begins with ***intake*** procedures. Here administrative decisions are made regarding the client's eligibility for services based on predetermined criteria. Once eligibility is determined, the client proceeds to the assessment components. As clients' concerns become more complex and the range of services broadens, the need for comprehensive assessment become increasingly important.

Without accurate and effective assessment there can be, at best, only marginal adaptation. From this base, the client and the rehabilitation counselor work together in plan development using the skills of the problem solving and resource analysis. Prescribed in the plan are those services necessary to assist the client in attaining the specific outcomes.

Services are selected that will allow the client to acquire skills and behaviors appropriate for the designed outcome. Services are generally either in the areas of education, or counseling. Education is usually prescribed for clients who lack the skills or knowledge necessary to reach their long- or short-term goal(s) and the objectives outlined in their individualized rehabilitation plan. Education may be formal or informal and generally lies outside the scope of practice of rehabilitation counselor. Restoration services are usually prescribed when there is a need for enhancing the physical functioning of an individual; prosthetics, or speech therapy is examples of these services. As with education, these services are often coordinated or managed by the rehabilitation counselor as they generally lie outside this individual's scope of practice.

Counseling as a therapeutic or psycho-educational service is often provided by the rehabilitation counselor within the relationship and parameter of the agency, organization, or facility in which a particular counselor functions. It is in the performance of this function that the rehabilitation counselor selects an individual, group, or family counseling theory to guide this aspect of their practice. A final service that the rehabilitation counselor provides is ***consultation*** and ***advocacy*** to those persons and environments relevant to the client's plan. The final component of the service delivery system presented herein is outcome. During this stage ***placement*** and ***follow-up***

occur. These activities may be performed by the rehabilitation counselor or they may be referred to a professional who specializes in these functions. Even though the traditional outcome of vocational rehabilitation success is reflected in a case-closed status 26 (closed rehabilitation), other outcomes related to **independent living** and **quality of life** are valued in ***contemporary rehabilitation process***.

Throughout the rehabilitation process the rehabilitation counselor performs differing functions depending on the needs of the client and the resource available within the services delivery system and the community. Hershenson (1990) proposed the "**C-C-C**" model of rehabilitation counseling, which prescribes the following functions.

- ✓ Coordinating
- ✓ Counseling
- ✓ Consultation

1-Coordinating: Coordinating is a function through which the counselor coordinates the "***restoration*** or ***replacement*** of ***assets*** and ***skills***… for example, coordinating the program that provide needed physical, social, and vocational rehabilitation services."

2-Counseling: Counseling is a function through which the counselor uses "the process of ***reintegrating*** the ***self-image*** and of the ***reformulating goals***."

3-Consultation: Consultation is a function through which the counselor engages in "the process of environmental restructuring and requires consultation with the client's family, employer, and community" (p.275).

Counselors are ***direct- service*** providers, and the manner in which they **manage** their **time** and **activities** contributes significantly to the efficiency and effectiveness of the rehabilitation process. Therefore, the counselor needs to develop **caseload management** practices that result in **effective allocation of time** and **services**.

The caseload management model of rehabilitation counseling presented by Greenwood (1992), requires the counselor to emphasize five functions:

- Intake interviewing

- Counseling and rehabilitation planning
- Arranging, coordinating, and/or purchasing rehabilitation services
- Placement and follow-up
- Monitoring and problem solving

The counselor and client must mutually establish the goal to be accomplished within the parameters of the practice setting which may occur in a public agency, a nonprofit program, or a private for profit organization. The practice setting will affect the range of functions and tasks that are to be performed.

No matter what other functions and responsibilities are engaged in by the rehabilitation counselor, counseling is the central function that is provided continuously throughout the rehabilitation process. It should be repeated that counseling is inherent of rehabilitation. G.N.Wright (1980) stated that, "this is a nontransferable obligation of the rehabilitation counselor. Consultant and rehabilitation services of other kinds may or should be purchased, but the ultimate professional responsibility for the function of counseling cannot be delegated. Professional counseling is indispensable to the proper selection, provision, and utilization of the other rehabilitation services" (p.55)

1.6.3 Rehabilitation outcome

NCMRR (1993) defines successful outcome of the process of rehabilitation in terms of restoring the individual to maximal functioning and provides the foundation for a fulfilling, productive life following rehabilitation. The areas that are considered include survival and productivity, as well as social and work relationships. Survival issues include maintenance of health, prevention of unnecessary medical complications, capacity for mobility, and control of the activities of daily living (ADL).

The outcomes of the rehabilitation process are strategies, products, and treatments that enhance the probability that people with disabilities will participate more fully in society. Activities that enhance productivity and give a sense of purpose and enjoyment to life must be possible; these may include employment, education, recreation, family, and community involvement. This participation should provide meaning and dignity to life so that persons with disabilities have a ***reason to live, not merely to exist***.

The focus of rehabilitation counseling effort is the improvement of function of people with disabilities so that they can live satisfactory lives in their community. Function within this context encompasses not only physical performance, but emotional, and cognitive functioning as well. The ability to develop and maintain social relationships with family, friends, and co-workers is a fundamental skill. The ability to manage finances, personal and work life, and supervise personal-car attendants is critical to successful community life.

Concern for the developmental cycle of an individual with disability is an essential feature of rehabilitation counseling as intervention strategies, life activities, and quality of life outcomes will vary according to age. Rehabilitation counseling should incorporate knowledge of the person's developmental life stage when assessing interventions or outcomes in persons with disabilities. The model provides for the growing awareness that the initial impairment may be complicated by subsequent impairments across the life span. Problems unique to growing up and aging with disabilities are seen as relevant to the rehabilitation process. The resulting variations in, or losses of function across time are important considerations in building a conceptual model of rehabilitation.

1.7 Professional ethics in rehabilitation counseling

Increased quality of life for clients with disabilities depends on professional rehabilitation counselors heeding the caution embodied in the word of the historical figure, Samuel Johnson: "integrity without knowledge is weak and useless; knowledge without integrity is dangerous and dreadful." The development of a strong professional ability rests on clear professional standard of practice. Rehabilitation counseling's unique legislative genesis as a profession over 80 years ago constitutes a covenants with both the society and its citizens with disabilities to exercise knowledge with integrity. The sociopolitical history of rehabilitation and research findings in the rehabilitation literature has demonstrated that that the rehabilitation counselor's clients often must deal with social, political and legal oppressions. Therefore, they particularly need solution-focused, respectful, non exploitative, empowering, and ethical relationship with their counselors.

Recognized ethical issues occur on a daily basis in rehabilitation and… have a powerful effect on counselor and client alike.

Clearly, persons with disabilities require the services of professionals who are grounded firmly in the awareness of their value-laden mission and who are willing and able to assist persons with disabilities through appropriate knowledge and competencies (Gatens-robinson& Rubin, 1995). The unusually strong tradition of explicit philosophical foundation is critical to the profession of rehabilitation counseling, and has led to an early recognition of the value based nature of rehabilitation counseling (B.A Wright, 1986). This treasured legacy provides a strong basis for understanding the ethical principles at the heart of the ethical decision making skills needed within the practice of rehabilitation counseling.

The nature and complexity of practice for all of the professions have changed and grown over the last several decades. The phrase professional standards no longer simply mean specifically the ethical standards of the profession. This term is a general term meaning professional criteria indicating acceptable professional performance (Powell & Wekell, 1996). There are three types of standards relevant to describing professional practice:

- ✓ the internal standards
- ✓ clinical standards
- ✓ external, regulatory standards

Taken together these professional standards increase the status of the profession, and its ability for self-governance; they also enhance the external representation and accountability for the profession's competence with the clients, the general public, employers, external regulators, and payers (Rinas & Clyne-Jacson, 1988). These type of standards, their major characteristics, and principal components are depicted below.

A-Internal standards

First, the internal standards of the profession form the underpinnings of the appropriate role and function of the profession. Internal standards are characterized by being focused on advancing the professionalism of the group in question, having the intent of setting profession-wide standard of practice, and assisting individual practitioner through defining their professional identity and obligations. Prominent examples are the professions code of ethics and any guidelines for specialty relevant to the discipline.

B-Clinical standards

These standards are close in locus to the internal standards described in that both are directly relevant to services delivered to the individual client or patient. Additional characteristics include focusing on a single disciplinary standard of clinical care, these ethical standards may be specific to a particular setting or client population, they evaluate the competence of individual professionals based on specific care rendered, and have a client or patient-care outcome measurement focus. Peer-review processes and standards as well as clinical care pathways are examples of this type of standard.

C-External regulatory bodies

The last component of the professional standards involves the standards of external regulatory bodies of diverse sorts. They are focused on regulatory or institutional level concerns. They usually involve legal or risk-management questions; and deal with funding or institutional fiduciary perspectives.

Ethics are the moral principles that are adopted by a group to provide rules for right conduct (Corey, et al., 1993). The code of ethics for professional organization is a specific document formally adopted by the organization that is an attempt to capture the profession's current consensus regarding what type of professional conduct are appropriate or inappropriate; they are normative statement rather than absolute dictates of situational guidance.

Chapter Two

Practice of Rehabilitation Counseling

2.1 Application of theories to rehabilitation counseling

Why is theory necessary and useful to rehabilitation counseling?

Theory is useful because it allows the practitioner to choose "reasonable "and constituent intervention strategies.

Dear students since the emergence of psychology as a field of study, there has been a number of issues treated with in it. As time goes psychology has shown huge progress in its branches and body of study. Now here after, we will see in detail on one aspect of psychology, i.e. theories of psychotherapy. Before, the 1950s there were relatively few theories of psychotherapy, and most were derived from Freud's theory of psychoanalysis. Since that time there has been a marked increase in the number of theories that therapists have developed to help people with

psychological dysfunctions. Corsini (2001) summarized 69 new and innovative therapies; now there may be a total of more than 400 (Corsini, 2008). Although most of these theories have relatively few proponents and little research to support their effectiveness, they do represent the creativity of psychotherapists in finding ways to provide relief for individual psychological discomfort. At the same time that there has been an increase in the development of theoretical approaches, there has been a move toward integrating theories, as well as a move toward eclecticism. Broadly, *integration* refers to the use of techniques and/or concepts from two or more theories.

Psychoanalytic theories (those closely related to the work of Freud and his Contemporaries) and psychodynamic theories (those having some resemblance to psychoanalytic theories) are a popular theoretical orientation that is subscribed to by therapists from a variety of fields. Cognitive, and to a lesser extent, behavioral methods are popular with a variety of mental health workers. There is some disagreement among studies of therapist preference for theory, due in part to ways in which questions are asked and to changing trends in theoretical preference. Including a number of significant theories provides a background from which students can develop or select their own theoretical approach. Some theories, such as psychoanalysis, have sub-theories that have been derived from the original theory. The following paragraphs present a brief, nontechnical summary of the chapters (and theories) in this book to give an overview of the many different and creative methods for helping individuals who are suffering because of psychological problems or difficulties.

1. Psychoanalysis

Sigmund Freud stressed the importance of inborn drives (particularly sexual) in determining later personality development. Others who followed him emphasized the importance of the adaptation to the environment, early relationships between child and mother, and developmental changes in being absorbed with oneself at the expense of meaningful relationships with others. All of these views of development make use of Freud's concepts of unconscious processes (portions of mental functioning that we are not aware of) and, in general, his structure of personality (ego, id, superego). Traditional psychoanalytic methods require several years of treatment. Because of

this, moderate-length and brief therapy methods that use more direct, rather than indirect, techniques have been developed. New writings continue to explore the importance of childhood development on later personality as well as new uses of the therapist's relationship.

2. Jungian Analysis and Therapy

More than any other theorist, Jung placed great emphasis on the role of unconscious processes in human behavior. Jungians are particularly interested in dreams, fantasies, and other material that reflects unconscious processes. They are also interested in symbols of universal patterns that are reflected in the unconscious processes so that patients can better integrate unconscious processes into conscious awareness.

3. Adlerian Therapy

Alfred Adler believed that the personality of individuals was formed in their early years as a result of relationships within the family. He emphasized the importance of individuals' contributions to their community and to society. Adlerians are interested in the ways that individuals approach living and family relationships. The Adlerian approach to therapy is practical, helping individuals to change dysfunctional beliefs and encouraging them to take new steps to change their lives. An emphasis on teaching and educating individuals about dealing with interpersonal problems is another characteristic of Adlerian therapy.

4. Existential Therapy

A philosophical approach to people and problems relating to being human or existing, existential psychotherapy deals with life themes rather than techniques. Such themes include living and dying, freedom, responsibility to self and others, finding meaning in life, and dealing with a sense of meaninglessness. Becoming aware of oneself and developing the ability to look beyond immediate problems and daily events to deal with existential themes are goals of therapy, along

with developing honest and intimate relationships with others. Although some techniques have been developed, the emphasis is on issues and themes, not method.

5. Person-Centered Therapy

In his therapeutic work, Carl Rogers emphasized understanding and caring for the client, as opposed to diagnosis, advice, or persuasion. Characteristic of Rogers's approach to therapy are therapeutic genuineness, through verbal and nonverbal behavior, and unconditionally accepting clients for who they are. Person-centered therapists are concerned about understanding the client's experience and communicating their understanding to the client so that an atmosphere of trust can be developed that fosters change on the part of the client. Clients are given responsibility for making positive changes in their lives.

6. Gestalt Therapy

Developed by Fritz Perls, gestalt therapy helps the individual to become more aware of self and others. Emphasis is on both bodily and psychological awareness. Therapeutic approaches deal with being responsible for oneself and attuned to one's language, nonverbal behaviors, emotional feelings, and conflicts within oneself and with others. Therapeutic techniques include the development of creative experiments and exercises to facilitate self-awareness.

7. Behavior Therapy

Based on scientific principles of behavior, such as classical and operant conditioning, as well as observational learning, behavior therapy applies principles of learning such as reinforcement, extinction, shaping of behavior, and modeling to help a wide variety of clients with different problems. Emphasis is on precision and detail in evaluating psychological concerns and then assigning treatment methods that may include relaxation, exposure to a feared object, copying a behavior or role playing. Its many techniques include those that change observable behavior as well as those that deal with thought processes.

7. Rational Emotive Behavior Therapy

Developed by Albert Ellis, Rational Emotive Behavior Therapy (REBT) focuses on irrational beliefs that individuals develop that lead to problems related to emotions (for example, fears and anxieties) and to behaviors (such as avoiding social interactions or giving speeches). Although Rational Emotive Behavior Therapy uses a wide variety of techniques, the most common method is to dispute irrational beliefs and to teach clients to challenge their own irrational beliefs so that they can reduce anxiety and develop a full range of ways to interact with others.

8. Cognitive Therapy

Belief systems and thinking are seen as important in determining and affecting behavior and feelings. Aaron Beck developed an approach that helps individuals understand their own maladaptive thinking and how it may affect their feelings and actions. Cognitive therapists use a structured method to help their clients understand their own belief systems. By asking clients to record dysfunctional thoughts and using questionnaires to determine maladaptive thinking, cognitive therapists are then able to make use of a wide variety of techniques to change beliefs that interfere with successful functioning. They also make use of affective and behavioral strategies.

9. Reality Therapy

Reality therapists assume that individuals are responsible for their own lives and for taking control over what they do, feel, and think. Developed by William Glasser, reality therapy uses a specific process to change behavior. A relationship is developed with clients so that they will commit to the therapeutic process. Emphasis is on changing behaviors that will lead to modifications in thinking and feeling. Making plans and sticking to them to bring about change while taking responsibility for oneself are important aspects of reality therapy.

In recent years, marriage counseling and family therapy have become a particular interest of William Glasser. Reality therapists often observe the choice systems of different family members

and how they interact and connect with each other. Attention is paid not just to the shared feelings but also to the wants and values of each family member. After an assessment of wants and needs, suggestions are made to focus on doing things together to promote family harmony. However, reality therapists also recognize the need for family members to develop their life separately from other members of the family. Reality family therapists may ask the child what activities she likes and how much of the activity she is doing. This way, reality family therapists can assess how well the family relationship is meeting the child's needs. Suggestions may be made to do activities that bring about interaction. For example, a father walking to the park with a daughter is a better activity than watching television together. Attention is paid to activities the family does as a group, as small groups, and separately so that these activities will meet needs of family members separately and together.

11. Constructivist Therapy

Constructivist therapists see their clients as theorists and try to understand their clients' views or the important constructs that clients use to understand their problems. Three types of constructivist theories are discussed: solution-focused, personal construct theory, and narrative. Solution-focused therapy centers on finding solutions to problems by looking at what has worked in the past and what is working now, as well as using active techniques to make therapeutic progress. Personal construct theory examines clients' lives as stories and helps to change the story. Narrative therapies also view clients' problems as stories but seek to externalize the problem, unlike personal construct theory. Frequently, they help clients re-author or change stories, thus finding a new ending for the story that leads to a solution to the problem.

12. Family Therapy

Whereas many theories focus on the problems of individuals, family therapists attend to interactions between family members and may view the entire family as a single unit or system. Treatment is designed to bring about change in functioning within the family rather than within a single individual. Several different approaches to family therapy have been developed. Some focus on the impact of the parents' own families, others on how family members relate to each

other in the therapy hour and yet others on changing symptoms. Some family systems therapists request that all the family members be available for therapy, whereas others may deal with parents or certain members only. Almost all of the theories in this book can be applied to families.

13. Integrative Therapy

Integrative therapists combine two or more theories in different ways so that they can understand client problems. They may then use a wide variety of techniques to help clients make changes in their lives. Prochaska and Norcross's transtheoretical approach examines many theories, selecting concepts, techniques, and other factors that effective psychotherapeutic approaches have in common. Their model for therapeutic change examines client readiness for change, level of problems that need changing, and techniques to bring about change. Paul Wachtel's cyclical psychodynamics combines psychoanalysis and behavior therapy, as well as some other theories. Arnold Lazarus's multimodal therapy uses techniques from many theories to bring about client change but uses social learning theory as a way to view personality.

2.2 Rehabilitation considerations and intervention

1-factors associated with the person himself

2-factors associated with the environment

1- factors associated with the disability

These three factors interacts together leads to unique disability experiences

1- The personal framework about meaning of disability has tremendous impact on the disability experience or reaction.
2- Not two individuals has the same reactions to the same disability
3- The rehabilitation counselor should never get with rehabilitation of rigid assumptions

2.2.1 Personal (individual) factors

- Sex, race, age, and, sexual orientation of the individual should be considered & respected
- Sociability, extrovert, introvert, interaction value, ability, and, interest
- Peoples with unifocal and multifocal disabilities

- Body image influence
- Lower self-efficacy beliefs

2.2.2 Environmental factors

- ✓ Outside the individual
- ✓ Family, friends, immediate community

2.2.2.1 Families

- Very positively contribute to rehabilitation counseling and in other extreme family can block the rehabilitation counseling program
- The rehabilitation counselor should appreciate the family and the client
- The requirement and the acceptance of the consumer should be taken in to consideration
- Parents should be aware about the further development of their child

2.2.2.2 Friends

Social support is very important in helping peoples with disabilities such as information, instrumental support, emotional, compassion support…etc. Rehabilitation counselor should put friends in the contact of intervention program.

2.2.2.3 Communities

2.2.2.4 Societies

2.2.3 Nature of disability

Components majorly considered are:

- ✓ Type of disability-physical, mental, communicative, adaptive
- ✓ Functions impaired- major life skill or not
- ✓ Severity of the disability
- ✓ Type of onset-acquired or congenital
- ✓ Time of onset- peri, pre, Post natal
- ✓ Visibility of the disability-adverse
- ✓ Stability of the disability- long term
- ✓ Involvement(pain and disability)-

These differences have implication for rehabilitation counseling.

2.3 Systematic practice: Case and Caseload Management

The practice of rehabilitation counseling rests on the confluence of two professional forces: **counseling** and **management**. Systematic practice by a profession in this arena is the result of this two forces working in **synergy**. No single professional force can be said to predominate, as synergy is only established through concepts and practice surrounding a "balance" principle.

The systematic practice of rehabilitation counseling is anchored in several elements and skills within a management practice paradigm. As noted by Cassel and Mulkey (1985)" *it is evident that even the most counseling-oriented rehabilitation practitioner cannot survive with-out implementation of at least minimal skills in management"* (p.xiv).

The practice of rehabilitation caseload management (CLM) is based on a five point model;

- Boundary definition;
- Skill clusters- define actions, organizing, coordinating, directing, controlling;
- Personal control- divers the system;
- Action decision- set objectives, proactive, outcome focus;
- A systematic approach- politico-mandated

When regularly practiced action consistently emanate from these ***defining areas***, the rehabilitation professional will be an effective caseload manager. This paradigm relies on several premises. Clearly, rehabilitation practitioners must; develop and become cognizant of the ***operational definitions*** that guide their job performance.

A basic definition of ***case management*** provided by the National Case Management Task force is reported by Mullahy (1995):

Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the ***options*** and ***services*** to meet an individual's health needs, using communication and available resources to promote the quality, cost effective outcomes (p.9).

Case management is a highly effective strategy that assists in coordinating the needs of the consumer with the available resource in order to maximize the outcome for the consumer and effectively manage costs. The case manager should facilitate communication between all members of the treatment team, the consumer and support system, and the payer in order to minimize the fragmentation inherent in any delivery system, avoids duplication of services and

waste in the system, and involve the consumer/ support system in all decision made on their behalf. The case manager is an advocate for the consumer as well as payer (in some practice settings) in order to facilitate a win-win solution for the consumer, the treatment team, and the payer. The case manager is the link between the consumer and all other members of the delivery system involved in the care of that individual.

Goals of case management are reported by the Case Management Society of America (1995) in the standards of practice for case management as follows:

- ⇒ Through early assessment, ensure that services are generated in a timely and cost effective manager.
- ⇒ Assist clients to achieve an optimal level of wellness and function by facilitating timely and appropriate health services.
- ⇒ Assist client to appropriate self-direct care, self-advocate and make decisions to the degree possible.
- ⇒ Appropriate expenditure of budget and timely claim determinations.
- ⇒ Enhance employee productivity, satisfaction and retention, when applicable. (p.10)

The case management process, used to facilitate these goals, includes the following elements.

- ❖ *Case identification and selection*- individuals who will benefit from case management
- ❖ *An in depth objective assessment*- areas of assessments may include physical, psychological, functional, financial, spiritual, environmental, vocational, support system, health expectations of the of the consumer, potential capabilities, resources, treatment options, prognosis, goals, and provider options.
- ❖ *Development of the plan of care*- utilizing communication with the treatment team, the consumer and the payer.
- ❖ *Implementation of the plan of care*
- ❖ *Monitoring and evaluation*

Case management is characterized, for example, by supervising a client appointment, arranging the service, and dealing with a customer's compliments/fears. Taking a particular case to

satisfactory conclusion for all concerned is the end result sought by a case management process. Mullahy (1995) note that the process of case management has at least eight stages:

- case finding and targeting,
- gathering and assessing information,
- planning,
- reporting,
- obtain approval,
- coordinating or putting the plan into action,
- follow up, and
- evaluation,

Caseload Management

Caseload management is the systematic process of organizing, planning, coordinating, directing, and controlling for the effective and efficient counselor and manager decision making to enhance a proactive practice.

Three stages of caseload management

⇒ Beginning stage-case finding and eligibility determination
⇒ Mid stage- service provision
⇒ Ending stage-case closure

CLM can be described as follows:
…how to work more than one case at a time, how to select which case to work with, how to move from one to another, how to establish a system to insure the movement of all cases, and how to the objectives one has established, in terms of numbers served. (p. 218).
Effective CLM is achieved through counselor and manager role interactions resulting in decision making activity.

CLM is a gestalt; CM is a process part within CLM. The caseload manager, then, draws from successes in dealing with case management part to achieve levels of outcomes.

Key concepts characterizing caseload management practices for the rehabilitation counselor include but not limited to:

- ✓ the focus on the total caseload, the relationship and issues between and among the various cases,
- ✓ coordinating counselor practices with consumer and support services demands,
- ✓ coordinating counselor practices wit agency/organization policies and procedures,
- ✓ taking multiple cases to logical conclusions in a timely manner, and
- ✓ accountability for outcome measures based on organizational standards and goals

Skill clusters

Skill clusters are patterns of action that revolve around central themes or axes.

A skill is a learned ability for doing something in a competent manner. Often the execution of one skill relies on another prerequisite skill. Thus, skills often occur in clusters, each skill relating to the other. Each cluster gathers together sets of specific actions that the caseload manager relies on for consistency of personal practices and for fulfilling organization standards.

Five major clusters of caseload managers are:

- ***planning***- assist in anticipating future demands and help guard against the exogenous influence that interfere with daily effort to produce desired outcome
- ***Organizing***- have a central focus of establishing the next priority to engage the caseload manager. Organizing is priority setting.
- ***Coordinating-*** involve being competent with public relations in order to interpret organizational philosophies, policies, programs, and practices of managers to the various rehabilitation constituents.
- **directing-** provides the action from which the previous skill cluster operate
- ***controlling-*** operates to weave among the previous skill clusters and pull them together into a system of codependent pattern of choice making, action initiating, results assessing, and insuring consistent repletion of the cycle.

Chapter Three

Counseling Family Members of Peoples with Disabilities

3.1 Models of family functioning

Disability is beyond doubt a disruptive event in the life of the family as a whole and it therefore has repercussions for the lives of each family member (Kew, 1975, p. 156). Families both affect and are affected by their members who have disabilities in various ways.

Models of family functioning

1-The transactional model

2- The ecological model

3-Family system model

1- Transactional model

In this model, development is believed to result from a continual interplay between a changing organism and a changing environment. Thus families are considered to both affect and be affected by their members who have has disability. Also, as people with disabilities pass through different developmental stages they will affect their families in different ways. The effect parent have on their child with disability will depend on the particular stage in the life cycle in which they find themselves.

2- Ecological model

In this model, human development and behavior cannot be understood independently of the context in which it occurs. Environment influence behavior and this occurs at several levels (Bronfenbrenner, 1979). Thus the effects on parents of caring for children with special needs are strongly influenced by the environment in which they are living, including the extended family, services available, and community attitudes.

- ⇒ Family constitute a micro system with the child, parents, and siblings reciprocally influencing each other
- ⇒ Meso-system influences the micro-system, such as the extended family, school, and work settings in which the family actively participates.
- ⇒ Ecosystem influences the meso-system include mass media, education system, and volunteer agencies in which the family is not actively involved but which events occur that affect the family.

⇒ Macro-system which comprises the ideological systems inherent in the social institutions of a particular society such as religious, economic and political beliefs.

Thus, the development and behavior of a family with a person who has a disability is influenced not only by interactions within its own micro-system but also by its interaction with other levels of the entire social system.

3-Family-system theory

In this model, the behavior of family members is considered to be a function of the system of which they are part. A change in the family system will inevitably lead to a change in the behavior of each of the family members. Likewise, the change in an individual's behavior will cause the family system to change. However, the functioning of the family system is considered to comprise more than the summation of the contribution of its individual members. Intervention at the level of family system is therefore likely to have more impact than intervention aimed at one of its members (Berber, 1984).

Family systems conceptual framework

Family systems conceptual framework has been developed by Turnbull and her associates.

The framework is made up of four components:

- **Family interaction component**- the relationships that occurs between and among the various sub-systems of family members. That is :
  - the spousal subsystem- husband-wife interactions
  - the parental sub-system – parent –child interactions
  - the sibling subsystem – child-child interactions
  - extra-familial interactions- those between children and grandparents or a father and his workmates.

- **Family resources components**

These consists of descriptive elements of the family, including

- Characteristics of the disability such as the type and severity;
- Characteristics of the family such as size, cultural background and socio-economic status

- Personal characteristics such as health and coping styles.

- **The family functioning component**

The family functioning component Refers to the different types of needs which the family provides, such as economic, physical care, recuperation, socialization, affection, self-definition, educational and vocational needs.

- **Family lifecycle components**

Family lifecycle component represents the sequence of developmental changes that affect families as they progress through various stages in the lifecycle, such as unattached adulthood, marriage, birth of children, school-entry, adolescent children, children leaving home, and retirement. The four components of the family system are interdependent.

3.2 Models of adaptation process

Several models have been proposed to explain the process which people experience in adapting to a family member with a disability.

3.2.1 The stage model of adaptation

In this model, it is suggested that the process of adaptation can be viewed as a continuum of reactions, beginning at the diagnosis, through which people pass in order to come to terms with the disabling condition.

The various reactions with the order of in which they may be experienced are:

a) **Shock**: this state typically lasts from a few hours to a few days. People report feeling of confusion, numbness, disorganization and helplessness.

b) **Denial**: disbelief of the reality of the situation follows the shock reaction.
As a temporary coping strategy this is quite healthy.

c) **Anger**: people may search for cause of the disability
They may blame themselves or hospital staff and experience anger which may be displaced onto a spouse, a child, or onto professionals involved.

d) **Sadness**: peoples may feel depressed and despairing.
This is a reaction which often reported to pervade the whole process to some extent

e) **Detachment**: many people experience a time when they feel empty of flat.
They accept the reality of the disability but have lost some

of the meaning of life.

f) **Reorganization**: this phase is characterized by realism and hope.

People consider their "cup is half full, rather than half-empty"

g) **Adaptation**: they exhibit mature emotional acceptance of the family member with disability. Fully aware of the person's special need and strive to provide for these.

3.3 The effects on the members of the family

Families

1-social life restriction

- ❖ Leisure activities such as sports and other clubs
- ❖ Family activities such as visiting friends, having picnics and attending family gatherings
- ❖ Use of community facilities such as beaches, restaurants and public transports
- ❖ Limitations in the type of holidays which families can take

The extent of social restriction is greatest when the:

- ⇒ Children is young
- ⇒ Physical disability and behavioral problems are present
- ⇒ Degree of disability is severe

2.Financial burden (additional expenses)

- ⇒ Medical care
- ⇒ Clothing and transport
- ⇒ One parent prevented to go out to work because of the daily care requirements of the child with disability.

Impacts on Parents

1-Marital difficulties

Difficulties in sexual relationships may result from lack of privacy, fatigue, a sense of isolation on the part of each spouse of a fear of producing another child with disability. High marriage breakdown and low marital satisfaction

Impact on Mothers

The bulk of household work and child care in families with members who have disabilities is carried out by mothers.

Mothers of children who have disabilities exhibit higher level of stress which led to such mothers suffering a higher incidence of stress- related physical and mental disorders.

Impact on fathers

- Difficult in accepting the disability or hiding their true feelings about the situation
- Mental and physical health may be less affected than that of mothers
- Fathers are often reluctant to accept involvement in counseling or supporting groups

Impact on Siblings

Females are more responsible than male on caretaking for their brother or sister who has a disability.

Affect their normal growth; missing out on some of the developmental stage necessary for normal growth, and experiencing considerable bitterness and anger.

Worry about finding a spouse who would be willing to share such a responsibility.

Many siblings feel the need to overachieve to compensate for the parental disappointment over the child with disability.

Over "catching" the disability- Young siblings may fear that they too will develop mental disability, go blind, or even die as the child with the disability has done.

Impact on grandparents

A common source of support for the family is the grandparents of the child who has a disability, particularly the maternal grandparents. However, the diagnosis of disabilities often leads to a breakdown in the relationship generations. This may be due to the difficulties of grandparents in adapting to the disability themselves. Therefore, it may be helpful to also make supportive available to grandparents and involve them, along with parents, in conferences about the child

Basic needs of family members

Five basic needs of families of people with disabilities are:

A) Having the diagnosis of disability, or the results of assessments,
   Communicated to them in a sensitive and constructive manner;

B) Obtaining information about the disabling /handicapping condition, the service available and Facilitating the development of the person with disability;
C) Receiving emotional support and help understanding feelings and reactions;
D) Meeting other members of exceptional families who are in a similar position to themselves.

Individual, group and family interventions

Aim of various interventions is facilitating the development and functioning of families with members who have disabilities. Although each tends to focus on different members of the family, it is considered that all interventions can be conceived and carried out in a way that takes the entire family into account.

1- **Counseling -**counseling individually and participating in group.
2- **Training-**guidance in order to help them to cope with their children's behavior problems and facilitate their development. Parent training, can be organized individually, as in the portage program or in groups as behavioral group training.

Group parent program- to combine training with group counseling

-to provide a supportive environment in which parents can learn new skills and gain confidence through talking with other parents.

Individual parent training- should be combined with the availability of Counseling

Advocacy skill training program for parents-parents are taught assertiveness skills in order to access services for people with disabilities

Coping skills –to develop their own personal coping strategies, social support networks, and community supports.

3- **Workshops-**for parents of children with disabilities in order to meet some of their counseling and training needs of siblings, fathers, and grandparents.
4- **Self-help groups-** organizations specifically for fathers, siblings and grandparents of people with disabilities.
5- **Family therapy-** focusing in the family structure or communication patterns, the dynamics of exceptional families can be better understood and therefore interventions

designed in orders to bring about constructive change in the functioning of the family as a whole.

3.4 Professional attitudes, knowledge and skills

Clearly there is certain knowledge, attitude and skills, over and above the expertise associated with each profession, which is needed in order to work effectively with people who have disabilities and their families.

1- **Knowledge** –good understanding of the adaptation process and of the needs of parents and other family members. Should be able to be non-defensive when parents react to events with anger, denial or sadness. Help them work through their feelings, and thereby progress to a mature emotional acceptance of the child and his or her disability. Professionals should also have a thorough knowledge of the dynamics of families of people with disabilities.

2- **Attitudes** –must possess the basic underlying attitudes of genuineness, respect and empathy.

3- **Skills-** needs good interpersonal skills, basic counseling skills, the ability to listen, understand and help decide what action to take.