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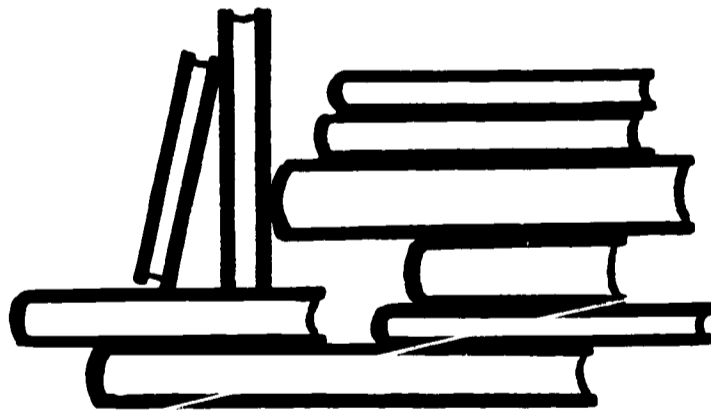
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ABSTRACT

Developed by a professor and an associate professor, this training manual provides a source of basic material which can be used by state agency personnel for the orientation of new counselors, for beginning courses in rehabilitation counselor training programs, and for inservice training of experienced rehabilitation counseling personnel. Major sections are: (1) Introduction and Background, which includes basic concepts of vocational rehabilitation, related legislation, and the locating of persons who need help, (2) Preliminary Study and Planning, which includes initiating the rehabilitation process, determining eligibility, and making a medical, psychological, sociocultural, and vocational assessment of the client, (3) Client Services, which includes planning services, providing prevocational and rehabilitational counseling, and locating places of employment, and (4) The Rehabilitation Counselor's Role. Suggested readings are included at the end of each section, and several client-study case abstracts are appended. (SB)

ED042011

**AN INTRODUCTION
TO THE
VOCATIONAL
REHABILITATION
PROCESS**



a training manual

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AN INTRODUCTION TO THE VOCATIONAL REHABILITATION PROCESS

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AN INTRODUCTION
to the
VOCATIONAL REHABILITATION PROCESS
Revised July 1967



JOHN F. MCGOWAN, *Professor*
University of Missouri
and
THOMAS L. PORTER, *Associate Professor*
University of Georgia

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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The materials in this publication do not necessarily represent the official views of the Vocational Rehabilitation Administration nor of State vocational rehabilitation agencies, and do not have the effect of law, regulation, or ruling. They do, however, reflect efforts by State vocational rehabilitation workers and VRA consultants to explore significant aspects of programs in order to encourage evaluation and stimulate professional growth.

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FOREWORD

STATE vocational rehabilitation agencies provide in their State plans for a program of staff development for their personnel. The implementation of a comprehensive inservice training program is designed to provide high-quality rehabilitation services to an increased number of handicapped individuals through the improvement of employee performance.

In many States, the staff development program includes leaves of absence for full-time study at institutions of higher learning, travel-study opportunities, part-time college and university study, and other organized training for professional, consultative, and clerical personnel. In all States, provision is made for a program of orientation training at the regional or State level.

Many institutions of higher learning offer, with Federal financial support, training programs to provide new personnel in the field of rehabilitation. These programs have been undergoing a steady growth and expansion as the demand for new personnel has increased rapidly.

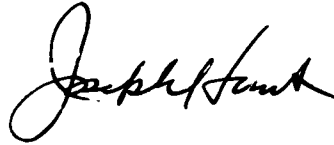
The Vocational Rehabilitation Act of 1954, as amended, provides the authority for the support of training of rehabilitation personnel in—section 4(a)(1), “* * * the Secretary shall make grants to States and public and other nonprofit organizations and agencies: (1) for paying part of the costs of projects for * * * training, and traineeships. * * *” and section 7(a)(3), “* * * the Secretary shall * * * (3) provide short-term training and instruction in technical matters relating to vocational rehabilitation services. * * *.” The 1965 amendments to the act made no changes in these provisions.

After completion of the manuscript of this manual, and prior to its publication, there was a major change and reorganization within the Department of Health, Education, and Welfare which included the Vocational Rehabilitation Administration. This reorganization places the Rehabilitation Services Administration (formerly Vocational Rehabilitation Administration) under the Social and Rehabilitation Service along with the Children's Bureau, Administration on Aging, Medical Services Administration, and Assistance Payments Administration. Secretary Gardner said in announcing the reorganization of these agencies: “* * * their placement together in one Service makes easier an approach which has long been a goal of those working in all these fields: A unified approach to the individual and to the family, and services available as a utility to all who can use them. * * * the Rehabilitation Services Administration, with its expanded responsibilities, will be able to make an even broader contribution to work with the handicapped.”

Extensive editorial work would have been required to change all references to VRA in this manual to RSA. This was considered impractical. Therefore, in using this manual the reader should substitute Rehabilitation Services Administration (RSA) for Vocational Rehabilitation Administration (VRA) whenever reference is made to the Federal rehabilitation agency.

This revised publication has been prepared to provide technical instructional materials so that State agencies, institutions of higher education, and RSA may better carry out their staff development responsibilities. It is hoped that it will be used widely in various rehabilitation situations and settings.

The Rehabilitation Services Administration is grateful for the extensive work, time, and effort donated by the authors, Drs. McGowan and Porter, in the preparation of this manual.



JOSEPH HUNT,
Commissioner,
Rehabilitation Services Administration.

PREFACE

THE purpose of this manual is to provide a source of basic training material which can be used by State agency personnel for the orientation of new counselors; for beginning courses in rehabilitation counselor training programs; and for inservice training of experienced rehabilitation counseling personnel.

The manual was originally published in syllabus form in 1955, following the enactment of Public Law 565 in 1954. With the passage of the law, funds were made available to the States which would allow them to increase the size of their professional counseling staff, and there arose an immediate need for the establishment of a series of regional orientation training institutes. Prior to the preparation of a manual for use in these institutes, a committee of the Council of State Administrators met in Washington, D.C., for the purpose of advising the Vocational Rehabilitation Administration on the objectives and content of the proposed institutes.

In line with their recommendations, staff members of the Vocational Rehabilitation Administration then prepared material covering the topics suggested. Much of the material eventually used had been developed by previous sessions of the "Guidance, Training, and Placement Workshops" sponsored by the Vocational Rehabilitation Administration, and merely needed revision, while other parts of it represented original writings by various staff members. This material was published in multilith form in October 1955, in time for the first of a series of orientation training institutes, under the title, "Orientation Training for Vocational Rehabilitation Counselors, a Syllabus for Orientation Institutes." Since 12 different staff members contributed to its preparation and very little time was available for detailed editing by any one person, the syllabus was found to contain a certain amount of unnecessary overlap and repetition, and some confusion as to the order of presentation, with a resulting loss of continuity.

In an attempt to correct some of these faults, a workshop was called at Gatlinburg, Tenn., in September 1957, under the sponsorship of the Richmond Professional Institute. As a result of the workshop, the manual was reorganized and certain parts were either revised or rewritten.

In June 1959, the University of Missouri received a grant to complete a final revision of the manuscript under the editorship of John F. McGowan. The revision consisted of adding a bibliography, case study material to go with part II of the manual, rewriting entire chapters to eliminate extensive outlining and differences in style, and finally, writing several new chapters to complete the manual. The manual was published in November 1960.

At the 13th Annual Guidance Training and Placement Workshop, which met in 1958, a committee was appointed to make recommendations regarding orientation and inservice training. The recommendations of the committee, which appear in the appendix, provide an outline for the orientation and inservice training of rehabilitation counseling staffs. It was the recommendation of this committee that training material can be presented either in scheduled regional orientation training institutes coordinated by VRA regional representatives, or at regularly scheduled inservice courses

within the State. As a general rule, orientation training meetings should include materials designed to produce and develop broad understandings, background knowledges, and general concepts; while materials and experiences aimed at developing specific skills and job effectiveness related to professional competencies are generally best provided at the State level. This manual contains material which will help develop the broad understandings, background knowledges, and general concepts outlined above, but each State, school, or agency using the manual will still need to prepare and refer to supplemental material.

This revised edition of the manual was completed and written under the direction of John F. McGowan, with the assistance of Thomas L. Porter. The revision attempts to incorporate suggestions received from State training supervisors who have used the original publication. Mr. Edgar B. Porter wrote to a group of State agency training supervisors asking for criticism of the manual and suggestions for a revision. A substantial number replied and nearly all of them made one or more suggestions for a revision of the manual. Consequently, we have revised some of the original chapters by deleting material that was either not clear or repetitive, by making substantial additions to other chapters, by bringing the statistics up-to-date, and by adding new sections written by the authors. Much of the material is new, and we hope the manual in its present form will be usable by any agency or school engaged in rehabilitation counselor training.

The case study abstracts were included in order to provide those who use the manual with a ready source of practical and realistic case material. It is hoped that this material will relate the information contained in each of the sections to the day-by-day activities, problems, and duties of the counselor, thus making the learning more real and permanent.

Acknowledgment is made to five former students at the University of Missouri who participated in the preparation of the original manual. They are, Mr. William Phelps, Dr. Richard Thoreson, Dr. Bob G. Johnson, Mr. Robert Heaberlin, and Mr. Robert Prouty.

Special thanks are due Mr. Edgar B. Porter, former VRA staff member, who initiated the work on the original publication, Mr. Ralph N. Pacinelli and Mr. Bernard E. Kelly formerly of the VRA staff.

The final revision to incorporate the 1965 amendments was completed with the help of Michael Ryan, a graduate student here at the university, and Mrs. Ellen Meier, who typed the manuscript. Mr. Seth Henderson and Miss Josephine M. Meers supervised the production for the VRA central office.

JOHN F. MCGOWAN
TOM PORTER

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PART ONE
INTRODUCTION AND BACKGROUND

Section 1

INTRODUCTION TO VOCATIONAL REHABILITATION

"Men who are occupied in the restoration of health to other men, by the joint exertion of skill and humanity, are above all the rest of the earth. They even partake of divinity, since to preserve and renew is almost as noble as to create."

VOLTAIRE

WITH the rehabilitation of almost 175,000 disabled persons to productive living and employment, in the 12 months ended June 1967, the public program of vocational rehabilitation for disabled men and women now has reached a record level of achievement. This program has signified the Nation's recognition of our social obligation to restore the disabled citizen to the mainstream of life, along with our recognition of the compelling economic necessities involved in rehabilitation. Operating for a number of years on a comparatively small scale, but with highly imaginative and versatile approaches to the problems of restoring the disabled to employment, it has proved the worth of the Nation's investment in rehabilitation.

The purpose of this introductory section will be to provide an overview of the current status of the field, to review traditional attitudes and beliefs about the handicapped, and to identify the philosophy behind the rehabilitation movement in America.

In the summer of 1962, the late President John F. Kennedy, standing on the White House lawn, stated:

We are saluting the fact that, for the first time in the history of this country, we have reached the target of 100,000 disabled people who are annually rehabilitated. Our goal is 200,000 and we are making a determined national effort * * * This program goes back to the Administration of Woodrow Wilson. It was made permanent during the Administration of Franklin Roosevelt. We have given additional funds and additional effort to it in the last year, and *we believe it is the kind of program that can produce the most useful results for our country.*

Recognition of the worth and dignity of the handicapped is traditional in our American way of life. As

a result the objectives of the vocational rehabilitation program have appealed to members of all major political parties. Thoreson (1964) offers the following explanation: "In rehabilitation the practical objective of restoring the individual to productive employment deftly intertwines with the humanitarian concern for the handicapped person's movement from abasing helplessness to a position of dignity and self-respect. Thus it is not surprising that rehabilitation has captured the imagination—and financial support—of State and Federal as well as numerous private agencies" (p. 12).

In the late President Kennedy's 1962 state of the Union address he emphasizes this point by saying, "To help those least fortunate of all, I am recommending a new program of public welfare, stressing services instead of support, *rehabilitation instead of relief*, and training for useful work instead of prolonged dependency."

President Lyndon B. Johnson expressed a similar concern for the personal and social satisfactions of *all* Americans. In his 1964 state of the Union message, President Johnson stated:

This budget—and this year's legislative program—are designed to help each and every American citizen fulfill his basic hopes: his hopes for a fair chance to make good; his hopes for fair play from the law; his hopes for a full-time job on full-time pay; his hopes for a decent home for his family in a decent community; his hopes for a good school for his children with good teachers; and his hopes for security when faced with sickness, or unemployment, or old age.

Later, on August 10, 1965, the President made the following noteworthy statement: "I can think of no better example of what this administration is trying

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to accomplish for the American people than the Federal-State program of vocational rehabilitation."

In recent years, medicine and related medical sciences have made great advances in basic knowledge, and new techniques have resulted in improving professional services. One of the results of these improved services is that individuals who might previously have died, or have been permanently disabled, are now treated and returned to society. Nevertheless, many of these people have residuals of disease or illness which prevent them from returning to the occupation in which they had previously made their living and are in need of rehabilitation services.

Within the context of the following observation by Mary E. Switzer (1964), Commissioner of Vocational Rehabilitation, there is a suggestion that we are evolving to a higher level of maturity:

Vocational rehabilitation, like many other aspects of human affairs, has evolved through three stages of public attitudes—compassion without action, followed by willingness to act for economic reasons, followed by willingness to act for social reasons. It seems to me that we are at a transitional stage between the last two, with almost universal acceptance of the economic soundness of returning disabled people to employment and a slowly growing philosophy that an advanced civilization like ours should so order its system that all disabled people will be restored as fully as possible, regardless of any economic benefits to anyone (p. 19).

The amendments of 1965 to the Vocational Rehabilitation Act, as passed by the 89th Congress November 8, 1965 (Public Law 89-333), literally doubled the financial support of the Federal Government to the program (see sec. 3 for details). With the additional resources provided by Public Law 89-333 we are moving into another era of rehabilitation which will undoubtedly be accompanied by many changes and innovations. And while the Federal-State vocational rehabilitation program as we know it today may be difficult to recognize in 1975, the fact that *it is the needs of the disabled individual which must guide the program if it is to fulfill its purpose and obligation to society* will remain constant.

Vocational rehabilitation of disabled persons is a worldwide concern. When elected president of the World Health Organization, in 1958, Dr. Leroy E. Burney, Surgeon General, U.S. Public Health Service, said: "For every child who is today saved from dysentery, we will have an adult who may eventually acquire a chronic illness. For every young worker who is today spared from premature death from malaria we will have an older person who may develop one of the diseases of later life. * * * It is our responsibility to do everything we can to assure that these

lives which are to be spared and lengthened are rewarding and productive" (Krusen, 1960, p. 30).

Mary E. Switzer (1960), Commissioner of Vocational Rehabilitation, in discussing international rehabilitation activities stated:

All of them face hopefully one of the major challenges of any time—the reduction of dependency. In every nation, dependency due to physical disability takes a heavy toll of national resources—financial, social, spiritual. No cause cries more eloquently for work, dedication, and material than the movement to give all peoples as individuals, the opportunity to fulfill their lives.

In many places, medicine, surgery, public health, and rehabilitation practices are advancing solidly against individual disability and its handicapping effects for employment and the normal activities of living. The philosophy of rehabilitation that has gained most ground holds that restoration or improvement of physical or mental abilities is not enough, not even when combined with vocational guidance and training. There is clear responsibility for the medical arts, of course. But restoration of the disabled and the handicapped in society involves other arts and sciences, and the practices of other professions; a fusion of government and private endeavor to provide funds and facilities; and, most essentially, a sustained public and legislative opinion that insists on the rights of the disabled for opportunity to overcome their handicaps (p. 1).

CONCEPTS ABOUT THE HANDICAPPED

Vocational rehabilitation is defined as a process of restoring the handicapped individual to the fullest physical, mental, social, vocational, and economic usefulness of which he is capable. This definition envisions a process aimed at helping handicapped individuals reach the *highest* possible capacity for usefulness. In many of the States, vocational rehabilitation provides services not only to those capable of attaining full-time competitive employment in the labor market, but extends services to those persons who are capable of only part-time, sheltered, homebound, or self-employment.

The underlying formation of special programs for the handicapped involves two basic assumptions:

First, that every member of a democratic society has an inherent *right* to the opportunity to earn a living, and make his contribution to society.

Second, that society has the *obligation* to equalize, as best it can by special services, the disabled person's opportunity to earn a living equal to the opportunity possessed by the nondisabled members of the society.

These assumptions are particularly important in American society "The status of independence is self-sufficiency, hard work, industriousness, contribution to society, and upward social mobility of the individual. To the extent that the handicapped individual is unable to reach these goals, he suffers a loss of personal dignity, prestige, and self-esteem both as a member of society and as a member of a family. Merton (1957) feels that these concerns are to be expected in a culture which stresses achievement yet closes the door and removes the means of attaining this goal. Wilcox (1958) notes that all of the definitions of adjustment offered by psychologists include the concept of independence and productivity, and that within American society, "The status of independence is generally considered to be a hallmark of the attainment of adulthood." Herein lies the dilemma of the handicapped person, for only insofar as he can demonstrate his physical or mental incapacity is his dependency accepted. The problem of achieving independence is difficult for all persons, but increasingly so for the physically and mentally handicapped individual. In addition to this there are several other variables which complicate the handicapped individual's attempts to reach a solution to the dependency-independency problem. *First*, the enforced idleness which is so frequently imposed upon the disabled person often has a large overlay of secondary gains, resulting in the intensification of dependency-seeking behavior and a general flattening out of affect. *Second*, the disability *per se* may come to constitute an unconsciously sought-for goal of dependency.

PREVIOUS ATTITUDES REGARDING ILLNESS

Studies of the history of the handicapped in earlier societies show that people have fluctuated widely in their attitudes and feelings toward the handicapped or crippled members of their community. In a particular society we may find that the handicapped are considered as being close to God or godlike while in another they are perceived as tools of the devil who should be destroyed. Theophrastus (Edmonds, 1929), writing in the fourth century A.D., states that when a person "sees a madman or epileptic he shudders and spits in his bosom." To the ancient Hebrew, illness and physical defect often marked the person as a sinner (Edmonds, 1929). In ancient Greece, a disease was

seen as a heinous thing, indicative of inferiority (Edmonds, 1929). Standing in contrast to these ideas is the strict scientific viewpoint which classifies disease as a physical consequence of amoral natural conditions, many of which can be understood and often controlled.

Attitudes concerning the disabled in American society, as expressed in humor, reveal the derogatory view taken by the general population toward physical abnormalities. Baker et al. (1953), found in their analysis of five collections of jokes, including nearly 7,000 jokes, that while only 4 percent were concerned with persons having physical defects, 80 percent of these jokes clearly deprecated disabled persons. In contrast with this, farmers, salesmen, judges, and dentists as subjects of jokes were deprecated in but 49 percent of the examples.

The fact that widespread prejudice toward the handicapped exists in many areas seems to be well established. Gellman (1959) attributes such prejudice toward the handicapped by the nonhandicapped in modern society to three deep and often unconscious mechanisms: (a) A belief that physical abnormality is a retribution for evil, and hence the disabled person is evil and dangerous; (b) a belief that a disabled person has been unjustly punished and is therefore under compulsion to do an evil act to balance the injustice, and hence that he is dangerous; (c) the projection of one's own unacceptable impulses upon the disabled, and hence that he is evil and dangerous.

Gellman (1959) asserts that prejudice toward handicapped persons is prevalent at all socioeconomic levels and in all regions of our country. He believes that the roots of prejudice are formed out of: (a) Social customs and norms, (b) child-rearing practices which stress normalcy and health, (c) the reawakening of neurotic childhood fears in frustrating or anxiety provoking situations and (d) prejudices by invitation—discrimination-provoking behavior by the disabled.

The rehabilitation counselor and members of related health professions are prone to feel that they are beyond the pressure of the traditional prejudices by virtue of their close helping relationships with the handicapped; however, those who have made a critical analysis of the total dynamics of the rehabilitation process see factors operating which often mitigate against full acceptance of clients by counselors, or of counselors by their clients. Some of the factors which tend to color the counselor's and the handicapped individual's perception would include: (a) The client's present social role as an inferior, helpless person, (b) the client's position in the status hierarchy of most agencies, (c) the tendency for some counselors to assume an omnipotent

role, and (d) the prevailing middle-class orientation of rehabilitation personnel which serves to increase social distance (Gellman, 1959).

THE REHABILITATION PROCESS DEFINED

The rehabilitation process consists of a planned, orderly sequence of services related to the total needs of the handicapped individual. It is a process built around the problems of a handicapped individual and the attempts of the vocational rehabilitation counselor to help solve these problems and thus to bring about the *vocational* adjustment of the handicapped person.

The process begins with the initial casefinding or referral, and ends with the successful placement of the handicapped individual on a job. The unique characteristic that distinguishes and differentiates the vocational rehabilitation process from all other forms of counseling is its primary objective, which is the realistic and permanent *vocational* adjustment of the handicapped individual. To accomplish this vocational adjustment, a wide range of services are provided.

Services are obtained, often by purchase, from virtually the full span of community resources, depending on individual needs. Private physicians, public and private hospitals, specialized clinics, rehabilitation centers, workshops, public and private educational institutions, and employers, are but some of the resources which are regularly drawn into effective rehabilitation.

The range of vocational rehabilitation services includes:

- (1) Full evaluation, including medical diagnosis, to learn the nature and degree of disability and to help evaluate the individual's work capacities.
- (2) Counseling and guidance in achieving good vocational adjustment.
- (3) Medical, surgical, psychiatric, and hospital care and related therapy, to reduce or remove the disability.
- (4) Artificial limbs and other prosthetic and orthotic devices needed to increase work ability.
- (5) Training, including training for a vocation, pre-vocational and personal adjustment training, and remedial education.
- (6) Services in comprehensive or specialized rehabilitation facilities, including sheltered workshops and adjustment centers.
- (7) Maintenance and transportation during rehabilitation.

- (8) Tools, equipment, and licenses for work on a job or in establishing a small business.
- (9) Placement in a job suited to the individual's highest physical and mental capacities and post-placement followup to assure that the placement is satisfactory to the employee and the employer.

Figure 1 on page 7 shows the types of services provided to clients during 1966.

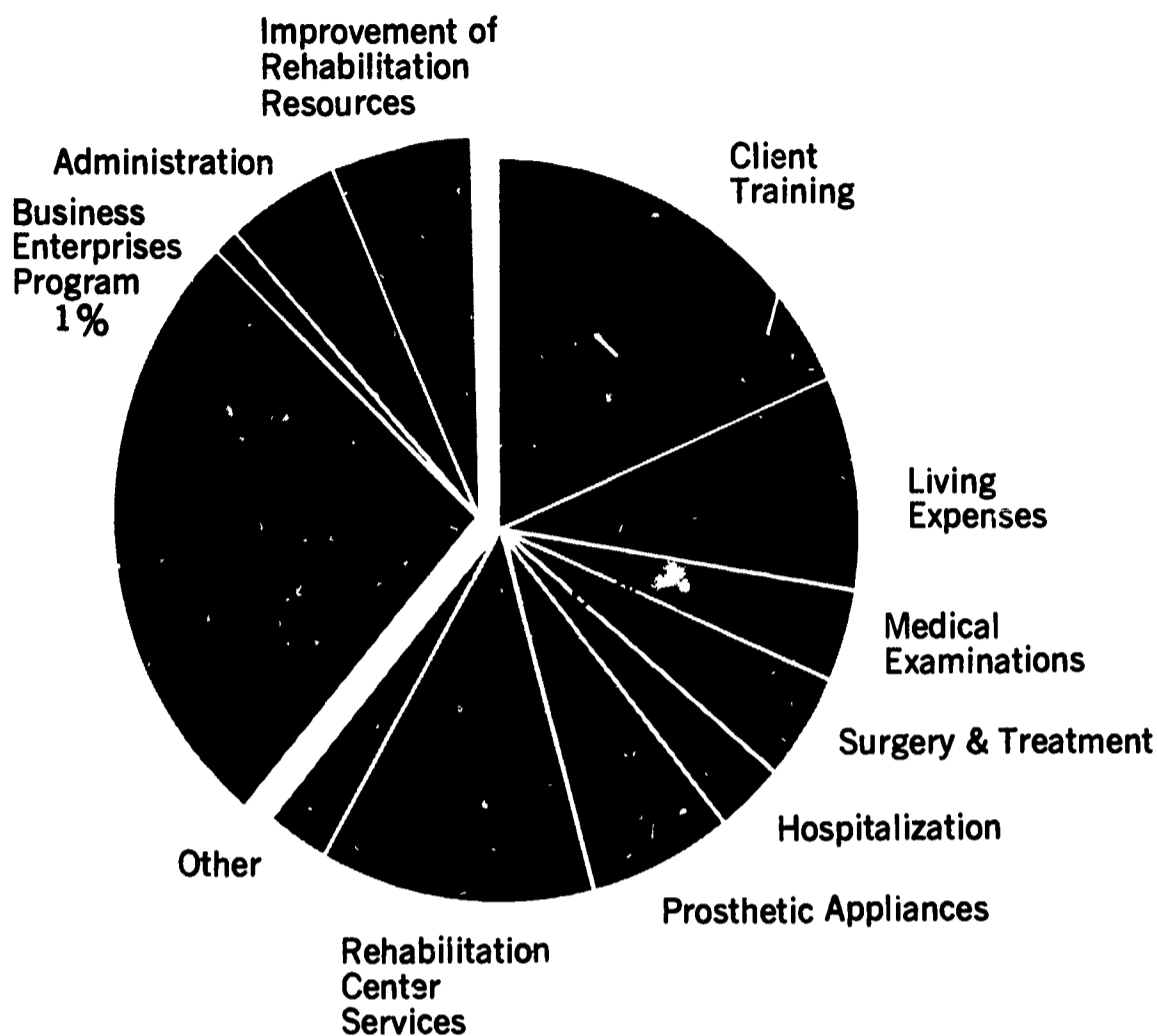
The program attempts to marshal all resources, in a coordinated way, to bring the disabled person to his best functioning level. In the Federal-State program, the rehabilitation counselor is the key staff member, making the determination as to whether the individual is eligible, arranging with the individual the development of a plan for his rehabilitation, managing the arrangements for the necessary services, counseling and guiding the individual, and staying with him through successful placement on the job.

REHABILITATION IN CONTEMPORARY AMERICAN SOCIETY

In America, our school system and our entire way of life are based upon the assumptions that every individual has the right of life, liberty, and the pursuit of happiness, as guaranteed in our Constitution, and that these rights of the individual impose a corresponding obligation upon the State to provide those necessary services which will allow all, not just part, of its citizens to reach a satisfactory level of personal productivity. An awareness of the intrinsic dignity of man is reflected in the concept that manpower is a precious resource, not to be treated wastefully, but to be utilized effectively and productively. The status of guidance in America's schools reflects the belief that an individual should be given maximum opportunity for the development of his potentialities. In vocational rehabilitation a primary goal is to uncover these interests, aptitudes, values, and aspirations of the individual as they relate to vocational assets.

While it is perfectly acceptable to speak of the underlying humanitarian base of the vocational rehabilitation movement, the practical fact that the Federal-State rehabilitation program is economically sound should not be obscured from view. *One of the purposes of a formally established program of rehabilitation is to prevent long-term expenditures of tax*

FIGURE 1.—What State Rehabilitation Agencies Do for Clients
(214 Million Spent in 1966)



money by making the individual capable of self-support. In actual practice, Federal legislative provisions have provided the impetus for the removal of disabled individuals from relief rolls by making them self-supporting, contributing members of society.

About 20,100 of the persons rehabilitated in fiscal 1966 were receiving public assistance at the start of or during their rehabilitation, and about 9,100 were living in tax-supported institutions. Public assistance payments to the 20,100 persons were about \$25 million annually.

In contrast, the 155,000 persons rehabilitated in 1966 will have paid about \$24 million in Federal taxes, plus additional State and local taxes. On the basis of an exploratory cost benefits analysis, an estimate was made of the increase in lifetime earnings accruing to disabled persons as a result of vocational rehabilitation services per dollar expended on them during the rehabilitation process. Persons closed from the active caseloads of State vocational rehabilitation agencies during 1966 will earn an additional \$35 for every dollar of Federal, State, and private funds spent on them.

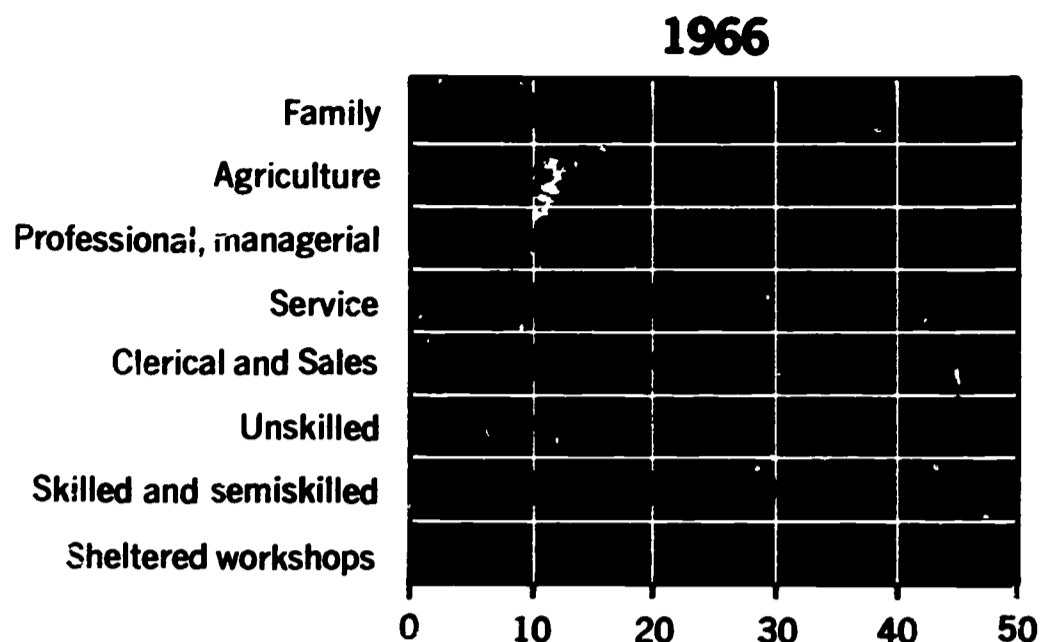
As a result of rehabilitation, the Nation gains in the man-hours added to its productive effort. The total

group of almost 155,000 persons rehabilitated in 1966 will contribute an estimated 216 million man-hours per year to the Nation's productive effort. The manpower pool in the professional occupations, such as engineering, teaching, medicine, and related health activities, was increased by about 6,000 as a result of the disabled persons rehabilitated in 1966. Nearly 18,000 went into the skilled trades, and 9,000 into agriculture. Figure 2 on page 8 shows occupations entered by percent of 1966 rehabilitants.

In terms of the Nation's drive to bring poverty under control and to prevent poverty wherever possible, the program of vocational rehabilitation makes a significant contribution. Almost 75 percent of the 155,000 persons rehabilitated in 1966 were not working when they started their rehabilitation. Others were in marginal or otherwise unsatisfactory employment.

An added dimension becomes graphic with the realization that some 67,500 of the 155,000 persons rehabilitated in 1966 had dependents. Many of the disabled individuals were freed from the need for constant attendance and enforced dependence. For those who do not make it to full vocational rehabilitation, but who do acquire full mobility, the gain is their ability to participate in family and community life.

FIGURE 2.—Major Occupations of Persons Rehabilitated in 1966



Also not to be overlooked is the reduction or the prevention of disability which can result from the prompt rendering of rehabilitation services. This preventive contribution has been dramatically demonstrated in the case of stroke victims and amputees. There is, moreover, a preventive force at work when a rehabilitated disabled person is able to maintain his gains from rehabilitation and to ward off deterioration of his physical or mental condition.

EFFECTS OF DISABILITY WITHIN THE FAMILY

There is a growing recognition that the disability of one member of a family has an effect on the whole family unit. This is most striking if the disabled individual is the father who, although the titular head of the family, is unable to provide for his family because of a vocational handicap. Similarly, when the mother is disabled she cannot give proper care to her children and they suffer as a result. Finally, when the disabled member of the family unit is a child, an extra burden is imposed upon the parents who must provide much more than they would for a nonhandicapped child. Besides material deprivation, disability of one family member causes a great psychological strain for all family members. The family unit is more susceptible to anxiety, guilt feelings, suppressed anger, etc. than is the family unit which has no disabled members.

With the cooperation of Federal, State, and local welfare organizations, measures have been put into effect which attempt to help family units while appropriate rehabilitation measures are taken for the handicapped family member. As an example of this cooperation, we can cite the efforts employed on behalf of young people and older people.

For the young people, school systems in States and communities collaborate with their rehabilitation agencies to identify and evaluate handicapped students. Then special classes are provided in an attempt to initiate early aid to youths handicapped by visual, aural, or speech problems. For those students with such disabilities as epilepsy, cardiac disorders, emotional disturbances, mental retardation, cerebral palsy, polio, and orthopedic handicaps, rehabilitation agencies often take extraordinary steps to reap a harvest of individual benefits. At the same time, rehabilitation programs of the future have their load lessened by the comprehensive aid given those whose handicaps have been identified in their early years.

As educational benefits, special courses are provided these students to stimulate their interest in furthering their education and thereby to combat dropouts and possible delinquency. For those students who are mentally retarded, simultaneous academic education and vocational training are provided in many localities in the United States. In more than 30 States, occupational training centers are preparing large numbers of retarded youths for jobs consistent with their abilities.

The growing proportion of older persons in our population prompted the need and development of

services designed to prepare them for full or partial employment, or lessened dependence on family or public funds. Research and demonstration projects have shown that many older persons—some beyond 65—can be rehabilitated into employment compatible with their condition. Other projects have demonstrated that many persons who had been confined to bed in public or private institutions could be rehabilitated into self-care and considerable independence, thus reducing the enormous number of hospital and similar facilities held for these purposes.

CONCEPTS ABOUT THE COMMUNITY

The problems of disability, chronic disease, and aging have a significant relationship to community welfare. Some basic understanding of these relationships is important to the rehabilitation counselor, for the community which maintains a large number of disabled and idle workers faces growing economic and social problems. The process of involving the community in rehabilitation will not succeed solely as a humanitarian venture, but only as it can demonstrate that vocational rehabilitation programs are "good business" for the community. In many cases this is quite easy to show, since unproductiveness results in a loss of income for the individual and makes it necessary for the community to provide support. The public feels the ultimate effect of the individual disability in the form of reduced purchasing power and generally lowered social tone. It also results in increased taxation for the individual members of society who are not handicapped (Porter, 1950).

Evidence would tend to indicate that many employers have an aversion to employing the disabled, as they believe them less effective and more accident prone. Some employers seem to have either a conscious or unconscious abhorrence of physical disability, fear a rise in insurance rates, and a disturbance in their pension systems if they hire the disabled. In some States the lack of a "second injury" clause in workmen's compensation places the burden of both second and previous injuries on the employer.

Among the millions of our citizens who are disabled, the Vocational Rehabilitation Administration estimates that there are over 3.5 million persons of working age who could be rehabilitated to employment. At the present rate, an additional 450,000 people each year will join the group who are disabled and who

could be restored to activity and work through vocational rehabilitation services. But this represents only a portion of the total group of the disabled in the Nation. The National Health Survey findings indicate that nearly 14 million persons at or near working age who live outside of institutions are limited either partially or totally in their ability to carry out their normal activities, that is, either in their ability to work, keep house, or go to school. The full picture should also include a sizable portion of the 5.5 million mentally retarded persons, a group which is not fully represented in the National Health Survey (see sec. 2 for further details).

Obviously, the Nation is a long way from meeting the need for vocational rehabilitation for the disabled. Also, quite obviously, it will take the combination of public and private rehabilitation efforts to make significant progress toward meeting the total need.

The next immediate goal of the public vocational rehabilitation program is the rehabilitation of 200,000 disabled persons annually. The expansion of the last 12 years has brought the program to the 1966 total of about 155,000 disabled persons rehabilitated in one year. It is therefore apparent that one of the keys to accelerating this commendable progress is additional funding. This will permit application of the extensive knowledge gained over the last 12 years and result in the rehabilitation of many severely disabled persons.

CONCEPTS ABOUT REHABILITATION

In discussing the rehabilitation process a distinction must be made between disability and handicap. A *disability* is defined as "a condition of impairment, physical or mental, having an objective aspect that can usually be described by a physician. It is essentially a medical thing" (Hamilton, 1950, p. 17). The 1966 regulations issued by the Vocational Rehabilitation Administration to implement the Rehabilitation Act as amended in 1965 define disability as "a physical or mental condition which materially limits, contributes to limiting or, if not corrected, will probably result in limiting an individual's activities or functioning. It includes behavioral disorders characterized by deviant social behavior or impaired ability to carry out normal relationships with family and community which may result from vocational, educational, cul-

tural, social, environmental, or other factors" (sec. 401.1(o)).

A *handicap* is defined as "the cumulative result of the obstacles which disability interposes between the individual and his maximum functional level. The handicap is the measure of the loss of the individual's capacity, wherever evident. It is an individual thing composed of the barriers which the handicapped person must surmount in order to attain the fullest physical, mental, social, vocational, and economic usefulness of which he is capable" (Hamilton, 1950, p. 17). The regulations identify a handicapped individual as one "who has a physical or mental disability which constitutes a substantial handicap to employment * * *" (1966, sec. 401.1(i)). Section 401.1(w) further explains that "substantial handicap to employment means that a physical or mental disability (in the light of attendant medical, psychological, vocational, educational, cultural, social, or environmental factors) impedes an individual's occupational performance by preventing his obtaining, retaining, or preparing for a gainful occupation consistent with his capacities and abilities." The rehabilitation process is concerned primarily with the handicapping problems resulting from disability, rather than with the disability per se.

The determination of eligibility for vocational rehabilitation is based upon considerations of the total interplay of factors surrounding an individual's handicap. (For definition and criteria see—"The Vocational Rehabilitation Diagnosis," sec. 6.)

The services that are necessary to render a person employable are based upon the individual needs of a given client. The nature and extent of services available for development of these individual plans are set forth in a State plan which is formulated within the guidelines established by the Vocational Rehabilitation Act and the regulations. (See sec. 3, "Legislation Related to the Vocational Rehabilitation Program.") Services that are a necessary part of the overall rehabilitation plan for each individual, but which the State agency may be unable to participate in financially, may often be secured from cooperating agencies.

The job of serving the handicapped population is a form of guidance-oriented human engineering; i.e., to find the disabled individual, ascertain his needs, and provide the necessary services. The means of determining the needs of any given client is through the individual client-study method. It is the responsibility of the rehabilitation counselor to integrate the activities of a number of people and thereby combine

the skills of a number of professions, in total rehabilitation planning. Clearly, all services are not contained within the rehabilitation agency. The agency contributes directly in: Determination of eligibility; determination of services needed; counseling, placement and followup services; making arrangements with other agencies for other necessary services; and supervising the rendition of these services.

Other necessary services are provided by purchase from, or arrangement with, other agencies, institutions or individuals.

CONCEPTS ABOUT THE REHABILITATION COUNSELOR'S JOB

The counselor's role in the rehabilitation process is basic to the success or failure of any given individual program. The agency is personified in the counselor, and through him the client gains his perception of vocational rehabilitation. The rehabilitation counselor establishes a professional relationship with the client, continuing from the onset or recognition of disability to the attainment of greatest competitive capacity. The counseling relationship is a dynamic, ongoing process in which the personalities of the counselor and client interact in such a way as to maximize present vocational assets and foster realistic self-acceptance in the client.

The development within the rehabilitation counselor of sound basic assumptions and an underlying philosophy of rehabilitation controls to a large extent his perceptions of his job, and therefore, his feelings regarding the services he should extend to his clients. The philosophy that the counselor eventually develops will be a reflection of his training, of the thinking of his superiors, and the general tone set by the agency for which he works. It is important that every counselor continue to evaluate his own attitudes and feelings toward the handicapped and toward the program in which he is engaged in order to grow and develop as a professional worker. Since a detailed discussion of the counselor's role will be found in part Four, the next few paragraphs are intended only to serve as a general discussion of the work of the rehabilitation counselor.

The vocational rehabilitation counselor offers help to those individuals whose handicapping conditions occurred prior to significant work experience (habilitation) and to those who engaged in gainful employment

before acquiring a vocational handicap (rehabilitation).

A handicapped person facing the realities of the world of work may require assistance from a State vocational rehabilitation agency. His eligibility for services would be based upon: (1) The presence of a physical or mental disability; (2) existence of a substantial handicap to employment; and (3) a reasonable expectation that vocational rehabilitation services may render him fit to engage in a gainful occupation. Meeting of the first requirement is determined through a general medical examination and specialists' examinations as appropriate. The second and third fall essentially within the counselor's area of specialty and are determined during the total diagnostic procedures. (A further discussion of this topic is presented in "Basic Principles for Determining Eligibility," sec. 11.)

Once the handicapped individual has been declared eligible for vocational rehabilitation, the services needed for his rehabilitation must be considered. The services offered by a State vocational rehabilitation agency may be provided without conditioning them on an economic needs test. If a State agency retains an economic needs test, it will not be applied as a condition for providing diagnostic and related services, counseling, and placement. Each State agency's policies will determine those other services dependent on the demonstrated economic need of the handicapped individual. The counselor has the responsibility for assuring that all necessary services are provided for in the total rehabilitation plan for each individual. (See sec. 12, "Planning and Provision of Services," for further discussion.)

Counseling is often spoken of as forming the core of the rehabilitation process and as the most substantial service offered by a State agency. In the manual "Rehabilitation Counselor Preparation," which was prepared by participants at the Charlottesville Workshop and published jointly by the National Rehabilitation Association and the National Vocational Guidance Association in 1956, the following statement is found: "The core of the rehabilitation counselor's work is counseling. He accomplishes this function by establishing and maintaining a counseling relationship, which serves to unify all the rehabilitation services into an organized plan resulting in an integrated experience. The counselor helps the disabled individual evaluate his assets and liabilities, understands his problems and the necessary steps to resolve them" (Hall and Warren, 1958, pp. 16-17).

In the manual, "Casework Performance in Vocational Rehabilitation," edited by Thomason and Bar-

rett (1959), which reflects the feelings of the participants in previous Guidance, Training, and Placement Workshops, the following statement is found: "Counseling is the one activity which pervades the entire process of vocational rehabilitation. It starts at the initial interview with the client, and continues until a satisfactory job adjustment has been achieved" (p. 51).

THE OUTLOOK

The vocational rehabilitation movement is now going through a period of unprecedented growth and expansion. Rehabilitation as an affirmation of human worth and as a conservation of human resources has a vital role to play. Problems, assuredly, have arisen as a result of this growth. For example, some workers and disciplines have tended to eye with suspicion anything that intrudes upon their closely knit professional family (Hunt, 1948). Some writers have deplored the interprofessional jealousy that develops as one specialty sees its domain encroached upon by another (Patterson, 1957). Physicians may occasionally feel pushed by psychologists and rehabilitation counselors. Social workers may feel threatened by rehabilitation counselors, and vice versa. Education, psychology and social work have all rigorously insisted on their claim as the rightful parents of the rehabilitation counselor (Patterson, 1957).

Our general techniques for the treatment of handicapping conditions, and our overall knowledge of and sophistication toward rehabilitation problems have shown marked progress in the past decade. The medical profession has seen the need for the designation of a medical specialty—physiatry—to signify the newly gained understandings in physical medicine and rehabilitation. There has been a rapid upswing in professional literature concerning all phases of rehabilitation. Funds appropriated for research in rehabilitation are now beginning to bear fruit with the result that professional workers in rehabilitation have a much wider array of useful knowledge to draw from.

Waldrep (1959), writing on the current status of rehabilitation, suggests that there is new hope for the disabled physically, socially, and psychologically. Better training, professional development, more imaginative treatment concepts, and enlightened cultural concern mean a brighter future for the handicapped. Rehabilitation, born small and obscure, has come of age in the mid-20th century.

Section 2

INCIDENTS AND OUTCOMES

THE growth of vocational rehabilitation during the past 25 years can be attributed in part to its appeal to basic humanitarian interest. Moreover, the tangible results of the program in terms of dollars and cents can and do justify its existence, for in addition to eliminating needless physical discomfort and psychological dependency the program not only pays its own way but offers considerable interest on the initial investment.

The purpose of this section is twofold: first, to present a general overview of the extent of the problem of vocational rehabilitation that we face in the United States; and, second, to present information on the results of the program.

SOME MEDICAL FORECAST

According to a report published by the United Nations (Covalt, 1961), the population of the world passed 3 billion in 1961. The same report forecasts that by the year 2000 the figure will be over 6 billion.

In our own country today we have a population of over 190 million. It has been prognosticated by the Social Security Administration that within the coming decade we will approach a population of 200 million; by 1980, 280 million; and by the year 2000 over 300 million (Covalt, 1961).

Social planners of today are concerned with what is going to happen in the next decade. What kind of medical problems, what kind of vocational problems, what kind of rehabilitation problems may we expect among the nearly 200 million persons who will populate our country in 1970?

Medical science has made broad strides in the past 25 years. A baby girl born today can expect to live more than 73 years, and a boy more than 67 years. This increase in lifespan will become even greater during the coming decade. Large numbers of people

no longer die of typhoid fever and diphtheria, the scourges of just a few decades ago; poliomyelitis can be prevented, and diabetes can be controlled. More and more people are living who would have died a few years ago. As the people of America come to represent an older population, the percentage of people over 50 years of age will increase tremendously. Along with this increase in age we can expect the ravages of chronic disease and disability.

In this century we have seen constant advances in the field of medicine and surgery and radically new concepts of medical services. Fifty years ago, one entered the hospital either to isolate a communicable disease or to die. Later the hospital became a first-aid or emergency center for accidents and acute illnesses. As it gained the confidence of the public, it took on more and more the aspects of a diagnostic center as well as a treatment center. Now, in addition to providing definitive treatment, research has become one of its very important functions. However, there is still a large gap in the provision of rehabilitation services. Covalt (1961) reports that of the nearly 7,000 hospitals in the United States less than 20 percent are adequately equipped with the physical facilities and the qualified personnel to provide comprehensive rehabilitation services.

THE NATURE AND EXTENT OF DISABILITY

In rehabilitation, as in medical and other related fields, one of the problems encountered has been the lack of up-to-date information on the number and characteristics of persons with chronic diseases and impairments. However, under legislation enacted by Congress in the summer of 1956, a continuing National Health Survey was inaugurated by the Public Health Service starting in July 1957, to provide current data,

on a regular basis, concerning the health status of the general population.

Estimates made by the Public Health Service, for fiscal year 1963 indicate that nearly 45 percent of the men, women, and children in the United States have some degree of chronic illness or impairment. Not including those in institutions, this would be equivalent to over 80 million persons. However, by no means are all of these people seriously handicapped or disabled in the sense of being limited in their ability to lead fairly normal lives.

Chronic limitation of activity is most prevalent among low-income families. Approximately 29 percent of persons in families with income less than \$2,000 per year have some degree of chronic limitation of activity. This proportion decreases steadily down to only 8 percent having any activity limitation in families with income of \$7,000 or more.

In regard to the incidence of disability in low-income groups Harrington (1963), states:

The poor get sick more than anyone else in the society. That is because they live in slums, jammed together under unhygienic conditions; they have inadequate diets, and cannot get decent medical care. When they become sick, they are sick longer than any other group in the society. Because they are sick more often and longer than anyone else, they lose wages and work, and find it difficult to hold a steady job. And because of this, they cannot pay for good housing, for a nutritious diet, for doctors. At any given point in the circle, particularly when there is a major illness, their prospect is to move to an even lower level and to begin the cycle, round and round, toward even more suffering (p. 15).

The U.S. National Health Survey of the Public Health Service, conducted in 1962-63, reports on the prevalence of chronic conditions in the civilian non-institutional population. According to their definition a "chronic" condition is one that exists for at least 3 months, and a "major limitation of activity" refers to a condition that renders a person unable to carry on his primary duties (holding a job, housework for the housewife, attending school full time, etc.). They list the following 28 chronic conditions: Asthma; tuberculosis; chronic bronchitis; repeated attacks of sinus trouble; rheumatic fever; hardening of the arteries; high blood pressure; heart trouble; stroke; trouble with varicose veins; hemorrhoids or piles; hay fever; tumor, cyst, or growth; chronic gallbladder or liver trouble; stomach ulcer; any other chronic stomach trouble; kidney stones or chronic kidney trouble; arthritis or rheumatism; mental illness; diabetes; thyroid trouble or goiter; any allergy; epilepsy; chronic nervous trouble; cancer; chronic skin trouble; hernia or rupture; and prostate trouble. It was estimated that in excess of 4.1 million persons in the United States suf-

fer a chronic major limitation of activity. However, this estimate includes the very severely disabled and 2.5 million individuals who are 65 years of age or over. Rehabilitation is most concerned with those persons who have a chronic limitation, with the exception of the above-mentioned categories, but as a general rule, those who have a partial limitation are often eligible for services.

The percentages of the total population that have a chronic major limitation of activity are presented in Table 1 (National Health Survey) according to age and sex.

TABLE 1.—Percent distribution of persons unable to carry on major activity due to chronic conditions according to age and sex. United States, July 1962-June 1963

Age group	Percent with major limitation ¹		Total percent ¹	Number in thousands
	Men	Women		
Under 15.....	0.2	0.2	0.2	118
15 to 24.....	.4	.3	.3	87
25 to 44.....	1.1	.5	.8	346
45 to 64.....	4.5	1.4	2.9	1,064
65 to 74.....	16.8	4.9	10.3	1,140
75 plus.....	34.1	20.0	28.0	1,509

¹ Percent of total noninstitutional population.

The National Health Survey (fiscal year 1963) also listed the chronic conditions according to type. Again the following summary includes only those indicated as being unable to carry on major activity, and are population estimates. Their figures also include persons over 65 years of age, and are presented in Table 2.

TABLE 2.—The average number of persons reported as unable to carry on their major activity due to selected chronic conditions; United States, July 1961-June 1963 (National Health Survey)

Selected chronic conditions	Average number in thousands	Percent of total with activity limitations
Heart disease.....	1,004	24.4
Arthritis and rheumatism.....	697	16.9
Impairment of vision.....	535	13.0
Paralysis of extremity or trunk.....	434	10.5
Nervous or mental disorders.....	425	10.3
High blood pressure without heart involvement.....	225	5.5
Impairment of hearing.....	184	4.5
Asthma and hay fever.....	183	4.4
Orthopedic back condition.....	160	3.9
Diabetes mellitus.....	167	4.1
Malignant neoplasms.....	108	2.6
Ulcers (stomach duodenum).....	113	2.7
Hernia.....	118	2.9
Sinusitis and bronchitis.....	94	2.3
Tuberculosis (all forms).....	46	1.1
Benign and unspecific neoplasm.....	55	1.3

NOTE.—The percentage column does not total 100 percent because: (1) Not all conditions have been included, and (2) many people are limited by 2 or more conditions and are therefore included 2 or more times in the figures.

Not all the individuals represented in the above figures could profit from rehabilitation services, and undoubtedly many others who could are not accounted for in these tables.

HOW MANY PEOPLE IN THE UNITED STATES REQUIRE VOCATIONAL REHABILITATION?

In the United States today, there are an estimated 3,500,000 disabled persons who need, want, and would benefit from vocational rehabilitation services to enable them to work in the competitive labor market, in sheltered employment, or in their own homes (VRA, HEW, 1965).

Findings from an extensive, long-term study in Kansas City (1959), begun in 1954, and completed in 1959, tend to confirm the national estimates. However, the study further indicates that nearly half of their sample may require special employment in sheltered workshops, etc.

Each year 450,000 disabled persons enter the group who need vocational rehabilitation (VRA, HEW, 1965).

THE PRINCIPAL CAUSES OF DISABILITIES AMONG AMERICANS

Chronic disease accounts for 88 percent of all disabling conditions. (These include such diseases as

arteriosclerosis, the main cause of heart and brain damage; poliomyelitis; tuberculosis; mental illness; multiple sclerosis; Parkinson's disease; epilepsy; diabetes; cancer; cerebral palsy; arthritis; and various eye disorders.)

Occupational accidents account for 5 percent; *home, highway and all other accidents* account for another 5 percent; and *congenital conditions* account for the remaining 2 percent (National Health Education Committee, 1961).

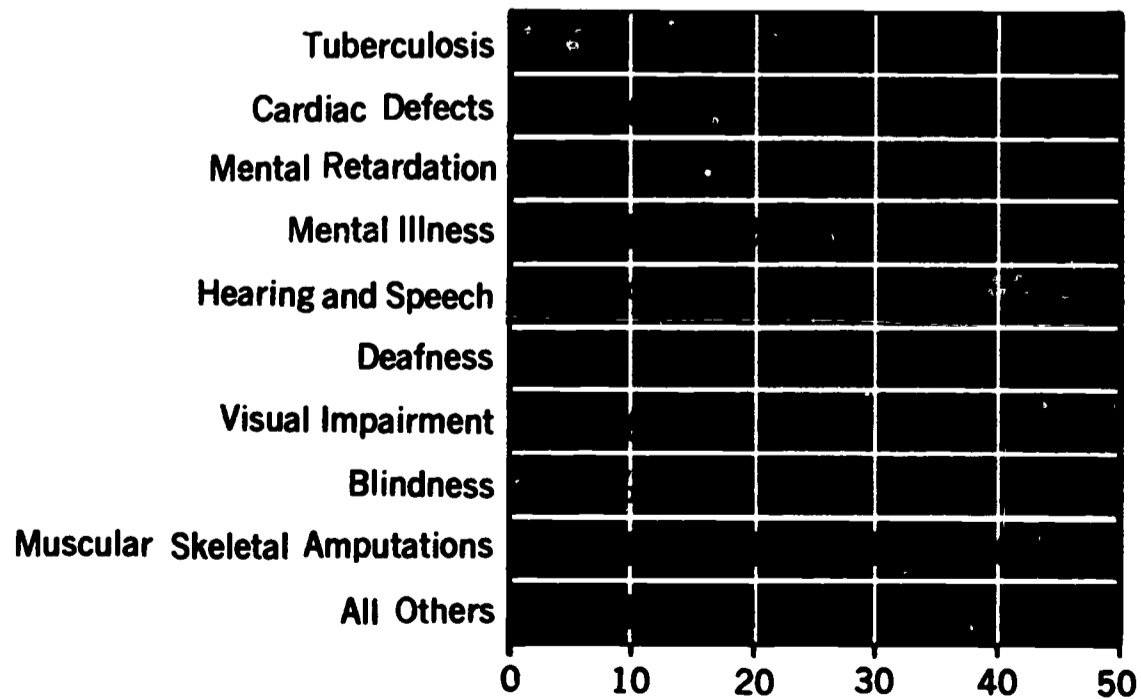
For the 155,000 people rehabilitated in 1966, Figure 3 below shows their main causes of disability. While the percentages listed are for particular conditions, it can be seen that the various chronic diseases still account for a substantial number of the disabling conditions.

HANDICAPPED FEMALES

"Disability is as prevalent, serious, and costly among women as it is among men. It can be catastrophic for women and their families, whether the women are homemakers or in the labor force proper, * * *" (Stubbs, 1960, p. 12).

Rehabilitation services are available through State agencies for women as well as for men. Nearly 11½ million females living outside of institutions have chronic conditions which limit their activity to some extent, according to the National Health Survey conducted for fiscal years 1962 and 1963. (The comparable number of men is nearly 11 million.) Of these, 1.4 million females (1.5 percent of the female

FIGURE 3.—Principal Causes of Disability Among 1966 Rehabilitants



non-institutional population) are unable to carry on their major activity which includes going to school, working, or keeping house.

Dr. Howard A. Rusk (Stubbs, 1960), Director of the Institute of Physical Medicine, New York University College of Medicine, estimates the number of physically handicapped women in and outside of institutions in the United States (exclusive of the blind and mentally ill) at some 10 million. Five major disability groups among these women are: Arthritis, 1,875,000; cardiovascular diseases, 4 million; active or arrested tuberculosis, 175,000; hemiplegia, 650,000; other orthopedic disabilities, 800,000.

About three in every 10 workers in the country's labor force are women. Of the total civilian labor force of more than 70 million persons, over 22 million are women. About 34 million women not in the labor force are occupied keeping house.

A highly significant development in the labor force has been the increase in employment of mothers; 7½ million women have children under 18 and about 30 percent of such mothers are in the labor force. These include nearly 3 million women with children under 6, or a little over 20 percent of such mothers.

More than 140,000 disabled women were rehabilitated from 1954 through 1959. This is about a third of the total number of persons rehabilitated during that period, roughly the same proportion as women in the Nation's labor force (Stubbs, 1960). However, the proportion of female rehabilitants is steadily rising. In the year 1966, 40 percent of the 155,000 persons rehabilitated were women. Following rehabilitation, some of the women chose to devote all their time to the care of their home and family, but the majority entered paid employment in a variety of occupations.

OLD AGE

The most obvious facts about the American population are its expanding proportion of aging and aged people and the resulting increase in chronic disease or disabilities.

Some 52 million people in the Nation are age 45 and over. Over 15½ million, or one-twelfth of the population, are 65 or more. It is estimated that by 1980 some 68,400,000 of our population will be age 45 or more and that 24,500,000 of these people will be 65 years of age and over (Rusk, 1961, p. 19).

National Health Survey estimates in fiscal years 1962 and 1963 indicated that 8.3 million people in this

country age 45 and over are limited in amount and kind of their major activities. The Vocational Rehabilitation Administration estimates that approximately 1.5 million of these older, long-term disabled people would be feasible for vocational rehabilitation services; i.e., they would need, could benefit from, and would want such services in order to return to work. These 1.5 million people have a chronic disease or physical or mental impairment that constitutes a substantial handicap to employment. Their disabilities are long-term rather than temporary in nature; yet their conditions are not so serious or of such nature that they could not be rehabilitated.

The VRA has increasingly become involved in the rehabilitation of persons over age 45. Figure 4 on page 16 shows that in 1965 the number of persons of 45 years or more rehabilitated into employment through the public program reached a total of 36,656, which is about five times that for 1945. In 1966, 41,484 persons 45 years or older were rehabilitated.

Without doubt, one of the major problems confronting the United States in the 1960's is providing rehabilitation services to the increasing number of our disabled citizens, particularly those in the older age group. According to some estimates, in 20 years every able-bodied worker in the United States will be matched with one disabled worker or one person over 65 if the current rate of disability and population increase continues. Unless there is a tremendous increase in the number of rehabilitation medicine specialists in that time, the Nation could be facing a serious medical and economic situation (LaRocca, 1960).

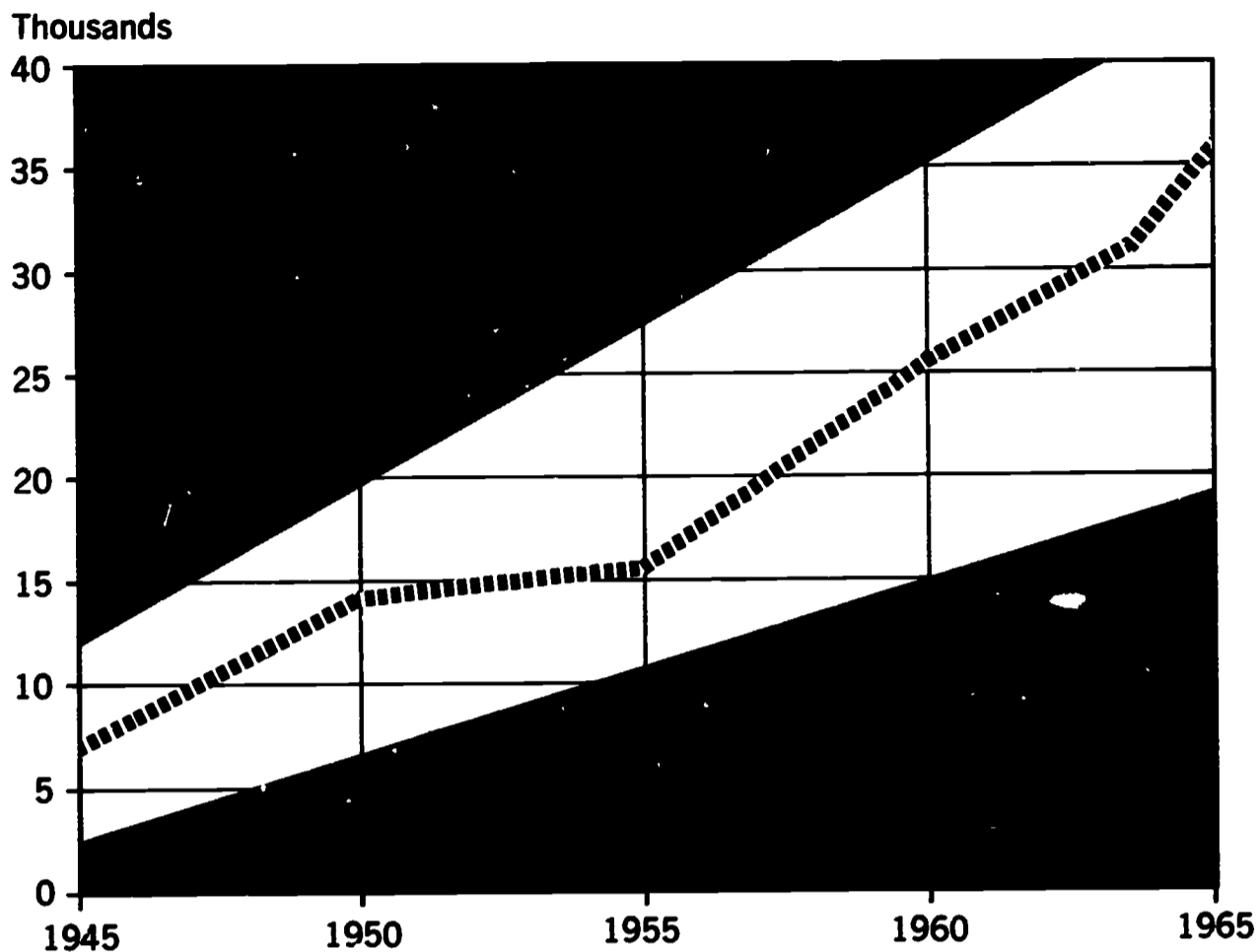
MENTAL ILLNESS AND MENTAL RETARDATION

The late President Kennedy's message to the Congress regarding mental illness and retardation on February 5, 1963, opened with a statement that gives a very comprehensive overview of the magnitude of this problem:

Mental illness and mental retardation are among our most critical health problems. They occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the afflicted, waste more of our human resources, and constitute more financial drain upon both the public Treasury, and the personal finances of the individual's families than any other single condition.

There are now about 800,000 such patients in this Nation's institutions—600,000 for mental illness and over 200,000 for mental retardation. Every year nearly 1,500,000 people receive

FIGURE 4.—Disabled Persons of Age 45 or More Rehabilitated 1945-65



treatment in institutions for the mentally ill and mentally retarded. Most of them are confined and compressed within an antiquated, vastly overcrowded chain of custodial State institutions. The average amount expended on their care is only \$4 a day—too little to do much good for the individual, but too much if measured in terms of efficient use of our mental health dollars. In some States the average is less than \$2 a day.

The total cost to the taxpayer is over \$2.4 billion a year in direct public outlays for services—about \$1.8 billion for mental illness and \$600 million for mental retardation.

Indirect public outlays, in welfare costs and in the waste of human resources, are even higher. But the anguish suffered both by those afflicted and by their families transcends financial statistics—particularly in view of the fact that both mental illness and mental retardation strike so often in childhood, leading in most cases to a lifetime of disablement for the patient and a lifetime of hardship for his family.

DISABILITY AS A SOCIAL PROBLEM

Disability is one of the important causes of dependency. It is not known how many disabled persons are self-supporting through living on savings, income from savings or investments, private or union pensions, private disability or other insurance payments, etc. Neither

is information available as to the number of disabled persons who are supported wholly or in part by their families, relatives, friends, or private, social charitable and religious agencies. The problem is apparent, however, in terms of public assistance. Estimates indicate that at the end of 1966 about 1.5 million persons under age 65 were receiving public assistance because of disability, including approximately 650,000 dependent children who were receiving aid due to the disablement of their fathers.

Disability reduces productivity and is a drain on the wealth of the community, the State, and the Nation as a whole. The effect of disability on the manpower resources of the Nation is, for the most part, concentrated in the 14- to 64-year-age group. It has been estimated that nearly 4 million disabled people of working age need vocational rehabilitation services if they are to become employable. Disability not only prevents people from working and receiving an income, thus contributing to the productivity and purchasing power of the community, but it requires taxes and voluntary contributions to carry on the programs needed to help maintain disabled persons who are in need.

The disabled individual frequently experiences a deterioration of his basic skills, and a loss of self-confidence, resulting in despondency. Unable to participate

in the normal life of the family and the community, he may become maladjusted because of a feeling of inequality, lack of prestige, and other concomitants of "not belonging." If there is a disabled individual in the family, it may well affect family life. Someone may have to give up working to care for the disabled individual. The social life of others in the family may have to be adjusted so there is someone in constant attendance. Frequently the disabled individual may have to leave home and go to an institution for long-term care, thus separating him from his family and breaking up the family unit. It is estimated that there are almost 1.2 million disabled persons in institutions for long-term care.

ECONOMIC CHANGE— IMPLICATIONS FOR REHABILITATION

Dr. Earl F. Cheit (1962), a research economist at the University of California, Berkeley, delivered a paper on this topic at the National Rehabilitation Association's 1961 convention. The relationship he points out between full employment and rehabilitation are most interesting. Dr. Cheit stated:

Persons interested in rehabilitation are keenly aware, I am sure, of the relationship of economic conditions to rehabilitation needs. That is: they move inversely. When the general level of employment prosperity falls, rehabilitation needs rise. Conversely, during periods of rising prosperity and employment, rehabilitation needs fall.

So strong is this relationship that it makes extremely difficult a truly warranted estimate of the total task which faces our rehabilitation resources. We have, of course, the estimates that each year some 250,000 new persons become disabled and face the need of vocational rehabilitation, that but one-third of these are in fact vocationally rehabilitated and placed each year, and that a backlog of perhaps 2 million cases exists.

If each of these persons were seeking employment, they would represent almost 40 percent of our present 5 million unemployed.

But the effect of the general level of employment on any such estimate is unsettling. Consider, for example, the results of a Heller Committee survey of permanently disabled workers in the San Francisco Bay area in 1942 and 1943. It found that wartime labor conditions left virtually no disabled workers unemployed and with earnings losses.

So our guiding aphorism is clear: The more we achieve full employment, the smaller our case backlog will be. Not only does a high level of employment open opportunities to workers to use existing or remaining skills, but it also increases significantly the productivity of money spent on vo-

ational rehabilitation. Everyone who has worked in this field has at one time or another been dismayed by what Dr. Elizabeth Austin has called "rehabilitation triumphs and social failures"—the successfully retrained individuals who cannot find employment.

I cannot overemphasize the importance of an influential organization such as this taking a strong legislative interest in the problems of achieving and maintaining full employment. And, in fact, this is an ideal time to do so, because for the first time in our history unemployment is being viewed as a training, retraining, and relocation problem. The rising rate of technological change and a continuing high level of unemployment have led the Labor Department to propose studies and programs of vocational retraining and relocation. With your background and experience in this area, you should be part of these studies and this planning.

I am urging that the rehabilitation problem must be seen in the labor market context. When we do this, however, and look at it carefully, we discover that my axiom (that prosperity and rehabilitation needs are inversely related) has been qualified. We all know from experience that while full employment is a necessary condition to solve the rehabilitation problem it is not a sufficient condition.

The Nation's work increasingly demands greater skill, and our medical abilities bring (in the words of one doctor) "the attainment of old age within the reach of every purse and every genetic disability." Both of these facts add to the rehabilitation problem and make placement more difficult. So does the rising rate of contest and litigation involving accident victims; so do some interpretations of workmen's compensation law.

In short, the problems, even if reduced during periods of full employment, will remain (p. 12).

THE PUBLIC COSTS OF DISABILITY

Programs to provide maintenance and medical care for disabled people through public assistance programs are now costing the public about \$780 million annually, plus a loss of productivity to the economy and a loss in taxes. Examples of such programs are indicated below.

- (a) Three programs authorized by the Congress provide estimated annual payments to recipients totaling:
- (1) About \$90 million annually for Aid to the Blind.
 - (2) About \$245 million annually for Aid to the Permanently and Totally Disabled.
 - (3) About \$240 million annually for Aid to Dependent Children in families where one or both of the parents is disabled and unable to support their children.

- (b) Payments to disabled persons through general assistance programs are estimated to be about \$206 million each year.
- (c) For service as well as non-service-connected disabilities, the Veterans Administration paid in 1959 in compensation benefits an estimated \$2,474 million to some 2,980,000 living veterans (National Health Education Committee, 1961).
- (d) Many of the disabled on public assistance rolls may *always* need some public aid for their support. Many others, however, may be enabled to return to productive work and financial independence through cooperative efforts of vocational rehabilitation and public assistance.

REHABILITATION DOES PAY

What the rehabilitation program means to the rehabilitated persons themselves in the enhancement of personal dignity through the ability to work is incalculable. But the program also has values readily measured in dollars and cents.

Over 70 percent of the almost 155,000 disabled persons rehabilitated into jobs in 1966 were unemployed when they began to receive services. The remainder had very low earnings, were about to lose employment because of disablement, or were on jobs that threatened to aggravate their disabling condition. The average weekly income of those in employment prior to receipt of services was less than \$8. Moreover, about 20,100 of those rehabilitated in 1966 were receiving public assistance at the beginning of or during their rehabilitation services, and about 9,100 resided in tax-supported institutions. Upon completion of rehabilitation services, these 155,000 disabled persons were in employment and earning an average of \$46.09 per week on jobs that were mostly entry level positions.

There is still another way of looking at the economic worth of rehabilitation of the disabled. On the basis of an exploratory cost benefits analysis, an estimate was made of the increase in lifetime earnings accruing to disabled persons as a result of vocational rehabilitation services per dollar expended on them during the rehabilitation process. Persons rehabilitated during 1966 will earn an additional \$35 for every dollar of Federal, State, and private funds spent on them.

ACHIEVEMENTS, TRENDS, AND GOALS IN THE REHABILITATION PROGRAM

The table below contains numbers of disabled persons rehabilitated in selected years:

1921	-----	523	1960	-----	88,275
1930	-----	4,605	1965	-----	134,859
1940	-----	11,890	1966	-----	154,279
1950	-----	59,597			

1962 was a banner year for rehabilitation; 100,000 disabled individuals were successfully rehabilitated. A longstanding goal was achieved and a new challenge was offered—200,000 rehabilitants in 1 year. Mary E. Switzer (1962), Commissioner of Vocational Rehabilitation, speaking of the new goal, stated: "Looking ahead to the day when 200,000 men and women will be made whole in 1 year and will be functioning members of our society * * * We know we can and will reach that 200,000 goal because we are halfway to it" (p. 12).

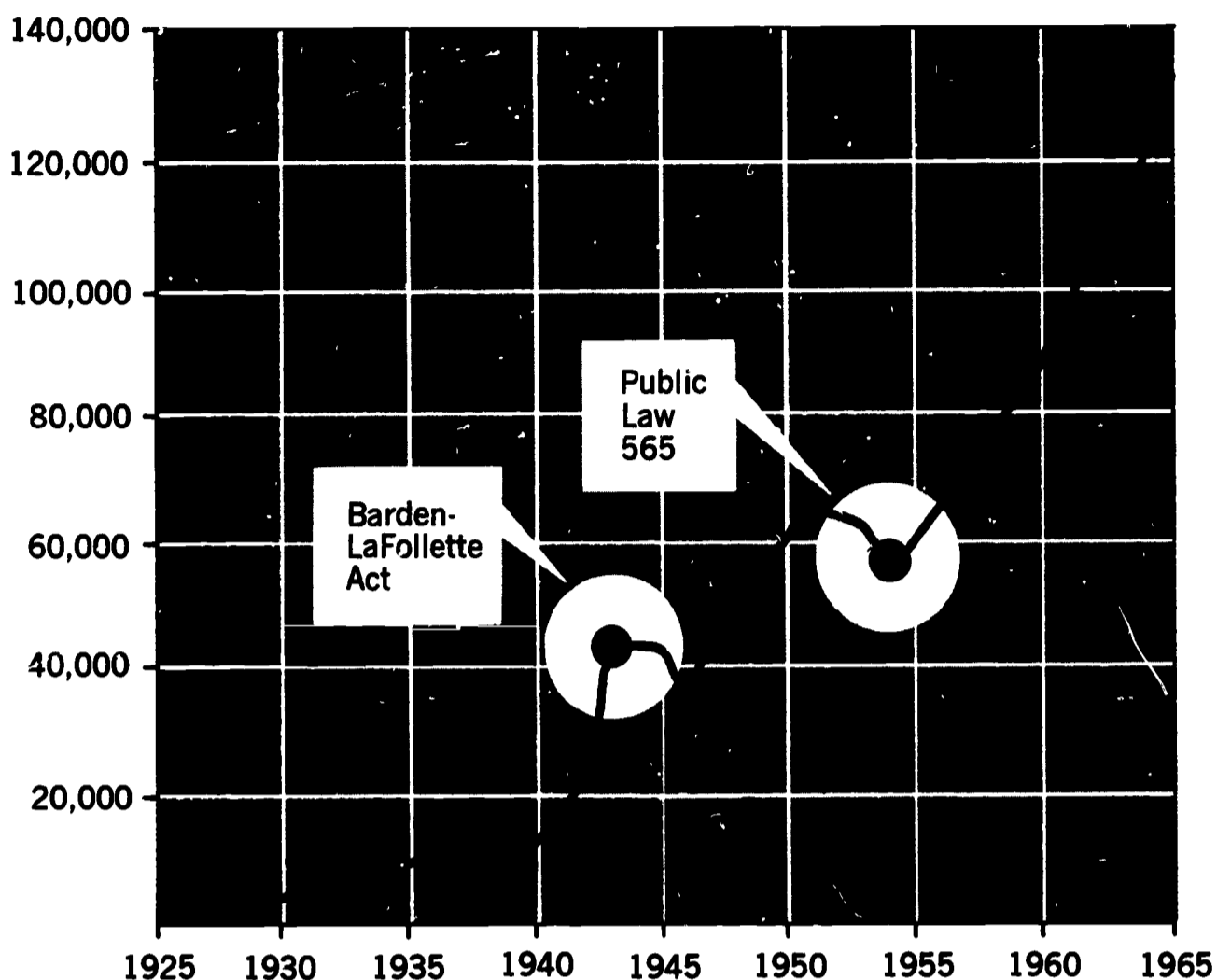
During the fiscal year that ended June 30, 1965, a total of 134,859 disabled persons was prepared for productive activity and placed in successful employment through the services provided to them by their State vocational rehabilitation agencies. It was a new high mark, 13 percent more than the previous year—and more than double the total of 1954. The total for the fiscal year 1966 was 154,279 which represents a 14-percent increase in 1 year. This marks the 11th consecutive year in which a substantial gain has been made. Preliminary estimates for the fiscal year of 1967 indicate that another significant increase will be achieved and that the goal of 200,000 appears attainable.

A new goal has already been set—the provision of rehabilitation services to all who need them by 1975. A program of statewide planning has been instituted in 52 of the 54 States and Territories to assess the specific meaning of this goal and to develop the resources with which to achieve it.

The past 10 years have been particularly fruitful in many areas that were opened through the legislation enacted in 1954. The States had new incentives to broaden the base of their rehabilitation activities, and the State-Federal partnership was so strengthened and revitalized that the annual totals of rehabilitations climbed swiftly. The 1966 total of almost 155,000 was a long step toward a goal of 200,000 annually.

The tremendous increase in the number of rehabilitants during recent years is indicated in Figure 5.

FIGURE 5.—Rehabilitations by Years



For an understanding of the public program's past decade of achievement and expansion, it will be necessary to go back to August 1954 for a review of the 1954 amendments then enacted.

Under these amendments, new responsibilities were placed upon the State rehabilitation agencies and the Vocational Rehabilitation Administration.

- To effect new fiscal relationships within the State-Federal partnership to give the public program a sounder base for broad action.
- To provide support for research and demonstration projects to find new ways to rehabilitate disabled persons for jobs.
- To establish and provide support for the training of professionals with skills in vocational rehabilitation to meet serious shortages in this kind of personnel.
- To evolve approaches to new concepts of the public program in its usefulness.

In the following 10 years, the results were:

The number of people rehabilitated annually increased from about 55,000 in 1954 to nearly 120,000 in 1964. Combined Federal and State expenditures on

services rose from \$34,411,124 to \$133,259,534 in that period.

The number of research and demonstration projects grew from 18 in 1955 to 795 in 1964, with Federal funds increasing from \$298,900 in the first appropriation to \$15,179,000 in 1964.

Training activities were expanded from the total of 77 teaching programs and 201 student traineeships that were supported in 1955 to encompass 447 teaching programs and 3,259 traineeships and research fellowships in 1964. The initial appropriation for training activities in 1954 was \$900,000. In 1964 the sum of \$16,528,000 was expended in the training program.

State agency staffs grew from about 2,700 in 1954 to more than 7,000 in 1964, along with greater selectivity and higher standards for the participating professions. Special emphasis was placed on rehabilitation of those with more severe forms of disability. Amendments to the Hill-Burton hospital construction legislation that were adopted in 1954 provided aid to scores of communities and organizations for construction of comprehensive rehabilitation centers, special centers for specific disabilities, clinics in connection with hospitals, and workshops of several kinds for various purposes;

scores of community and statewide facilities were built with the aid of funds available for States basic programs. New patterns of service were developed not only for the rehabilitation of those already disabled, but for the broader purpose of early detection and diagnosis of disabling conditions among those preparing for the world of work.

The Congress further amended the Vocational Rehabilitation Act in 1965 (Public Law 89-333). Among the changes made by these amendments are:

- Further broadening of the base of financial support.
- Clarification of the definition of disablement so as to assure the eligibility of many persons handicapped for employment.
- Adjustment of the rehabilitation process to provide for extensive study of the vocational potential of the severely disabled.
- Provision of special financial support for innovative effort, statewide planning, expansion grants, and construction and improvement of facilities and workshops. Under these changes, accelerated growth of the State-Federal program has been phenomenal.

Prevention of dependency through vocational rehabilitation measures—a target in the attack on poverty—has become a principal aim of the program. The movement toward that goal has become one of its strongest trends. It extends through accentuation of youth programs, through the great volume of services for those disabled persons in their prime working years, and through the mounting total of older persons in our population beset by chronic illness and infirmities.

THE PRODUCT OF REHABILITATION

Since its beginning, the vocational rehabilitation program has resulted in the rehabilitation of more than 2 million disabled persons. In the 1954-66 period, the total number of disabled persons rehabilitated was more than 1 million. With program growth and the application of new knowledge have come notable changes in the range of disabilities represented among those who have been successfully rehabilitated. State agencies have made great strides in extending rehabilitation services to major disability groups, sometimes in response to highly articulate public interest and sometimes in advance of such public interest. The last decade has seen mounting interest and applied effort devoted

to rehabilitation of the mentally ill, the mentally retarded, the deaf and hard of hearing, the aging, and those on varied forms of assistance. New lines of emphasis are emerging in relation to those disabled by heart diseases, cancer, stroke, epilepsy, alcoholism, narcotics addiction, the disabled youth of school age, and the public offender who is disabled (see Table 3).

TABLE 3.—Key facts and characteristics in relation to 1966's group of 155,000 persons rehabilitated

Age:	27 of every 100 were age 45 and over. 23 of every 100 were under age 20. 50 of every 100 were between age 20 and 44.
Sex:	40 of every 100 were women.
Education:	30 of every 100 had never been to high school. 7 of every 100 had at least 1 year of college level education.
Disability:	33 of every 100 had either an amputation or an impairment or deformity as the major disability. 14 of every 100 had a mental illness as the major disabling condition. 9 of every 100 were blind or otherwise visually handicapped, as the major disabling condition. 9 of every 100 had mental retardation as the major disabling condition. 7 of every 100 had a hearing or speech impairment as the major condition. 4 of every 100 had a cardiac defect as the major disabling condition.
Earnings at acceptance:	82 of every 100 had no earnings when accepted for services.
Dependents:	29 of every 100 had 1 to 3 dependents. 15 of every 100 had 4 or more dependents.
Referral source:	16 of every 100 were referred by hospitals and sanatoriums. 14 of every 100 were referred by physicians. 14 of every 100 were referred by educational institutions. 12 of every 100 were referred by public and private welfare agencies. 11 of every 100 were self-referred. 6 of every 100 were referred by the State employment services.
Major occupation following rehabilitation:	24 of every 100 went into skilled and semiskilled occupations. 21 of every 100 went into service occupations. 16 of every 100 went into homemaking and unpaid family work. 15 of every 100 went into sales and clerical occupations. 8 of every 100 went into professional and managerial occupations. 8 of every 100 went into unskilled occupations. 6 of every 100 went into agricultural occupations. 3 of every 100 went into sheltered workshops.

The portion of women among the disabled who are rehabilitated has risen to two-fifths of the total. The major portion of women who are rehabilitated go into paid employment in a variety of occupations, the remainder returning after rehabilitation to resume responsibilities for families and homes.

This decade also showed the program's potential for financial growth under the new system of financing provided in the 1954 amendments for the basic Federal-State program of rehabilitation. The problems inherent in the previous financing system had contributed substantially to slowing program growth and had made for serious fiscal problems for both the Federal and State agencies. The new financing provisions assured

the stability of State programs at the level each had attained in 1954 and then set in operation a new fiscal arrangement for allotting funds to States on a specific formula set in the law. The formula aimed at reflecting each State's need expressed by its population and its ability to pay as expressed in its per capita income.

The amendments of 1965 (Public Law 89-333) eliminated the formula for Federal participation and established a fixed ratio for all States. Provision was made for additional Federal grants to State agencies and private agencies. These arrangements still further increased the financial support available for the program.

The growth in Federal and State financial support of this program under the 1954 law is shown in Figure 6.

THE WORK IS NEVER DONE

In a statement regarding the 100,000 rehabilitants of 1962, Mary E. Switzer, the Commissioner of Vocational Rehabilitation, coined a fitting title for all reha-

bilitation efforts; i.e., "The Work Is Never Done." She concluded her statement by saying:

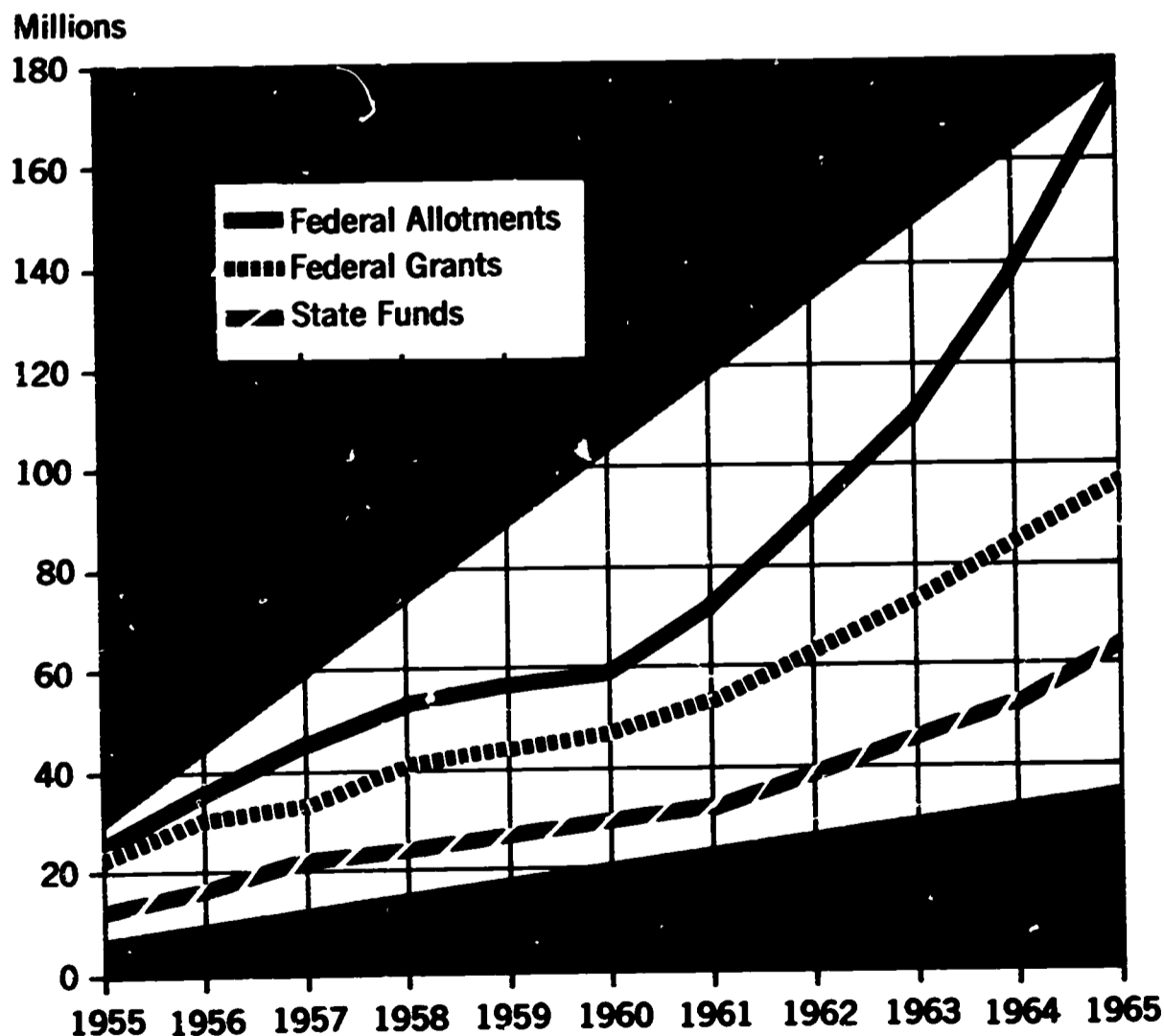
We who work in rehabilitation need new words to speak and more people to listen. For we want to give hope to every disabled person, perhaps not the promise of complete recovery, but for most far more than they or we can ever now suppose. But we must be joined in our "canter" to get the work done by people from other parts of the world, and remind ourselves once again that "No man is an island entire of himself, every man is a piece of the continent, a part of the main" (p. 15).

Then in 1964, Miss Switzer in a discussion titled "Rehabilitation a Decade Hence" stated:

In any 10-year forecast, one thing is certain: The long-time goal of rehabilitating 200,000 persons in a year through the Federal-State program will be achieved and surpassed. In fact, within 5 years we will reach this goal or be so close to it that the future of the vocational rehabilitation program—its aims, its contributions, and its role in the whole rehabilitation movement—will require our serious study. While population increases and other factors may require some upward adjustment in the goal of 200,000 the program growth will be so strong that the result will be about the same.

Once we are on a current basis—that is, when the number of disabled people being rehabilitated into employment each year by public and private agencies equals the number of new cases coming into the picture each year—we shall have

FIGURE 6.—Funds for State Rehabilitation Programs



to consult with many organizations and draw up a national plan which addresses itself to a backlog well in excess of 2 million disabled people who are capable of rehabilitation. This is in no sense an impossible task. It is both feasible and necessary. Much of the groundwork has been laid already (p. 22).

This statement clearly shows the real goal of re-

habilitation; i.e., the millions of disabled people who need, and are capable of vocational rehabilitation. Miss Switzer poses this as the challenge to all members of the rehabilitation team. The rehabilitation counselor can do much to answer this challenge by helping great numbers of disabled people to lead happy useful lives.

Section 3

LEGISLATION RELATED TO THE REHABILITATION PROGRAM

THE vocational rehabilitation program, one of the oldest grant-in-aid programs for providing services to individuals, had its start when President Wilson signed the Smith-Fess Act in 1920. However, the program was preceded by private programs established to provide services to disabled individuals. Some of the more notable events are listed below:

CHRONOLOGY OF LEGISLATION

1863: The Hospital for the Ruptured and Crippled opened in New York. The establishment of this hospital recognized the vocational needs of crippled children.

1893: The Boston Industrial School for Crippled and Deformed opened with vocational training as its major objective.

1897: Minnesota made the first direct State provision for medical care for crippled children.

1908: The Social Research Commission of the Russell Sage Foundation and the Bureau of the Handicapped of the New York City Charity Organization Society studied problems of the handicapped in New York. They decided that placement alone was not enough, and that specialized training and/or retraining was required.

1914: By this date many large school systems had become interested in problems of the handicapped and special school classes had been established in Baltimore, Chicago, Cleveland, Detroit, New York, and Philadelphia.

1914: The Massachusetts Industrial Accident Board sent its medical adviser, Dr. Francis D. Donoghue, to Germany to study and report on Germany's system of workmen's compensation. In 1916, Dr. Donoghue reported to the Third Annual Convention of the Inter-

national Association of Industrial Accident Boards and Commissions. He made three recommendations: First, that a system of rehabilitation be established; second, that financial relief during periods of readjustment be provided; third, that a program of accident prevention be initiated. The group met again the following year and adopted a resolution endorsing "every wise effort to rehabilitate those injured in industry and also those injured in military service."

By this time the Smith-Bankhead bill, which was designed to provide a system of vocational rehabilitation, was before Congress. The Association endorsed the bill and appointed a committee "For the purpose of furthering legislation along that line."

1916: The New York Federation of Associations for Crippled established a program which led to the establishment of the Red Cross Institute for Crippled and Disabled Men.

1917: The Smith-Hughes Act was passed. This act served as a "model" for future State-Federal legislation. It provided Federal moneys for vocational education to States which met certain requirements as listed in a State plan. Each State had to pass enabling or accepting legislation and establish a State board. Money was provided on a matching basis, and this law established procedures whereby Federal money was budgeted to the States, and handled through State offices, within the guidelines of a Federal plan.

November 1917: The Surgeon General submitted to the Secretary of War a memorandum which set forth a comprehensive plan for: (a) Physical restoration, and (b) vocational retraining for disabled soldiers.

December 1917: The United States had been at war for nearly a year, and the Federal Board for Vocational Education and the Red Cross Institute for Crippled and Disabled Men undertook studies to prepare services and facilities for wounded and disabled veterans.

June 1918: The Soldiers Rehabilitation Act was passed. The act gave exclusive control of retraining disabled veterans, after their discharge from the service, to the Federal Board for Vocational Education. The eligibility requirements were: "Any disabled veteran who was unable to carry on a gainful occupation, to resume his former occupations, or to enter upon some other occupation, or having resumed or entered upon such occupation was unable to continue the same successfully."

Introduction of the proposed Soldiers Rehabilitation Act in Congress resulted in debate regarding the inclusion of services to civilians. Those in favor of including civilians in the proposed act argued that the problem of the war disabled was insignificant compared to the number of industrially disabled, and that the sorely needed services of rehabilitation should be rendered to the disabled, both veterans and civilians. The opposition felt that the Federal Government should be involved in the rehabilitation of the war disabled, but that the States should bear some of the financial burden for rehabilitating civilians. They also argued that the problem of the war disabled was a large enough task to undertake without considering the problem of the disabled civilians and that consideration of a civilian program was not an appropriate war measure. The proponents' stand was eventually compromised to insure expeditious passage of the bill.

1918: Massachusetts became the first State to enact rehabilitation programs; in 1921 twenty-five States had entered the program; by 1924 three more States were added; by 1930 eight more; by 1940 seven more. However, more than 35 years elapsed before all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam were engaged in rehabilitation work.

1920: The Smith-Fess Act of 1920 (Civilian Vocational Rehabilitation Act). This act was inaugurated under a special act of Congress to provide a program of rehabilitation for disabled civilians. It was stimulated by the success of the Soldier Rehabilitation Act. The primary purpose of the act was to encourage States to undertake similar legislation and provide similar services for disabled civilians. The appropriations under this act were on a temporary basis and provided the following services:

(a) Allocation of funds to the States were to be made according to population, with expenditures authorized on a 50:50-matching basis.

(b) The funds were to be used to provide vocational guidance, training, occupation adjustment, prosthetics, and placement services only.

(c) The act provided a maximum Federal authorization per State.

(d) The authority for granting funds was enacted on a temporary and not a permanent basis. This basic act continued from 1920-24, when it was extended by Congress for 6 additional years.

1930: Public Law 317. Congress extended the Vocational Rehabilitation Act for 3 additional years. The Couzen's Amendment of Public Law 317 provided for grants to States prepared to match them, and withheld funds from States that were not in a position to match their population allotment with funds on a 50:50 basis. In 1932, further extension of 4 years was granted by Congress.

1935: The Federal Social Security Act did not amend the Vocational Rehabilitation Act. Rather, it authorized that certain appropriations be made in order to extend and strengthen the cooperative program of vocational rehabilitation and "to continue to carry out the provisions and purposes" of the National Rehabilitation Act of 1920, as amended. Congress was now authorized to support the vocational rehabilitation program as a continuous policy.

Prior to 1935, the program had existed through a series of short-term congressional extensions. In discussing this tenuous state of affairs, Mary MacDonald (1944) states:

A primary objective of those who were interested in legislation for vocational rehabilitation, and particularly the National Rehabilitation Association, was to secure an indefinite extension of the authorization of appropriations. While no authorization could be permanent, if a future Congress chose otherwise, an indefinite extension would require action by Congress to discontinue it. With the short-term extensions, those who sought continuance of Federal grants had to organize legislative campaigns every few years (pp. 76-77).

But in 1935, these previous legislative campaigns bore fruit since the Social Security Act, which was designed to provide "economic security to individuals", also provided an indefinite extension of the vocational rehabilitation program. The passage of this act clearly demonstrated that the consensus of congressional thought was that vocational rehabilitation should be a permanent program in the United States.

1936: The Randolph-Sheppard Act authorized the States to license qualified blind persons to operate vending stands in Federal buildings or federally sponsored buildings. This legislation opened the way for preferential employment opportunities for handicapped persons.

1939: Amendments to the Social Security Act again increased authorization and appropriations. These amendments increased the Federal allocation from \$1,-

988,000 in 1936, 1937, and 1938, to total of \$3,500,000 in 1939. This was the largest financial increase since the beginning of the program.

LEGISLATIVE DEVELOPMENTS SINCE 1943

The entry of the United States into World War II caused a manpower shortage which gave rehabilitated clients the opportunity to prove to the Nation that a disabled individual can be a productive capable worker. The general public began to perceive disabled individuals in a new light and called for rehabilitated workers who could utilize their abilities in competitive employment.

Unfortunately, the vocational rehabilitation program was not then prepared to meet the Nation's demands. For more than 20 years, the program had been limited in its scope and uncertainly financed. It had been characterized by separate States movements and uneven development on a national scale. Many of these problems were either entirely eliminated, or else were largely reduced, by the passage of three major laws.

Public Laws 78-113, 83-565, and 89-333 are the three laws which were instrumental in bringing the rehabilitation movement to its present place as a meaningful and effective program. Because they are so important to vocational rehabilitation, these three laws will be discussed in detail.

The Vocational Rehabilitation Act Amendments of 1943, Public Law 113, 78th Congress

When it became law on July 6, 1943, Public Law 78-113 superseded the act of 1920 (as amended up through 1942) and authorized major amendments to broaden the vocational rehabilitation program. It provided much more liberal financing, vastly increased the amount of State services to the disabled, and significantly broadened the concept of rehabilitation.

For the first time, services were extended to the mentally handicapped and to the mentally ill. Under this law, the separate State agencies established to serve the blind first came into the Federal-State rehabilitation program. It was also under this law that the 48 States, Alaska, Hawaii, and Puerto Rico were all placed on the same footing with respect to Federal grants.

The main provisions of the 1943 amendments were:

1. *Financing Provisions.*—Payments by the Federal Government to States with approved plans for vocational rehabilitation were authorized for: (1) The entire expense for vocational rehabilitation of the war disabled; (2) half the expense for vocational rehabilitation of other disabled persons, with the State paying the remaining half; and (3) the entire expense of administration, including guidance and placement services. Up to this time, the costs of the program had been shared equally by the State and the Federal Government, but now the latter began to accept more of the costs.

2. *New Definition.*—The 1920 act had limited the meaning of "person disabled" to a person with a physical defect or infirmity. The 1943 law defined "vocational rehabilitation services" as "any services necessary to render a disabled individual fit to engage in a remunerative occupation." By deleting "physical", the new definition made the mentally ill and the mentally handicapped eligible for services for the first time.

3. *State Services.*—Previously, services had been limited by administrative interpretation since the old law had not listed services. Now, Federal funds were authorized for one-half of the expenditures necessary for certain specified rehabilitation services to those individuals who were found to be financially unable to meet the costs involved, provided that they were not eligible for any similar benefit by way of pension, compensation, or insurance. For the first time, medical, surgical, and other physical restoration services were provided.

Under this act, money could be spent only for a specific list of services. These services included: (1) Corrective surgery or therapeutic treatment necessary to correct or substantially modify within a reasonable length of time a static physical condition which constitutes a substantial handicap to employment; (2) all hospitalization, for up to 90 days, which is necessarily connected with the above surgery or treatment; (3) transportation, occupational licenses, and customary occupational tools and equipment; (4) such prosthetic devices as are essential to obtaining or retaining employment; (5) maintenance during training, including the cost of any necessary books and other training materials.

4. *Change in Federal Administration.*—Administration of all grants was transferred from the Commissioner of Education to the Federal Security Administrator. The Administrator was authorized to make all the rules and regulations governing the administration of this act, but could delegate to any U.S.

officer or employee such of his powers and duties as were necessary to carry out the purposes of Public Law 78-113.

Exercising his authority to delegate powers and duties, the Federal Security Administrator established the Office of Vocational Rehabilitation on September 8, 1943. This Federal office established eight regional offices and also organized State and National Advisory Rehabilitation Councils, plus organizing Professional Advisory Committees, all in an effort to insure better program planning in each State.

5. *State Plans.*—In order to qualify for Federal aid, each State was required to submit a State plan for vocational rehabilitation and have it approved by the Federal Security Administrator. Public Law 78-113 lists 10 conditions which must be met before a State plan can be approved.

The first condition required that the State Board of Vocational Education be designated as the sole agency for the administration, supervision, and control of the State plan. However, this first provision made an important exception in that it authorized the vocational rehabilitation programs for the blind to continue with their own administration and still be eligible for Federal support. For the first time, the separate State agencies serving the blind entered the Federal-State program.

6. *Facilities and Services for State Boards.*—In order to facilitate the operation of State plans, the Federal Security Administrator was authorized to furnish on a cost basis special facilities and services as needed by two or more State boards. He was also authorized to establish facilities, with the provision that the costs of establishing such facilities and of furnishing such services were to be considered as expenditures under their State plans. These expenditures were to be paid by deducting an amount equal to such costs from the planned Federal payments to these States.

The effect of this provision was to permit two or more States to jointly request aid in establishing the rehabilitation facilities which they needed. It was first authorized under Public Law 78-113 and was especially intended to help the smaller States.

The Vocational Rehabilitation Act Amendments of 1954, Public Law 565, 83rd Congress

By the early 1950's, the vocational rehabilitation program had unmistakably begun to plateau in its growth. Program growth was being held back in part by the

financing system then in use and in part by the lack of provisions for capitalizing on research, professional training, and other features which brought progress in other fields such as health and science.

On August 3, 1954, when President Eisenhower signed Public Law 83-565, a new era in the vocational rehabilitation of handicapped men and women was initiated. Designed to improve and expand the Nation's resources for restoring disabled persons to productive employment, the law was passed unanimously by both Houses of Congress. It was the first legislation since the Barden-LaFollette Act of 1943 to effect major changes in the State-Federal vocational rehabilitation program.

Retaining the basic patterns of services for disabled persons, the 1954 revisions added sweeping changes in financing provisions, professional training, and in expansion of service resources. This new law provided the base for a major forward move which aimed at bringing the number rehabilitated annually more nearly into line with the number of people who are in need of rehabilitation. In fact, the 1954 amendments included modernized provisions, such as authority for research, demonstration, and training activities, which were added to other Federal grants-in-aid statutes throughout the decade following its passage.

The main changes made by the 1954 amendments were:

1. *Financing Provisions.*—The State's share under this act was determined by a formula which took into account the individual State's population and its per capita income. The object was to give greater financial support to States with relatively large populations and relatively small per capita income, calling for these States to pay smaller portions of the total cost of the State vocational rehabilitation program than other States with larger financial incomes. The Federal share varied from 50 to 70 percent, with the national average being about three Federal dollars to two State dollars invested in vocational rehabilitation.

2. *Extension and Improvement Project Grants to States.*—A new system of project grants to State agencies provided Federal financial support at more favorable rates to induce States: (a) To develop new aspects of their programs (improvement grants), and (b) to extend their services (extension grants) to disability groups and geographical areas previously reached inadequately or not at all. Extension and improvement grants provided up to \$3 of Federal funds for each dollar invested by the State, and continued up to a maximum of 3 years for each project.

3. *Research and Demonstration.*—For the first time,

grants of Federal funds were authorized to encourage and support research into better rehabilitation and to conduct demonstration projects to spread the application of new knowledge to communities across the country. These grants are made to public and private nonprofit organizations such as State rehabilitation agencies, voluntary groups, universities, and rehabilitation facilities.

4. *Training*.—Grants to support the training of more professional personnel for rehabilitation services include: (1) Long-term training grants to educational institutions and rehabilitation agencies for support of basic or advanced professional training, which are awarded in the form of teaching grants, or traineeship grants for students selected by the educational institution, or a combination of these two; (2) short-term grants for training less than a semester in duration; e.g., institutes, workshops, seminars, and other training courses; (3) inservice training grants to State vocational rehabilitation agencies for staff development programs; and (4) rehabilitation research fellowships.

5. *Randolph-Sheppard Vending Stand Program for the Blind*.—The 1954 amendments included features to strengthen the provisions for giving preference to blind persons in the operation of vending stands on Federal and other property.

6. *Rehabilitation Facilities, Centers, and Workshops*.—The new law also authorized for the first time the use of Federal grants-to-States funds for establishment (alteration or expansion) of rehabilitation facilities and workshops.

The Vocational Rehabilitation Act Amendments of 1965, Public Law 333, 89th Congress

The legislation passed November 8, 1965, typifies the people-oriented character of the rehabilitation movement. Although not yet fully implemented, the provisions of the new law are clearly intended to bring the public and voluntary agencies into a closer working alliance so as to produce the very best of services for each disabled individual.

Through a broadened legal and financial base, the Federal-State program is expected to reach increased numbers of disabled people. Services to the severely disabled, the mentally retarded, the blind, the deaf, etc. have been increased and provisions have been made to promote the removal and prevention of architectural barriers to the handicapped. Federal financial support has been extended to local areas so that more voca-

tional rehabilitation programs can be funded. This will especially help the high population and multiproblem urban areas.

These new provisions call for a direct drive to build more rehabilitation facilities and workshops. Funds have been allocated for a multifaceted, comprehensive program to improve and strengthen the workshops of the Nation. Funds have also been allocated for another program which is primarily directed to the construction of vocationally oriented rehabilitation facilities.

Some of the main provisions of the 1965 amendments are:

1. *Financing Provisions*.—The allocation of Federal appropriations to States continues to be made on the basis of the population and per capita income formula that was established by the 1954 amendments. However, the amounts of Federal funds available to State agencies has been increased by establishment of a uniform matching ratio for all States. For fiscal years 1967 and 1968, a State will have its funds matched at a rate of three Federal dollars for each State dollar available. No State may receive more than its allocation under the formula and no State may reduce its State appropriation because of the additional Federal money available.

By a new provision, the "statewideness" requirements of the Federal law may be waived to encourage local jurisdictions (counties and cities) to make local funds available for increasing vocational rehabilitation services to their disabled citizens. When made a part of the State agency and its program, local funds can be matched with Federal funds at the same rate that other State funds are matched.

2. *Determining Employability*.—Under previous law, State rehabilitation agencies were expected to predict whether a handicapped person could become employable as a result of rehabilitation services. Many handicapped persons did not receive services because it was impossible to determine their employment potential.

Now a handicapped person can be provided services up to a maximum of 6 months (and 18 months for mentally retarded and others designated by the Secretary of Health, Education, and Welfare) to evaluate his employment potential.

3. *Economic Need Eliminated*.—Prior to the enactment of these amendments, certain rehabilitation services could be provided without regard to the individual's ability to pay for them and certain other services could be provided without cost to the individual only when he was unable to purchase them for himself. The new law eliminated economic need as a prerequisite

for any vocational rehabilitation service, but allows each State to apply such economic need tests for other than diagnostic and related services, counseling, and placement.

4. *Innovation Project Grants.*—Special grants may be made to States for two general purposes:

- (1) The development of methods or techniques for providing services which are new in that State.
- (2) Projects to serve those who have catastrophic or particularly severe disabilities.

In any State that applies for and receives such a grant, Federal funds provide 90 percent the first 3 years and 75 percent the remaining 2 years of each 5-year grant. This provision replaces the former program of extension and improvement grants to States.

5. *Construction of Centers and Workshops.*—For the first time, Federal funds are authorized to help construct new rehabilitation centers and workshops. The Federal share varies from 33 $\frac{1}{3}$ percent to 66 $\frac{2}{3}$ percent and also provides for assistance in initial staffing and for constructing residential accommodations in connection with workshops for mentally retarded individuals.

6. *Workshop Improvement.*—In addition to providing partial support for the establishment of new rehabilitation centers, these amendments made several provisions for assisting with the improvement of existing workshops for the handicapped. The assistance available for this purpose includes:

- (1) Training services projects to help support proposals to provide more and better job training for handicapped persons in workshops and rehabilitation facilities.
- (2) Workshop improvement grants to make workshops more efficient.
- (3) Technical assistance is provided without charge to workshops. Experts from many different fields are made available for short periods of time to advise and help on specific problems.
- (4) A National Policy and Performance Council is established to develop policies and criteria to guide the Secretary of HEW and the Vocational Rehabilitation Administration in carrying out the various programs designed to improve and expand rehabilitation facilities.

7. *Statewide Planning.*—Each State is encouraged to enter into planning activities designed to identify the State resources for rehabilitating the disabled and develop a pattern of foreseeable needs, to help assure orderly growth and development of program, and to arrive at an organized statewide plan for providing

rehabilitation services to all disabled persons who need them.

8. *Expansion Grants.*—Federal grants are available for paying part of the cost of programs by both State agencies and voluntary nonprofit agencies to expand vocational rehabilitation services where needed. The objective must be the rehabilitation and return to gainful employment of larger numbers of disabled individuals.

9. *National Commission on Architectural Barriers.*—A National Commission on Architectural Barriers to rehabilitation of the handicapped is created by this act. It is to function for 3 years and develop proposals for making buildings more accessible to and more usable by seriously handicapped persons.

10. *Professional Training.*—An individual may now receive assistance for professional training in the field of vocational rehabilitation to a maximum of 4 years, rather than 2 years as under the previous law.

11. *Research and Information.*—Earlier law established a program of research in the field of rehabilitation through the medium of a system of grants to appropriate organizations and institutions. This new law authorized a program of intramural research within the Vocational Rehabilitation Administration.

To make the information developed by the programs of research and demonstration more available to field operations and further research, a national data system is authorized by this act.

CURRENT STATUS OF REHABILITATION ADMINISTRATION AND MAJOR SUPPORTIVE PROGRAMS

Although this section of the manual is devoted to legislation, a survey of vocational rehabilitation administration, of selected programs necessary to the vocational rehabilitation movement is included at this point since both were created by legislation. They also help explain the legislation just discussed since they illustrate its direct results. A further reason for their overview here is the influence they exert on shaping the legislation of the future.

Administration

The Federal-State program is carried out through an organizational scheme which has been carefully worked out and which is demonstrably effective. The

separate responsibilities and functions of the program are described below, first as they relate to the Federal organization and then as they relate to the States organization.

1. *Organization and Functions of the Vocational Rehabilitation Administration.*¹—The Vocational Rehabilitation Administration is the focal point in the Department of Health, Education, and Welfare for programs to foster the vocational rehabilitation of disabled persons and their greater utilization in suitable, gainful employment.

In broad perspective, the overall objective is to provide the leadership and the means for furnishing vocational rehabilitation services to all the disabled who need and can be expected to benefit from them. Within this objective, these are the five main objectives of the Vocational Rehabilitation Administration:

- (1) To build State vocational rehabilitation agency programs of services for the disabled.
- (2) To increase rehabilitation knowledge and techniques and their application to practice.
- (3) To increase the Nation's supply of trained rehabilitation manpower which will continue to be in severe shortage.
- (4) To increase and improve the physical plants for serving the disabled, including rehabilitation facilities and workshops, training settings, specialized clinics, and other special facilities.
- (5) To educate the general public and specific publics—like employers, researchers, public and voluntary agencies—about vocational rehabilitation of the disabled and to disseminate available rehabilitation knowledge.

The Vocational Rehabilitation Administration also maintains continuing liaison with numerous other agencies of the Federal Government, including the Department of Labor in connection with the selective placement activities of the employment service and

¹ In August 1967, after the manuscript for this publication was prepared, a major realignment of Federal welfare, rehabilitation, and social service programs was announced. A new agency, the Social and Rehabilitation Service, was established to carry out the functions of the Welfare Administration, the Vocational Rehabilitation Administration, the Administration on Aging, and the Mental Retardation Division of the Bureau of Health Services in the Public Health Service. The Social and Rehabilitation Service is composed of five major divisions: The Rehabilitation Services Administration, the Children's Bureau, the Administration on Aging, the Medical Services Administration, and the Assistance Payments Administration. The goal of the realignment is a stronger emphasis on rehabilitation in the social and welfare programs of the Department of Health, Education, and Welfare.

the manpower development and training program; with the President's Committee on the Employment of the Handicapped; with the Office of Economic Opportunity; and with the various other agencies in the Department of Health, Education, and Welfare, with regard to all activities involving the disabled and their vocational rehabilitation, such as special education, vocational education, health, welfare, and social insurance.

The Vocational Rehabilitation Administration staff of some 325 persons in the central office and in the nine regional offices includes experts in the various areas of rehabilitation and program management, such as State program services; research, demonstrations, and training; international research and training; management services, including statistics, reports, and budgeting; legislation and public affairs; and regional operations. With this comparatively small staff, under the direction of Mary E. Switzer as Commissioner for Vocational Rehabilitation, VRA carries a leadership role in relation to the Nation's Federal-State rehabilitation program as well as the voluntary rehabilitation efforts so closely allied with the public efforts.

2. *Organization and Functions of the State Vocational Rehabilitation Agencies.*—In the Federal-State program, services are provided to the disabled through 91 State vocational rehabilitation agencies in the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam. Along with the 54 general agencies in each of these jurisdictions serving all the disabled, 37 States have separate agencies serving exclusively the blind. These State agencies maintain some 1,000 State, district, and local offices over the country. They employ about 12,000 staff, of whom 4,000 are rehabilitation counselors and 1,500 are engaged in disability determinations for the Old-Age, Survivors, and Disability Insurance program.

In most States, the vocational rehabilitation agency is organizationally associated with the State education agency, although there are some vocational rehabilitation programs organized as separate commissions or departments. In the majority of States, vocational rehabilitation agencies for the blind are located as part of the welfare agency.

As already noted, the key staff person who deals directly and continuously with the disabled person is the rehabilitation counselor. From the initial interview—and on through the steps needed to gain a full picture of the person's aptitudes, interests, problems, physical and mental state, through placement and followup in the first weeks of employment to check on success on the job and help with any difficulties or

needed adjustments—the counselor guides the individual through the various stages to successful rehabilitation. This is an individualized process with a single person, the rehabilitation counselor, to whom the individual looks, while he is receiving many different services from a number of sources; e.g., private physicians, hospital or clinic staff, prosthetists, psychologists, social workers, and schoolteachers.

Research and Demonstration and Training Programs

The Vocational Rehabilitation Administration has established several programs to solve particular rehabilitation problems. For example, the program of research and demonstration was started by the 1954 legislation and now has sponsored more than 1,000 projects. Similarly, the program of training workers for rehabilitation has resulted in increased professionally trained workers for every year since it began. Both of these programs are discussed in detail below.

1. *Research and Demonstration.*—The VRA grant program to encourage research investigations and demonstration projects was first authorized by the 1954 legislation. In universities, hospitals, rehabilitation centers, scientific institutes, State agencies, and other qualified public or private nonprofit agencies, these project grants support needed research and provide test demonstrations of new procedures. The increasing importance of the research and demonstration program is illustrated by the new grants and mounting financial support which it received from 1955–66. This growth picture is indicated in Table 4.

TABLE 4.—VRA research and demonstration grant program: New grants and funding by years: 1955–66

Year	Number of new grants	Funds obligated, net
1955.....	18	\$298,000
1956.....	20	1,180,700
1957.....	48	1,999,000
1958.....	81	3,599,600
1959.....	67	4,599,700
1960.....	101	6,389,500
1961.....	116	8,112,500
1962.....	90	9,441,600
1963.....	91	10,493,500
1964.....	154	15,179,100
1965.....	148	17,060,000
1966.....	153	20,568,000
Total.....	1,096	98,980,100

The next few pages of discussion separate the two phases of this program and focus initially on its research phase and then on its demonstration phase.

Since its authorization in 1954, the program of vocational rehabilitation research has proved its worth over and over again. It has come up with new knowledge about the nature of disability and has developed new techniques for controlling and reducing the impact of disability. These research efforts continually provide new procedures which successfully help numbers of previously neglected disabled persons.

Research and special training centers were established 5 years ago in selected universities at strategic places of the United States. These centers bring together the most able researchers, teachers, and practitioners so that they can share their knowledge, and function as a unit. This unique combination of clinical resources, State rehabilitation program resources, and research and training talents result in rapid research breakthroughs.

To advance the rehabilitation of the disabled, VRA now supports 18 of these special research and training centers. Eleven are medically oriented, three are vocationally oriented, three deal with mental retardation, and one with deafness. In the medically oriented centers, which were the first to get underway, many patients each year get better, more comprehensive rehabilitation at an earlier stage of their disability. All 18 centers have shown the values of drawing together the top specialists from a variety of disciplines to work coordinately on common problems affecting the disabled.

In 1961, a program of international rehabilitation research was started. The aim is to share the combined experience and ideas of rehabilitation experts from many nations. In 1966, after a modest beginning, more than 100 projects in eight countries had been financed with U.S.-owned foreign currencies, which result from our sale of agricultural surpluses abroad, and are excess to our Government's regular requirements. Related to this is another program which provides for interchange of rehabilitation experts between this country and other nations.

The Vocational Rehabilitation Administration is currently trying to expand the storehouse of rehabilitation knowledge by utilizing recent advances in science and technology. For example, in the field of sensory aids for the blind, the deaf, and the hard of hearing, research grants given to leading scientific and technical universities provide the funds for merging the professions of engineering, medicine, speech science, and psychology in an effort to develop new sensory aids. Similarly, plans are being made with the National Aeronautics and Space Administration to search the new inventions coming from the space research and

development programs in order to find devices or ideas which could be adapted to the needs of the blind, the deaf, and for those with speech or hearing impairments. VRA funds also support the current collaboration of General Electric and the Woodrow Wilson Rehabilitation Center Foundation to review General Electric's fund of technology from industrial, military, and space research in an attempt to develop and improve orthotic and prosthetic appliances and equipment so that they can be used in medical rehabilitation.

The other phase of this program is the phase of demonstration. As a companion to the research investigations, the demonstration project serves to translate new findings into rehabilitation practice. It has proved to be an important channel for both testing the effectiveness of new or improved procedures and for widely disseminating successful new methods via published project reports.

In such disability groups as mental retardation, cerebral palsy, epilepsy, mental and personality disorders, blindness and visual handicaps, disabled public assistance recipients, older disabled workers, chronically ill, the homebound, and many others, over 100 demonstration projects have been conducted for each group. Whenever a demonstration project turned out particularly well and seemed suitable for widespread use, a prototype was tried out in a group of States. After an initial period with VRA grant support, the demonstration is usually taken over by a local community or agency which then provides full sponsorship and support to convert the demonstration project into a permanent part of its own services.

The newest legislation, Public Law 89-333, has extended the present program of research and demonstration. The 1965 legislation, authorizes the Vocational Rehabilitation Administration to directly undertake those research and developmental activities which it can carry out more expeditiously by its own efforts rather than by grants to outside personnel. This addition to the 11-year-old program of research and demonstration continues the practice of awarding grants to universities, hospitals, rehabilitation agencies, etc. while initiating a new program of intramural VRA research activities.

Public Law 89-333 provides a further aid to researchers by authorizing a national data system in rehabilitation. Computers will be developed to store, analyze, retrieve, and disseminate the variety of scientific, industrial, and other data, which are needed by rehabilitation workers. This is to be established as a national service, available to rehabilitation agencies

and institutions, scientific and professional organizations, and other elements of the total rehabilitation effort in the United States.

2. *Training.*—In 1954, no plan for expanding rehabilitation services was realistic unless it took into account the serious shortages of professional personnel required to render these services. Both public and voluntary programs were limited in their expansion because of the difficulty in recruiting qualified personnel. Public Law 83-565 recognized this need and authorized a training program to provide funds for short-term specialized courses and long-term degree training. As a result of this training program, every year since it started in 1955 has marked an increase in the supply of rehabilitation specialists.

Currently, long-term training grants are made for support of educational programs on an academic or calendar year basis in the fields of rehabilitation counseling, medicine, dentistry, nursing, occupational therapy, physical therapy, prosthetic-orthotic education, psychology, recreation for the ill and disabled, social work, sociology, speech pathology and audiology, and rehabilitation facilities administration. Grants are also made for programs of a specialized nature in rehabilitation of the deaf, blind, mentally ill, mentally retarded, the public offender, and for interdisciplinary training in rehabilitation. These training grants have enabled schools to employ additional faculty and clinic supervisors. Schools have changed their curriculums in order to incorporate more rehabilitation content. As a result, there is now more information being disseminated about the nature and effects of disability and about rehabilitation techniques and services than ever before.

In terms of program objectives, the broad, long-range goal of the training program is to produce qualified personnel in sufficient numbers to staff the rehabilitation programs of the Nation, both governmental and voluntary, in the areas of service, research, and training in institutions of higher education. To accomplish the objectives of the training program, different types of support are provided. Grants are made for instructional costs of rehabilitation training projects, traineeships to students and inservice training programs of State vocational rehabilitation agencies. Funds are made available for support of instructional costs and traineeships in short-term training courses. Research fellowships are awarded directly to individuals for independent research in rehabilitation or advanced training in research.

The growth and scope of the training program is best reflected in the statistics of its budget and in the

numbers of teaching projects, traineeships, and research fellowships receiving support. The training program began in 1954 with an initial appropriation of \$900,000. Each year has seen an increase and in fiscal year 1966, with an appropriation of \$24,800,000, 451 teaching projects receiving support and grants were made for 4,546 traineeships and research fellowships. In addition, support was provided for short-term continuing education courses which reached about 8,500 individuals.

The effectiveness of this program can best be seen by the increased manpower it has produced in all fields of rehabilitation. In the field of medicine, special emphasis is placed upon training in physiatry; i.e., residency training in physical medicine and rehabilitation. The number of physiatrists passing the physical medicine and rehabilitation specialty board examinations has increased from 18 in 1954 to 33 in 1963 and will increase even more when the 139 physicians awarded VRA traineeships in 1964 complete their physiatry residency. Besides this direct increase in physiatrists, the VRA has provided basic rehabilitation orientation to undergraduate medical students in 70 of the 90 U.S. medical schools. Altogether, about 23,000 medical students are learning some of the fundamental concepts of rehabilitation and are acquiring a working knowledge of the total rehabilitation process. In an effort to fully cover the spectrum of rehabilitation medicine, the VRA has established an academic careers program for physicians. This program offers grants to promising physicians for advanced study in rehabilitation topics so that they might readily qualify for academic posts as instructors in physical medicine and rehabilitation.

Rehabilitation counseling provides one of the most dramatic illustrations of the effectiveness of the training grant program. In 1954, only 12 rehabilitation counselors were completing their graduate work. But in 1964, just 10 years later, about 360 rehabilitation counselors were graduating from the 2-year master's degree course and were ready for employment. By 1966, about 3,250 individuals had graduated from VRA-supported rehabilitation counselor training programs; about 2,892 of these individuals received VRA traineeships and about 367 students completed training without VRA assistance. In 1966, 41 programs were in actual operation with graduate students and 16 were in various stages of curriculum planning and recruitment of students. In addition, training programs for counselors in psychiatric rehabilitation had been established in four universities. Six post-entry programs for newly employed rehabilitation counselors were re-

cently initiated in State vocational rehabilitation agencies. These six programs cooperate with universities, using the plan of formal study in an academic institution and interspersing study with periods of work in the State vocational rehabilitation agency.

Since 1958, traineeships have been awarded to 85 physical therapists for graduate study in physical therapy or related sciences such as anatomy and physiology. VRA assistance now represents the largest scholarship program for this field, as is witnessed by the 1964 grants for physical therapy which assisted 400 undergraduate or certificate students from 41 of the 42 approved schools. Furthermore, schools received training grants in physical therapy which provide for improving and expanding the training program of approved schools; accelerating the growth of newly established schools in geographical areas needing them; providing opportunities for advanced study by graduate physical therapists; and lastly, fostering experiments in new methods of training.

Trained personnel in prosthetics (artificial limbs) and orthotics (brace construction) are urgently needed to staff clinic teams and rehabilitation centers throughout the country. There is also a great need to train resident physicians in orthopedic surgery. The VRA recognized both these needs and responded by sponsoring traineeships and special courses at three universities. Since 1953, prosthetists, orthotists, physicians, rehabilitation counselors, physical therapists, occupational therapists, amounting to more than 9,000 people altogether, have attended these universities for specialized training in prosthetics and orthotics. The VRA sponsored traineeships have brought teams of medical personnel to these classes to work closely with the experienced "students." The clinic team approach to rehabilitation, now practiced in all the major hospitals and specialized rehabilitation centers, had its initial impetus and development at these special classes through student participation in amputee clinic practice sessions.

In an effort to train workers for the blind, university courses for mobility instructors of blind persons were recently established, starting with 28 trainees during 1964. Short-term courses for services to the blind are also being conducted for State agency personnel through VRA training grant support. These courses included a series on placement of the blind in competitive occupations; on vending stand supervision and operation; on home teaching of the blind especially intended for home teachers and their volunteer assistants; employment of blind persons as telephone switchboard operators; courses in industrial arts for the blind;

placement of the blind in Federal employment; and inservice training of home teachers of the blind. Special training programs have recently been started to teach rehabilitation counselors the basic principles and specialized techniques of placing blind persons in competitive employment.

From a quantitative standpoint, the training program efforts as outlined would appear to be eliminating manpower shortages. However, as new programs are developed, the demand continues to mount and there are still personnel shortages. These shortages will become even sharper with the demands growing out of the recent medicare and community health programs. The newest legislation, Public Law 89-333, has taken note of this and has authorized support of professional training for an individual to a maximum of 4 years. The funds available for training have been increased to support rehabilitation training for more people and for longer periods of time.

In 1966, another major area for program emphasis was rehabilitation workshop administration. Grants were made to nine training centers for the preparation of personnel including executives, floor supervisors, and work evaluators. These programs were chiefly at the master's degree level and dealt with both the business aspects and the human relations aspects. In addition, grants were made to two training centers for the continuing education of administrative personnel in State vocational rehabilitation agencies. Course content consisted chiefly of basic principles of management, program planning, work simplification, and organizational teamwork.

Short-term training courses financed in 1966 included courses in prosthetics-orthotics, rehabilitation of the mentally retarded, rehabilitation of the deaf, supervision, advanced counseling techniques, mobility instruction, manual communications for the deaf, interpreting for the deaf, audiology, hearing aid evaluation and followup, vocational rehabilitation of the older disabled worker, dentistry for the handicapped, psychiatric rehabilitation, vending stand (blind) supervision, placement of blind persons in professions and service occupations, and rehabilitation workshop administration. In addition, a number of courses were conducted in the area of rehabilitation of heart disease, stroke, and cancer patients. A series of seminars were held for faculty of medical schools and representatives of the State-Federal program of vocational rehabilitation for the purpose of disseminating the latest research findings with a view to incorporating them into ongoing training and service. Short-term courses were also held on aphasia associated with hemiplegia re-

sulting from stroke and on post-laryngectomy speech.

By these measures, the VRA training program works to overcome the shortage of trained rehabilitation personnel and to improve rehabilitation services. It constantly strives to provide the best possible training and to utilize the most effective teaching materials. Among the teaching materials produced in 1966 were a textbook on medical information and a film depicting the supervisory process in vocational rehabilitation counseling. To improve rehabilitation services, the Institute of Rehabilitation Services conducts year-round studies of critical problem areas to develop guidelines for inservice training of staff to improve performance in the areas selected. At the conclusion of this discussion, it should be noted that the national efforts to rehabilitate the handicapped are immensely aided by the qualified personnel who are produced as a result of all the VRA training activities.

RELATED LEGISLATION

In addition to the Vocational Rehabilitation Act amendments already discussed, there is a steadily increasing number of other laws which have an impact on vocational rehabilitation. Individual States have passed laws which authorize spending State funds to pay the entire costs of constructing facilities and providing services to specific groups of the disabled. Similarly, various Federal agencies are administering programs that also provide services which contribute to the rehabilitation of the handicapped. Furthermore, there are cooperative programs involving the VRA and other agencies. These programs are discussed in Section 4. The remaining pages of this section are devoted to briefly noting certain State and Federal legislation which contributes materially to a strong program for rehabilitation of the disabled.

State Legislation

In addition to vocational rehabilitation services provided under the Federal-State program, each State may have its own laws which benefit disabled individuals. For example, Missouri and Illinois passed legislation providing financial assistance to a rehabilitation workshop supervisor for each handicapped person employed by the workshop. Many States engage in rehabilitation by creating and supporting such State agencies as a division of mental diseases or a commission on alcoholism. To make public buildings available

to the handicapped, several States have passed legislation requiring that all public buildings be modified in accordance with the recommendations of the American Standards Association.

Nearly all States have legislation dealing with the matter of mental retardation and providing for the efficient State administration of referral, workshop training, and placement of the State's mentally retarded. In most States, legislation authorizes the State department of education to provide services through its crippled children's associations to all disabled children under 16 years of age. Each State has much legislation pertaining to rehabilitation; for this reason, the rehabilitation counselor should familiarize himself with the exact provisions of the legislation passed by the State in which he works.

Federal Legislation

In recent years, the Federal Government has made a concerted effort to help all residents of the United States who are handicapped. Legislation has been passed to combat poverty, to promote mental health, and to aid many disability groups. The programs generated by this legislation are sometimes administered by one agency and sometimes are jointly administered. The discussion in section 4 will inform the reader about the jointly administered major cooperative programs. The following discussion is intended to briefly describe the Federal agencies and legislation which are also involved in rehabilitation of the disabled. A more complete report can be directly obtained from the sources for much of this material; i.e., "The Congressional Quarterly Almanac" and the "Annual Report of the U.S. Department of Health, Education, and Welfare." The latter publication is especially helpful to the rehabilitation counselor since it covers the yearly activities of several Federal agencies; e.g., the VRA, the Public Health Service, and the Social Security and Welfare Administrations.

A. The Mental Retardation Facilities and Community Health Centers Act Amendments of 1965; the Community Health Services Extension Amendments of 1965; the Health Research Facilities Amendments of 1965.—These laws, and other current Federal legislation authorize the Public Health Service to administer a variety of programs which often provide vocational rehabilitation.

The rehabilitation counselor needs to be aware that the PHS Community Health Divisions administer nursing and community health services, operate pro-

grams for mental retardation, diabetes, arthritis, and other chronic diseases, and provide funds to modernize or construct hospital, medical, and mental retardation facilities. The rehabilitation counselor should especially note the programs operated by the PHS National Institutes of Health. The various Institutes conduct research and demonstration projects dealing with such areas as allergy and infectious diseases; arthritis and metabolic diseases; child health and human development; cancer, dental, and heart research; neurological diseases and blindness; and mental health training, research, hospital improvement and community services.

B. The Hospital and Medical Facilities Amendments of 1964. Public Law 88-443.—This act is intended to help urban areas. It amends the Hill-Burton Act which had made Federal funds available to States since 1946 to pay part of the costs of constructing public and other nonprofit hospitals and public health centers. Just as did the 1954 amendments, the newest legislation authorizes appropriations for construction of public or other nonprofit rehabilitation facilities. The rehabilitation facilities constructed under this act may be made available to all persons in the community irrespective of whether they are being rehabilitated for employment. Rehabilitation facilities can be constructed as separate institutions and do not have to be part of hospitals.

C. The Mental Retardation Facilities Construction Act of 1963.—This act, Public Law 88-164, provides funds for public and private nonprofit institutions for constructing mental retardation research centers. It also provides funds to aid in the construction of university-affiliated clinical centers for treatment of the mentally retarded. Further funds are authorized to aid in constructing public and private nonprofit facilities for the treatment and training of the mentally retarded. Finally, in an effort to assist in improving mental health, it authorizes grants for construction and initial staffing of community mental health centers.

D. Social Security Amendments of 1965.—Public Law 89-97 made a multitude of changes in social security law and is generally considered the most important welfare measure since passage of the original Social Security Act in 1935. It established a Federal medical care program for the aged and provided a 7 percent increase in retirement benefits while liberalizing regulations and extending coverage.

For people 65 and over the new legislation establishes two related programs of health insurance: (1) A hospital insurance plan, providing protection against the costs of hospital and related care; and (2) a sup-

plementary medical plan which helps to pay for physicians' services and certain other medical and health services not covered by the hospital insurance plan. Child's insurance benefits are now payable until the child reaches age 22, provided the child is attending a public or accredited school as a full-time student after he reaches age 18. All children of deceased, retired, and disabled workers are included as long as they are unmarried.

For a rehabilitation counselor, the most significant features of the new law are the changes in the disability provisions and the payment of costs of rehabilitation services from trust fund allocations. By the 1965 modification of the definition of disability, an insured worker is eligible for disability benefits if he is under a disability which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of 12 months or longer.

According to the new law, State vocational rehabilitation agencies are to be reimbursed from social security trust funds for the cost of rehabilitation services furnished to selected individuals who are entitled to disability insurance benefits or to disabled child's benefits. The objective of this provision is to make it possible for more disability insurance beneficiaries to receive vocational rehabilitation services.

E. Public Welfare Amendments of 1962.—When Public Law 87-543 was signed into law on July 25, 1962, it made far-reaching changes in the Federal-State public assistance and child welfare services programs. In these programs, the Federal Government reimburses the States for part of their costs in supporting the needy and in providing welfare services to children. This law increased the Federal share of costs of service from 50 to 75 percent in order to reduce dependency and provide for rehabilitation of adults and a strengthening of children's family life.

Public Law 87-543 directly affects vocational rehabilitation. It stipulates that the Social Security Administration would pay 75 percent of the costs of services provided by State welfare " * * * to applicants for, or recipients of, assistance under the plan to help them attain or retain capability for self care, or other services * * * likely to prevent or reduce dependency * * * provided: That no funds authorized shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such act." This law has great potentials for both the State vocational rehabilitation agencies and for the public assistance agencies in ex-

panding services to disabled people on welfare rolls. A more detailed discussion of Public Law 87-543 appears in section 4 under the discussion of public assistance programs.

F. The Economic Opportunity Act of 1964.—This act, Public Law 88-452, created a host of new resources for helping families to escape from the endless cycle of poverty, ignorance, and dependency. It was divided into seven titles to express how it was aimed at seven specific groups of impoverished or neglected people.

Title 1 concentrated on underprivileged youth and: (a) Established the Job Corps program to aid those school dropouts who would benefit from a change in environment; (b) the work-training program to give occupational training to youths in their own communities; and (c) the work-study program which obtained part-time jobs to aid those students who have reached college but whose families have no financial means to help them. Title 2 created urban and rural community action programs and called for, among other things, local adult education programs and an office to help volunteers locate and give financial assistance to needy children. Title 3 authorized programs to raise the income and living standards of low-income rural families and migrant workers. Title 4 authorized the director to make or guarantee loans, repayable in 15 years, to establish and strengthen small businesses and to help them employ the long-term unemployed. Title 5 authorized the director to transfer appropriated funds to the Secretary of HEW for pilot projects to employ and train heads of families receiving help under the aid to families with dependent children program. (These training projects were also authorized by the Public Welfare Amendments Act of 1962.) Title 6 established the Office of Economic Opportunity in the Executive Office of the President and provided that the coordinators of the program; i.e., the director, deputy director, and three assistant directors, be appointed by the President and confirmed by the Senate. Title 6 also authorized the director to recruit, select, and train the Volunteers in Service to America. Title 7 established the policy that an individual's opportunity to participate in certain programs under this act would neither jeopardize, nor be jeopardized by, his receipt of public assistance.

The rehabilitation counselor should note that these programs have as their goal the mobilization and utilization of the individual's assets in order to combat dependency. Some programs of OEO should refer to vocational rehabilitation programs while some vocational rehabilitation clients would best be served by referral to OEO programs. In this way, the services of

both agencies can be more fully utilized in helping the disabled individual achieve his highest psychological, sociological, and economic potential.

G. *The Civil Rights Act of 1964.*—This act, Public Law 88-352, marks the most far-reaching civil rights legislation since the Reconstruction Era. When signed into law July 2, it contained new provisions to help guarantee all citizens the right to vote; guaranteed access to public accommodations such as hotels, motels, restaurants, and places of amusement; authorized the Federal Government to sue to desegregate public facilities and schools; extended the Civil Rights Commission for 4 more years and gave it new powers; provided that Federal funds could be cut off where programs were administered discriminatorily; required most companies and labor unions to grant equal employment opportunity; established a new community relations service to help work out civil rights problems; required the Census Bureau to gather voting statistics by race; and authorized the Justice Department to enter into any pending civil rights cases.

For vocational rehabilitation, Title 6, prohibition of discrimination, is the most important provision. This requires that no person in the United States shall, on the grounds of race, color, or national origin, be subject to discrimination under any program or activity receiving Federal financial assistance. Any program or activity supported by grants from the Vocational Rehabilitation Administration, like every program or activity receiving financial assistance from the Department of Health, Education, and Welfare, must be operated in compliance with this law.

H. *The Correctional Rehabilitation Study Act of 1965.*—This act, Public Law 89-178, authorized the Secretary of HEW to make grants to cover part of the cost of a coordinated 3-year study of the personnel needs, training resources, and teaching methods in correctional rehabilitation. The program is administered by the VRA and the grants can go to one or more non-governmental organizations engaged in correctional rehabilitation activities. The act established the National Advisory Council on Correctional Manpower and Training, to consist of 12 members appointed by the Secretary to advise him on application for grants. To carry out this study program, \$500,000 is appropriated for fiscal year 1966 and \$800,000 for each of the 2 succeeding years.

I. *Other Recent Legislation.*—Public Law 89-601 amends the Fair Labor Standards Act and delegates to State rehabilitation agencies certain responsibilities in connection with the issue of subminimum wage certificates covering handicapped persons.

Public Law 89-614 delegates to the Secretary of Health, Education, and Welfare certain responsibilities for referral of dependents of active duty military personnel to appropriate medical and rehabilitation resources. Negotiations are in progress which may involve State rehabilitation agency staff members in these referrals.

Public Law 89-792 amends the Manpower Development and Training Act and includes provisions for minor medical services to applicants and trainees, under an agreement with the Secretary of Health, Education, and Welfare.

Section 4

HOW AMERICAN SOCIETY HAS ORGANIZED

BACKGROUND

MANY foreign countries are now expressing concern about how to handle problems of disability, and are looking to the United States as a model. The Vocational Rehabilitation Administration has answered their request for help through the establishment of a special division to arrange and coordinate services to foreign countries, and a number of projects are now underway. The United Nations has also been active in this particular field. Early in its development, several of the specialized agencies of the United Nations recognized the urgent need to do something about problems connected with the prevention of disability and the rehabilitation of handicapped persons. These problems were among the first to be given special attention by the Economic and Social Council of the United Nations. At its first session in 1946, the General Assembly of the United Nations, on recommendations of the Council, established the Program of Advisory social welfare services under Resolution 58(I). This program specifically pointed out that services for the handicapped were an area in which expert advice, demonstration, and technical equipment should be made available to the governments of underdeveloped countries (International Society Welfare of Cripples, 1955).

Arnold Toynbee, British historian, said a few years ago: "The 20th century will be chiefly remembered * * * as an age in which human society dared to think of the welfare of the whole human race as a practicable objective" (Holderman, 1962, p. 34). And yet, action has not kept pace with thought, or perhaps the thinking has not permeated where it is most needed—at the community level.

Mary Switzer has so aptly used "The Open Door" as a symbol of rehabilitation in her messages in the *Rehabilitation Record*. The State agency could be likened to the hinges of that door. It can be, and generally is, a focal point in the development of broad understanding of the need and support

for rehabilitative and habilitative services in a healthy economy. Its services are far-reaching in their social and economic effect upon the individual, his family, and the community (Holderman, 1962, p. 34).

W. Scott Allan (1958) in a discussion of the tools of rehabilitation, points out that rehabilitation is a philosophy which permeates many aspects of our cultural life, both for groups and individuals. It is primarily the performance of a task; namely, the organization of the means to overcome the effects of disability. His discussion of rehabilitation programs continues:

Programs may be described as broad plans of procedure initiated and carried out by groups of individuals not directly concerned with the details of rendering a service in some specific area of rehabilitation but rather with the planning and organization incident to rehabilitation generally, either on a comprehensive or specialized basis. Rehabilitation programs differ in scope, organization, purpose, and practical operation (p. 21).

In our complex world many kinds of programs are needed to cope with problems of disability. The diversity of disabilities, differences in abilities, and needs of handicapped persons, and the complicated structure of our society call for programs organized under a variety of auspices. There is, for example, emphasis on prevention, early discovery, treatment or control of disabling conditions. Some of the other varied approaches include: Development of public understanding, including employer acceptance; special education; engineering of jobs and homes (e.g., modified equipment); special privileges (e.g., income tax exemption for the blind); recreation (e.g., clubs, basketball teams); crippled children's services; facilities such as rehabilitation centers and workshops; talking books for the blind; employment services; income-maintenance programs, etc.

In the United States, programs may be governmental, voluntary, National, State, or local. Some are for

designated types of disabilities; some for defined age groups; some for certain types of services. Many are not organized solely for the disabled, but serve larger groups which include disabled persons.

ORGANIZATION

The scope of a rehabilitation program may be National, State, or local. Many programs operate at all three levels and coordinate their activities in the promotional, informational, and service areas. An example of a national program would be the National Society for Crippled Children and Adults. An example of a State program (which could be on a regional, county, or single-community basis) would be the Rehabilitation Council of the United Community Services of Greater Boston. Certain programs will be exclusively devoted to rehabilitation, while others will deal with rehabilitation through only one part of their organization, or as only a portion of their overall activity. The National Rehabilitation Association would be typical of the former, and the American Heart Association would exemplify an organization devoting only a part of its time and effort exclusively to the subject of rehabilitation.

Organization of a program may be either public, such as the Vocational Rehabilitation Administration, or private, such as the National Foundation Incorporated. By the same token, organization may be along either professional lines, such as the American Congress of Physical Medicine; disciplinary lines, as in the American Physical Therapy Association; technical lines, as in the Orthopedic Appliance and Limb Manufacturers of America; or general lines, as in the case of civic groups like the "Just One Break" committees, the fraternal associations of the Shriners and Lions, or the charitable activities of women's clubs, junior league, etc.

A program may focus on a single type of disability, as in the case of the National Tuberculosis Association and its subsidiary chapters and divisions; it may deal with a more general category or group of handicaps, as would be true of the National Association for Mental Health and the Commission on Chronic Illness; or it may concern itself with a comprehensive approach to the whole field of disablement, as does Goodwill Industries. The agency's interest may be restricted to a particular part of the rehabilitation process. For instance, the American Speech and Hearing Association is interested primarily in therapy and training directed at the

correction of vocal and auditory handicaps. The Association of Rehabilitation Centers, Inc., attacks the problem of better organization and administration of centers (Allan, 1958).

In actual practice the operation of programs in rehabilitation takes many forms based upon their objectives. Several typical examples (Allan, 1958, p. 22) are given below:

<i>Purpose</i>	<i>Typical program</i>
Establishment of services.....	State and county Societies for Crippled Children and Adults.
Information and publicity--	President's and Governors' Committees on Employment of the Handicapped.
Coordination of activities....	U.S. Public Health Service or the National Industries for the Blind.
Professional or disciplinary-- exchange of ideas.	American College of Surgeons or Association for Medical Social Workers.
Fund raising.....	National Society for Crippled Children and Adults (Easter Seal Drive). Community funds or "red feather" services.
Research or education.....	Baruch Committee on Physical Medicine and Rehabilitation Commission on Chronic Illnesses.

Most programs include a combination of the components or classifications outlined. Vocational Rehabilitation Administration, after passage of the 1954 amendments, greatly extended its interests and activities in all areas, but it still had its primary emphasis on the vocational aspects and was somewhat limited by the legal and practical definitions of eligibility. However, the revision of eligibility requirements in Public Law 89-333 (1965) removed many of these legal barriers and makes it possible for State agencies to serve thousands of disabled persons heretofore labeled "not feasible" or "ineligible." (See sec. 11 for a discussion of eligibility requirements.)

COMMUNITY ORGANIZATION AND REHABILITATION

The reassimilation of the disabled within a community is not something that can be done *for* a community. It must be done *by* and *within* the community itself. Rehabilitation of the handicapped is a facet of the democratic communities' expression of an en-

lightened people's concern for the dignity, worth, and participation of its own membership.

Rehabilitation can be divided into two equally important parts: (1) Direct services to the person needing them, and (2) provision and coordination of the facilities through which the services can be extended. Services to individuals constitute one part of the work while community organization constitutes the other. The local community must take an active part in providing the facilities, the purposes, and the understanding that make possible the rehabilitation of the handicapped. Responsibility for the initiative of solutions to these problems must come from the community in which the handicapped member has his roots. The extent to which independent Federal or State action can effectively solve the problem is much more limited than is commonly realized. Such action presupposes the development of adequate, efficient local resources and broad understanding within the local community. Health and welfare planning is seldom more dependent on local initiative than it is when facing the problem presented by the handicapped citizen. When a person is impaired so as to limit his ability to pull his own weight and take his place as a self-reliant member of the community, he is immediately a problem of that community.

Kenneth W. Hamilton made this comment about community organization:

The differing capacities of individuals and the various types of problems which make up their particular handicaps run the gamut—in fact exceed the range—of the knowledge of specialized skills. A community may expect to cope effectively with the problem—to have its handicapped utilize its resources effectively—only when its facilities permit the fullest individualization of its handicapped citizens. The necessity for orderly, related, and purposeful contributions to a common goal from diverse sources precludes dispensation of rehabilitation as a single commodity from a single agency. A common understanding, a common purpose, and a pooling of resources and services are required (Hamilton, 1950, pp. 185-186).

THE COUNSELOR'S ROLE IN COMMUNITY ORGANIZATION

In order to attain maximum effectiveness, a counselor needs to find out what programs or agencies are active in his area, acquaint himself fully with them, and develop a comfortable and mutually satisfactory way of working with them.

Few, if any, communities have all the resources and

programs needed for complete, well-rounded services to meet all the needs of all the disabled persons who live there. However, the counselor needs to know and work constructively with the programs in his area, and to help build broad community programs to meet the varied needs of his clients.

Principles and methods of maintaining productive working relationships with specific programs operating in the counselor's area include:

Knowing the specific services offered by each agency and the circumstances under which they are provided.

Understanding the philosophy, purpose, and basis for limitations of services of each agency.

Knowing how services are provided and the individuals who provide them.

Interpreting vocational rehabilitation services, needs, and methods.

Explaining the basis for vocational rehabilitation policies and actions.

Jointly developing practical plans for working together; e.g., agreeing on respective responsibilities; referral criteria and procedures; reporting back to referral source; team evaluation and services; sharing information about individuals as appropriate; communication with appropriate persons before intended visit.

Fulfilling responsibilities promptly and fully.

Joining in specific cooperative projects.

Giving good service to disabled individuals.

Some of the methods for community organization in behalf of a sound and integrated plan to meet the varied kinds of needs include:

Taking active part in community planning for services to individuals and groups.

Supporting establishment of new programs and development of existing programs to meet demonstrated unmet community needs.

Cooperating in community efforts to identify extent and nature of needs related to disability in the area and the kinds of programs needed to meet them.

Interpreting the vocational rehabilitation program to community groups.

MAJOR COOPERATING PROGRAMS

The multiplicity of programs to serve the needs of disabled persons has been previously discussed. Some

agencies that almost all rehabilitation counselors will have extensive contact with are: Crippled Children's Services; Public Health Programs; Workmen's Compensation Programs; Special Education; Economic Opportunity Act programs; and national programs for selected disability groups; e.g., National Association for Retarded Children, United Cerebral Palsy Association, National Tuberculosis Association. The rehabilitation counselor should especially note the programs of services to the handicapped of the Employment Service, public assistance agencies, and the disability insurance program of the Social Security Administration, since by law, these three agencies have a structured responsibility to assist and participate with VRA in the rehabilitation of disabled individuals. Because of their importance, these three major cooperating programs are discussed in detail.

Employment Service Responsibilities to the Handicapped

The Employment Service has a long history of providing special services to the handicapped. In 1945 Congress passed a joint resolution declaring the first week in October of each year as "National Employ the Handicapped Week" and also gave the Employment Service a major responsibility for the placement of the handicapped and disabled veterans in jobs.

Public Law 83-565 (1954) amended the Wagner-Peyser Act (1933) and stipulated that specially trained Employment Service personnel be designated to serve the handicapped in each State employment office. Congress also made it clear that there was particular concern about extending and improving counseling, placement, and rehabilitation service to the more severely disabled. Public Law 89-333 (1965) continues this congressional emphasis when it states that "Job opportunities must be promoted for State rehabilitants."

In the State Employment Services, a person is assigned in most local offices to provide specialized services to the handicapped. Several State administrative offices have a staff member devoting full time to assisting the local employment offices in the technical aspects of serving the handicapped and acting as liaison between the State Employment Service and the various State and Federal agencies concerned with serving the handicapped. "Program of Services to the Handicapped" is the phrase coined by the Employment Service to describe its activities to serve physically, mentally, or emotionally handicapped persons. It entails all serv-

ices provided by the local employment office from the time the handicapped applicant enters the local office until he is occupationally adjusted in a job. The term "handicapped applicant" is used to identify applicants whose handicaps meet certain definitions. The Employment Service has established a range of handicaps with 63 code numbers from 001 through 300 which specify the nature of the handicap; i.e., upper extremities; lower extremities; vision, hearing and speech; cardiovascular, etc. For Employment Service purposes, a veteran is considered disabled and entitled to preferential treatment if: (1) He can be given any of the 63 handicapped codes; (2) if the Veterans Administration is rating him 10 percent or more disabled on a service-connected disability; or (3) he has been retired by the Armed Forces due to a physical disability.

One difference between interviewing handicapped applicants and those without handicaps is that the Employment Service must obtain and record more information about the physical capacities of the applicant so that this information can be matched with the physical demands of a job. To obtain information about a physical condition, two methods are used: A physical capacities appraisal which is completed by the Employment Service, or a physical capacities report which is filled out by a physician (Arizona State Employment Service, 1960).

Public Assistance Programs

Recently the prevention and reduction of financial dependency through rehabilitation has been emphasized in vocational rehabilitation and public assistance programs. The purpose of the Federal-State vocational rehabilitation program to preserve, develop, and restore the ability of disabled men and women to work includes an obligation to the disabled that require public assistance for their support.

Enactment of the Public Welfare Amendments of 1962, Public Law 87-543, marked a new milestone in the history of social legislation in the United States. The Department of Health, Education, and Welfare is committed to fulfilling the amendments' purpose of "prevention, restoration, and rehabilitation." Whether this purpose is attained will depend upon a *joint endeavor* going beyond anything previously achieved.

The new public welfare legislation provides for a wide range of social services and vocational training for public assistance recipients, or those who may become in need of assistance. Emphasis is placed on services designed to help these welfare clients attain increased personal and economic independence. Special

Federal financial incentives are provided to encourage State agencies to develop resources for conveying these services to more and more people. In addition, they specifically involve the State vocational rehabilitation programs to the greatest extent possible. These factors have contributed to a series of activities by the Vocational Rehabilitation Administration designed to increase the participation of State rehabilitation agencies in helping welfare recipients.

The present emphasis on vocational rehabilitation is a continuation and a renewal of previous effort. VRA's hope for a substantial increase in service to welfare clients is partially based on a history of rehabilitation and welfare agencies working together for many years. These agencies have cooperated on all governmental levels—local, State, and Federal. Many of these cooperative efforts have produced gratifying results.

It is impossible to estimate the number of people now living on public assistance who could be returned to work. There are about 85,000 persons receiving aid to the blind and more than 588,000 receiving aid to the permanently and totally disabled. There are about 165,000 homes in which aid to dependent children is being paid because of the disability of a parent. Vocational rehabilitation will not solve all the problems of all disabled public welfare recipients. At the same time, there can be no question that concentrated effort could yield substantially more than the approximately 20,100 public assistance cases rehabilitated in 1966.

Current attempts on the national level to expand and emphasize the efforts of State rehabilitation agencies are not new. In 1943, when the Office of Vocational Rehabilitation and the Bureau of Public Assistance developed a cooperative agreement, similar agreements were developed in most States. In 1955 the joint OVR-BPA booklet "Working Together to Rehabilitate the Needy Disabled" was developed, issued, and used widely.

Today, national action is being concentrated in three areas: (1) Purchase of rehabilitation services from vocational rehabilitation agencies by public welfare agencies; (2) staff training; and (3) demonstration projects on the rehabilitation of welfare clients. All of these are designed to underline the importance of strengthening and expanding working relationships between State public welfare and vocational rehabilitation agencies.

For the first time, the 1962 legislation authorized State welfare agencies to purchase specialized services from other State public agencies, including vocational

rehabilitation agencies. If a State public welfare agency believes that vocational services are essential for a client, the agency may purchase evaluation, counseling, training, and placement services from the State rehabilitation agency. Physical restoration services may be purchased only when they are part of a comprehensive service provided in a rehabilitation facility. The State welfare agency may receive 75 percent reimbursement from the Federal Government for purchase of these services.

This purchasing arrangement is designed to make vocational rehabilitation services more widely available through: (1) Extension to larger number of clients; (2) providing a broader range of service to more clients; (3) introduction of services in additional geographic areas; and (4) the development of more effective cooperative methods. Thus the objective is to augment services by State vocational rehabilitation agencies, rather than to replace State agency efforts that were normally made for public welfare recipients (Howard, 1963).

Social Security Administration

As a result of social security legislation, more than 600,000 people annually applying for disability cash benefits are screened by State agencies for possible vocational rehabilitation. This legislation has two basic objectives: (1) To provide workers with insurance protection against the hazards of disability incurred through accidents and debilitating diseases, and (2) to make available rehabilitation services which may help these workers overcome their disability and return to useful and gainful employment.

The Social Security Act reflects the congressional intent that every applicant for disability insurance benefits, including disabled children over age 18, shall be referred to a State vocational rehabilitation agency for possible service. Among the act's provisions are: Benefits may be withheld from those who refuse, without good cause, to accept rehabilitation services available to them; and benefits for beneficiaries who undergo rehabilitation services may be extended through the period of rehabilitation and for a 12-month trial period after placement in gainful employment.

Congress viewed insurance protection for the worker against the hazards of disability as a proper extension of the social insurance system. Yet it was recognized that these benefits could not supplant wages, nor could monetary benefits alone insure the well-being of a disabled individual.

State agency involvement in the disability determination process gave the program a strong rehabilitation emphasis. In this way disabled workers would be evaluated for: (1) The extent of their disability (for disability benefit purposes); and (2) their rehabilitation potential.

The disability provisions of the Social Security Act made it essential that there be close working relationships among the Vocational Rehabilitation Administration (VRA), the Social Security Administration (SSA) and the State rehabilitation agencies. Agreements with the States to make disability determinations are operative in all the States and Territories except the Virgin Islands. The vocational rehabilitation agencies make the determinations in all but five States. In Arkansas, a separate department was created to make disability determinations. In North Carolina, Oklahoma, New York, and Washington, welfare departments perform this function.

VRA and SSA have developed a joint policy to insure that every disabled person applying for benefits

promptly receives a determination of his disability. An assessment of his rehabilitation potential is provided and, if a favorable work potential is found, rehabilitation services are offered by the Federal-State vocational rehabilitation program.

The relationships of SSA with State rehabilitation agencies in this program are based essentially on the agreements they have made. For purposes of uniformity in administration and equal treatment of applicants, the agreements usually provide that State rehabilitation agencies will be governed by the guides and standards developed by the SSA for making determinations of disability. Costs to State agencies in making determinations of disability are paid in full from the Social Security Disability Trust Fund, as are the costs of services provided these disabled people. That this program aids vocational rehabilitation can be seen by the fact that out of the half million applicants screened annually, about 50,000 are being accepted for rehabilitation services (Van Hyning, 1962).

Section 5

LOCATING PERSONS IN NEED OF REHABILITATION SERVICES

BEFORE a handicapped person can receive vocational rehabilitation services, he first has to learn about the existence of rehabilitation agencies in his community. Unfortunately, many people who could profit from vocational rehabilitation services have never come in contact with a rehabilitation agency. The use of general news media to reach these people can help them make contact with the appropriate agency.

Many others who could profit from rehabilitation services and who *do* know about them, sometimes refuse to seek or accept services for a variety of reasons. Some may not understand the purpose of rehabilitation; some may fear the corrective surgery they know they need; some may not want to change their dependent role; some do not want to accept "welfare," etc. Generally, handicapped individuals who fall in these categories do not come to the attention of rehabilitation agencies unless it is through a referral source.

TRENDS IN REFERRAL SOURCES

In 1966 only 11 percent of the 150,000 persons rehabilitated were self-referred while 89 percent received their first information regarding vocational rehabilitation from a "second-hand" source. Agencies that commonly refer handicapped individuals need to have a comprehensive understanding of the vocational rehabilitation process in order to prevent errors in communication that might distort the prospective client's perception of vocational rehabilitation. Research studies (McGowan and Schmidt, 1962) have shown that "client expectation" is an important variable in the formation of a relationship. The accuracy with which referral sources explain vocational rehabilitation's function and limitations can be an important factor in the rehabilitation of disabled persons.

The trend in referral source over the past 5 years

is one of consistent change. Although private physicians remain a prime source of clients, they are nevertheless declining in favor of educational institutions and hospitals and sanatoriums. The most outstanding change in the past half-decade has occurred in referrals from schools. The number referred from this source has almost doubled from 1962 to 1966.

In 1966, the sources of referrals continue to be headed by hospitals and interested individuals. Figure 7 on page 44 provides information on referral sources during the year 1966.

In order to attack the problem of dependency due to disability, it is imperative that vocational rehabilitation personnel develop and nurture referral sources. The remainder of this section is devoted to considerations of this task.

REFERRALS

The term "referral" applies to any individual who has applied to or has been referred to the agency by letter, telephone, or other means and who presents sound need for, and interest in, rehabilitation services. Minimal identifying data required for referrals are personal identification information (name, age, address, apparent disability, and the referral source).

Referral Considerations

- Every disabled individual is entitled to *know* about available vocational rehabilitation services and he has the right to be considered for them according to his needs and interests.
- Suitable referrals should be based on a *realistic understanding* of the general objectives and services that the rehabilitation agency is equipped to provide.

- Referral should be made *early* in the period of disablement, thus providing for contact with the client at a time when he is considered most receptive psychologically and physiologically to rehabilitation measures. Early referral allows more time for the provision of effective planning and services, thereby lessening the development of adjustment problems occasioned by continued psychological and physical stress and enforced dependency.
- The casefinding program needs to be aggressive and comprehensive in order to keep referral channels open and referrals flowing from all potential sources.
- There should be a continual exchange of information between the rehabilitation agency and the community, and there should be good coordination of services.
- A courteous and effective way to nurture a referral source is to supply "feedback" regarding the progress of a referred individual. This will also enhance other agencies' understanding of the rehabilitation process. Information should be given discretely and professionally, with care taken not to disclose data that might be embarrassing to the client.

A planned public relations program should be an

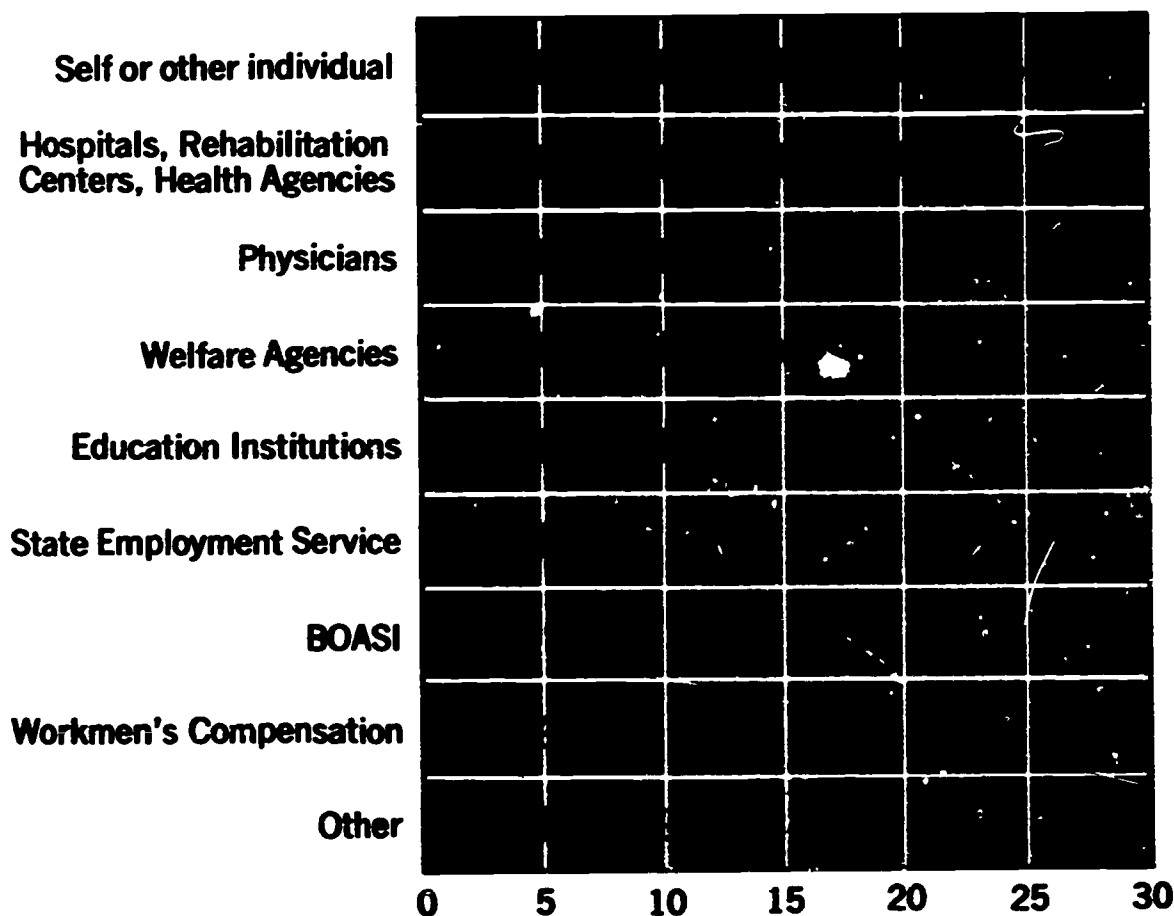
integral part of the casefinding program. Such a program will encourage better understanding on the part of the public toward the rehabilitation effort, and result in a positive community climate in which the problems of disablement are approached with realism and in context with broad community planning. Mutual professional respect, with all that it implies, is thus developed and promoted between referral agency personnel and personnel in the rehabilitation agency.

Development of Referral Sources

Adequate referral sources are to a large degree dependent upon good community organization for rehabilitation. Good community organization in turn is dependent on understanding and acceptance of rehabilitation by various community social service agencies. These agencies, including the vocational rehabilitation agency, should cooperate toward common goals based on: Formal agreements on areas of responsibility; good interpersonal relationships of staffs; regular interagency visits; joint case staffing; joint training programs; and cooperation in public education and other community activities for the handicapped.

Rehabilitation personnel should be continually

FIGURE 7.—Sources of Referrals Among 1966 Rehabilitants



aware of opportunities to gain public exposure. Not only in formal situations, but also informally, rehabilitation is a good topic of conversation.

A maximum number of referrals can be expected when the rehabilitation agency has a community-wide reputation for providing effective services to disabled persons. Good counselor-client relationships also promote the image of rehabilitation, for adequately functioning clients offer the best proof of the value of rehabilitation.

GUIDES FOR EFFECTIVE CASEFINDING

Each rehabilitation agency needs to develop its own referral sources and techniques for casefinding with a community. Listed below are eight suggestions for effective casefinding.

- Maintain an open door policy for new referrals to agency. Let referral sources know your agency would like more referrals.
- Make periodic examination of sources of referrals to assure a continuing flow of cases from all potential community resources.
- Assign each counselor responsibility for maintenance of contact with certain agencies and potential sources of referrals.
- Prepare formal referral forms for use by referral sources.
- Develop prompt and cordial reporting back procedures to referral sources on referrals made.
- Give prompt attention to referrals; some people are seeking help at the time they apply.
- Maintain a record of referrals by date of referral, source, and actions taken, for evaluation and followup purposes.
- Provide for preliminary evaluation as basis for acceptance or rejection of referrals. Advise the client, referral agency or other interested parties of decisions and reasons.

SOURCES OF REFERRALS

In every community there exist many sources of referral. The sources from which vocational rehabilita-

tion agencies receive the majority of new cases are listed below. Continual contact must be maintained with these agencies.

- Health Agencies.*—Public and private, general and special hospitals, clinics, TB sanatoriums, mental institutions, physicians, public health service, nursing groups, artificial appliance companies, etc.
- Employment and Guidance Service Agencies.*—Public and private employment offices, public and private guidance and counseling agencies such as B'nai B'rith, Urban League, and other voluntary religious, racial, and welfare units.
- Welfare Agencies.*—Public and private assistance and relief agencies such as Red Cross, Salvation Army, Catholic Charities, and State and city public welfare.
- Educational Institutions.*—Public, private, and denominational schools and colleges, including schools for the handicapped and business colleges.
- Special Interest Agencies.*—Crippled children's services, heart associations, TB associations, polio foundations, and other organizations of and for the handicapped.
- Insurance Companies.*—State workmen's compensation boards, Bureau of Old Age and Survivor's Insurance, and private and fraternal insurance companies.
- Civic Service Groups.*—Lions, Masons, Kiwanis, Rotary, YMCA, etc.
- Religious Group.*—Protestant, Hebrew, and Catholic social and helping organizations.
- Employers.*—Especially those who have handicapped employees on their payroll who are good workers.
- Labor Unions.*—Have a vested interest in rehabilitation services and will often take an active role in the rehabilitation of their members.

The above organizations and individuals are excellent sources of referrals for rehabilitation services. However, they must be informed of the services available from the rehabilitation agency before they can make referrals. Each rehabilitation agency should encourage its counselors to contact all of these agencies and obtain their cooperation.

In the final analysis, a continual supply of referrals to rehabilitation agencies from outside sources will be dependent upon how well the agencies have met the needs of the clients who had been previously referred.

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PART TWO
PRELIMINARY STUDY AND PLANNING

48/49

Section 6

INITIATING THE REHABILITATION PROCESS

PRIOR to a detailed discussion of client study procedures, a more complete definition of the rehabilitation process is presented in order to provide the reader with a framework from which he can conceptualize how each of the parts of the process are related to the final goal; i. e., the best possible vocational adjustment of a handicapped individual.

THE REHABILITATION PROCESS

The rehabilitation process is a planned, orderly sequence of services related to the total needs of the handicapped individual. It is a process built around both the problems of a handicapped individual and the attempts of the vocational rehabilitation counselor to help solve these problems and thus to bring about the *vocational* adjustment of the handicapped person. There are several basic principles underlying the process. These are:

- (a) Action must be based upon adequate diagnostic information and accurate and realistic interpretation of the information that is secured.
- (b) Each rehabilitation client must be served on the basis of a sound plan.
- (c) Guidance and counseling of clients and close supervision of all services are essential at each step of the process.
- (d) Each service must be thoroughly rendered and followed up.
- (e) The cooperation and involvement of the client and all others concerned with his rehabilitation are necessary and must be secured before adequate rehabilitation can be accomplished.
- (f) Adequate records must be kept.

The process begins with the initial casefinding or referral, and ends with the successful placement of the handicapped individual on a job.

The unique characteristic which distinguishes and differentiates the vocational rehabilitation process from all other types of counseling is its insistence upon the realistic and permanent *vocational* adjustment of the handicapped individual as its primary objective.

Steps in the Process

(1) *Selection and Preliminary Investigation.*—The counseling interview is the basic method of securing information. The purpose of the interview is to help the counselor understand as much about the applicant as may be necessary to assist in his vocational adjustment. A case investigation interview is not a routine form-filling exercise; it is a planned, but flexible, procedure for securing vocationally significant information, including the emotional significance to the client of his health, educational, vocational, and social history. The information from the interview is fully recorded on interview forms or fact sheets and supplemented by narrative recording. The exact form used will vary from State to State and from agency to agency.

During the initial interview, the counselor attempts to determine if the applicant is eligible for rehabilitation services, and if he is interested in the program.

(2) *Client Study Data.*—As the starting point of the client study, the information from the interview is an important factor in determining the types and amount of case information needed to supplement the client's history. These include the following:

- (a) *Medical Evaluation.*—Each applicant receives a complete medical evaluation in order to establish the nature and extent of the disability; appraise the general health status of the individual for a determination of his capabilities and limitations; ascertain if physical restoration services might remove, correct, or minimize the disability condition; and contribute a sound

medical basis for selection of a rehabilitation objective. Medical evaluation is a continuing or recurring activity throughout the rehabilitation process, not merely something undertaken as an initial step in the case study.

- (b) *Psychological Evaluation.*—Psychological evaluation is closely related to counseling and subsequent rehabilitation services for all clients, and it is required for mentally retarded clients and certain cases of behavioral disorders. Section 401.22(e) of the regulations implementing the Vocational Rehabilitation Act Amendments of 1965 states—

(1) in all cases of mental retardation a psychological evaluation will be obtained which will include a valid test of intelligence and an assessment of social functioning and educational achievement;

(2) in all cases of behavioral disorders a psychiatric or psychological evaluation will be obtained, as appropriate.

Psychometric data and information obtained during interviewing, counseling, and other evaluation procedures are included in the overall evaluation. Each State agency determines who is qualified to perform the specific evaluations required by the regulations.

- (c) *Vocational evaluation.*—To evaluate vocational factors means to gather, interpret, analyze, and synthesize all the vocationally significant data regarding the individual and to relate them to occupational requirements and opportunities. This includes considering the disability, age, employment opportunities, personal adjustment, mobility and family circumstances of the client, and relating his work and vocational training history to present circumstances and reasonable expectation that vocational rehabilitation services will render him fit to engage in a gainful occupation. Public Law 89-333 provided also for extended evaluation to determine rehabilitation potential if such a determination cannot be made initially.
- (d) *Educational evaluation.*—The educational level at which the client is functioning and his potential for further education and training should be assessed, in addition to the formal level completed. Indicators of proficiency and performance should be considered in addition to standard measures of achievement.
- (e) *Social evaluation.*—This involves securing social history material which, taken as a whole, brings the client into focus as an individual dis-

tinct from others and points up his potential for benefiting from the rehabilitation process. A social history is necessary for a diagnosis of the total problem. The client's past and present social adjustment must be considered in formulating a plan of service.

- (f) *Cultural and environmental evaluation.*—The impact of cultural and social deprivation, chronic poverty, public offense, illiteracy, long-term unemployment or dependency, community prejudices, belonging to a disadvantaged group, residence in ghetto areas or pockets of poverty must all be considered in diagnosing the problem and in developing a plan of service.

(3) *Rehabilitation diagnosis.*—The rehabilitation diagnosis entails:

- (a) Determination of eligibility.
(b) The identification of problems.
(c) Identification of rehabilitation services needed.
(d) Vocational appraisal for purposes of selection of a job objective.

The steps do not necessarily follow in this precise order. For example, rehabilitation services can be provided under the extended evaluation provisions of Public Law 89-333 as part of, and prior to, a determination of eligibility.

(4) *Planning and Provision of Rehabilitation Services.*—Once the counselor has secured the necessary diagnostic information, he needs to work out a plan which is acceptable to the client, and which he can justify on the basis of medical, psychological, and social data. He then attempts, through the counseling process, to help the client accept and implement the plan.

The counselor will then make the necessary arrangements and initiate steps to authorize the needed services.

(5) *Selective Placement and Followup.*—An integral part of each plan is placement and followup. The counselor is responsible for job placement and in this connection should interpret clients' disabilities and abilities to employers; refer clients to the Employment Service; and inform clients as to how to apply for a job. Placement planning should be done far enough in advance so that clients can find work soon after the completion of rehabilitation services.

(6) *Evaluation of Placement and Case Closure.*—The work should be suitable and in line with the plan at the time of placement. The job duties, working conditions, wage rates, client adjustment, employer satisfaction, and completion of all necessary services are

key factors in determining if a case is ready to be closed as successfully rehabilitated.

Each of the steps in the rehabilitation process is discussed in detail in following sections.

THE INITIAL INTERVIEW

During the preliminary study the major source of information is the client himself. The interview serves as a major source of contact at this point. It introduces the individual to the agency, its purpose, services, and objectives, and relates this information to the client's individual situation. During the initial interview, the counselor should: Obtain from the applicant a statement of his problems; give an explanation of the overall functions of the vocational rehabilitation program; confirm the applicant's desire for rehabilitation services; record the pertinent facts and data obtained; and identify the areas of study requiring further exploration.

The initial interview should follow as quickly as possible after the referral is made to the agency. The setting may be in the counselor's office, in another agency, in a hospital, in the individual's own home, etc. Wherever the initial interview is held, the basic purposes outlined above are the same.

The rehabilitation counselor should be careful to maintain a sound balance between his own personal needs and interests in the case and the aims and policy of the agency for which he works. He can accomplish this by objectively explaining the legal limitations of the agency and the procedural requirements which the client himself must follow in order to qualify for service. He identifies himself with the agency in respect to these limitations and requirements and does not apologize for them. While the counselor should attempt to understand the client's problems and requests, he nevertheless must deal with reality factors involved in the situation and make clear to the client the kind of help that he is in a position to give and that his agency can provide. In short, he operates within the general policy framework of his agency.

Examples of desirable outcomes of the first interview are as follows: The client should feel free to express himself; the client should leave with the feeling of satisfaction that he and the counselor will do all they can to work out a satisfactory solution to his problem; rapport should be established to the point that the client is beginning to feel free to both talk about personal issues and, if necessary, to express any

feelings he may have of apprehension, hostility, or inadequacy, without fear of any counselor reprimands.

In terms of specific counseling techniques, there are several dangers inherent within any preliminary interview survey structured exclusively around the use of a survey questionnaire as used in many rehabilitation agencies. These may lead to the preliminary interview becoming a mere question and answer type interview in which the counselor asks specific questions and the client responds with specific information. In order to avoid these dangers, the counselor should be careful about asking questions which the client can answer with a specific yes or no. Rather, he should present material in such a way that the client feels free to respond and to develop his answers in detail. If questions are asked, they should be asked one at a time, and in a general rather than specific manner.

Since counseling represents a learning situation, the counselor must be aware of the fact that the client begins to "learn" what is expected of him during the initial part of the interview. As a result, he must be careful to structure the initial interview in such a way that the techniques used will be equally profitable during later phases of the counseling process. He must learn to know and control his own emotional reactions and give the client the freedom that he needs in order to express himself during the initial interview. He must communicate to the client, both verbally and non-verbally, a lack of personal negative evaluation and set up a situation free from any feelings of personal threat. He must not attempt to play a role or to change his own pattern of natural verbal responses to fit any particular counseling techniques, rather he should adapt a counseling technique to his own verbal delivery pattern. He should communicate to the client a real interest in him and a real willingness to help.

In most cases it is not necessary to tell the client what counseling is since he will experience it within the relationship and learn from what the counselor *does* as well as from what he *says*. The counselor should have the ability to listen and observe. Counseling is built around techniques of observation, and observation should become one of the main tools of the professional counselor. In this regard, the counselor needs to respond to minimal cues expressed through the client's behavior, and to listen not only to what he says but to observe quite closely his reaction to the material that he is discussing.

In the field of rehabilitation counseling, the counselor needs to know his own limits, and to develop his capacity to control personal reactions to extremely difficult problems and environmental situations. In a

sense, it is necessary for the counselor to give a good deal of himself personally in order to communicate anything to the client, and yet at the same time he must avoid becoming "over-identified" with the very difficult problems that he will encounter in the day-by-day work of a rehabilitation agency. He must remember his obligation is to many clients, and that he must maintain an objective and realistic balance between the time and the service that he can give to any one client of the agency. In a sense, in order to be able to help clients, he must know himself, his limits, his capacities, his strengths, and his weaknesses.

ESTABLISHING A VOCATIONAL REHABILITATION DIAGNOSIS

The preliminary study phase of the rehabilitation process is often referred to as formulating a vocational rehabilitation diagnosis. In specific terms, establishment of a vocational rehabilitation diagnosis means:

Selecting significant facts from the data available for the purpose of making necessary program decisions with respect to determination of eligibility and the identification of significant problems interfering with the client's job adjustment.

One purpose of the vocational rehabilitation diagnosis is to ascertain whether or not an applicant appears to be eligible for rehabilitation services and if further investigation is indicated. A screening-type interview can eliminate many people who have heard about vocational rehabilitation and merely want to know more about it, or who have been referred by misinformed people, or who are obviously not eligible for services.

Determination of Eligibility

Implicit within the establishment of a vocational rehabilitation diagnosis are the requirements of eligibility for vocational rehabilitation services. The regulations governing the vocational rehabilitation program (1966, sec. 401.20(b)) state that eligibility shall be based upon:

- (1) The presence of a physical or mental disability.
- (2) The existence of a substantial handicap to employment.
- (3) A reasonable expectation that vocational rehabilitation services may render the individual fit to engage in a gainful occupation.

The establishment of eligibility criteria is by no means the only or most important purpose of the initial diagnostic phase. Data gathered at this time provide the counselor and the client with pertinent information about the client's needs and problems that will serve as the basis for formulating a plan of service relative to the attainment of a rehabilitation goal. (Eligibility determination is discussed in more detail in sec. 11.)

Extended Evaluation

The 1965 amendments allow for the provision of a period of extended evaluation as an aid in determining a client's potential for rehabilitation. Client acceptability for extended evaluation is covered in the regulations governing the vocational rehabilitation program (1966, sec. 401.21) which require the same basic conditions cited in (1) and (2) above for establishing eligibility, but the following is substituted for the third condition:

- (3) Inability to make a determination as to the third condition of eligibility (a reasonable expectation that vocational rehabilitation services may render the individual fit to engage in a gainful occupation) without an extended evaluation, including the provision of vocational rehabilitation services.

Necessary rehabilitation services may be provided during a period not to exceed 18 months for the mentally retarded and those with the catastrophic disabilities specified in the regulations; for other disabilities the period of extended evaluation is not to exceed 6 months.

After certification for extended evaluation, the regulations (1966, sec. 401.23) provide that an individual plan will be formulated which shall:

- (1) Be based on data secured in the preliminary diagnostic study.
- (2) Indicate the nature of the vocational rehabilitation services necessary to determine the rehabilitation potential of the individual and the arrangements for providing (or otherwise securing) such necessary services.
- (3) Be formulated with the assistance of appropriate agency consultants when necessary and with the client's participation.

The extended evaluation plan is terminated or revised when it becomes evident that the client's vocational rehabilitation cannot be completed, his needs

have changed, or sufficient facts have been secured to determine his vocational rehabilitation potential.

CLIENT STUDY

For purposes of this presentation, the total case study of a rehabilitation client is divided into four sections: Medical, psychological, sociocultural, and vocational. *These are not discrete variables; they are interrelated and their evaluation may and often will be carried on concurrently.*

The first part of the client-study process is the medical evaluation. An accurate medical report of the client's physical or mental impairment gives the counselor a guide in establishing eligibility, appraising the needs of the client, and working out a suitable plan of service. A medical appraisal is obtained for every client served by a State agency.

The second part of the client-study process is the psychological evaluation. Psychological evaluations are required by the regulations in all cases of mental retardation, and in some cases of behavioral disorders (as an alternative to a psychiatric evaluation), and are recommended for all other cases. The extensive-

ness of this evaluation is individually determined. By using standardized procedures such as aptitude and achievement tests, and interest or personality inventories, the counselor can obtain information that will be helpful in planning *with* his client.

The third part of the evaluation process is an investigation of the client's sociocultural environment, both past and present. This should be reviewed in considerable detail because the client's past adjustment at school, home, and in the community can provide many indications of the type of adjustment he will make in the future.

Another part of the client-study process is a consideration of the client's vocational history. The counselor should have complete data on past job performance, length of each job, why client left each job, what he learned to do, extent of job training, etc. A review of these factors can supply information relative to a client's vocational interests and skills, his work habits, and occupational maturity.

It should be reemphasized that no one of the above factors is completely independent in itself. An attempt to isolate and treat one of them without considering the effect the change in one area will have in the client's total adjustment often leads to an unsuccessful vocational rehabilitation effort.

Section 7

CLIENT STUDY: MEDICAL

THIS section is intended to serve as a guide to counselors in applying established standards related to the medical aspects of client study and diagnosis. It also presents recommendations for obtaining adequate medical evaluation, including suggestions with respect to the responsibility of the medical consultant.

A general medical examination for every rehabilitation applicant is significant in that it not only verifies the existence of an apparent or suspected disability but it may also indicate a condition which has not been suspected. Such a "hidden" disability may indicate the need for further evaluation.

PURPOSE OF MEDICAL DIAGNOSIS

The major purposes of the medical diagnostic study and evaluation in vocational rehabilitation are—

- (1) to establish, through competent medical judgment including psychiatric or psychological evaluation as appropriate, that a physical or mental impairment is present which materially limits the activities which the individual can perform, as one aspect of determining the individual's eligibility for services as a disabled person;
- (2) to appraise the current general health status of the individual, including the discovery of other impairments not previously recognized, with a view to determining his limitations and capacities;
- (3) to determine to what extent and by what means the disabling condition can be removed, corrected, or minimized by physical restoration services; and
- (4) to provide a realistic basis for selection of an employment objective commensurate with the disabled individual's capacities and limitations.

Medical diagnosis is concentrated in the initial period of the case, but may be needed again as a plan develops. Changing conditions in the client's life or physical status may, at any time, necessitate reevaluation of the need for rehabilitation services, or a need for new or additional medical treatment, or may require a reconsideration of the suitability of the employment objective.

Individuals receiving services over long periods of time should have at least an annual medical examination which is comprehensive enough to provide information as to the individual's current total health situation.

MEDICAL CONSULTATION

Medical consultation is a valuable and accepted procedure in the rehabilitation of disabled individuals. The regulations governing the vocational rehabilitation program (1966) specifically state that: "The State plan shall provide for and describe the arrangements made to secure adequate medical consultation and to assure the availability of medical consultative services of high quality on all medical aspects of the vocational rehabilitation program, as needed in all State, district, or local offices of the agency" (sec. 401.11).

Medical consultation may be defined as: A regularly scheduled, face-to-face visitation between the agency medical consultant, rehabilitation counselor(s), and/or supervisor regarding the medical aspects of selected cases and the relationships of these aspects or problems to the rehabilitation process (IRS, 1963, p. 1).

The scope of this discussion will be limited to the effective use of medical consultation at the counselor operational level, as opposed to administrative aspects of medical consultation.

The Need for Medical Consultation

The availability of medical consultation in the vocational rehabilitation program is an important aspect of the successful rehabilitation of disabled clients. Rehabilitation personnel need to be able to make effective use of medical consultation in working with disabled clients. It is important to remember that medical consultants *do not* determine eligibility for rehabilitation; this is the rehabilitation counselor's responsibility. Medical consultation is necessary in many cases to *help* the counselor make this determination of eligibility as well as to assist with the determination of the types of medical services that will be provided. One of the more important functions of the medical consultant is to assist in determining what the client can do with his residual capacity to work.

Medical consultation is needed for the following reasons: (a) To secure an interpretation of medical terms and medical information; (b) clarification and explanation of physicians' reports and the diagnosis in order to better understand an individual's disability as it relates to his functional capacity; (c) to indicate need for specialist consultation or further diagnosis, and to determine the adequacy of medical information; (d) to evaluate the medical prognosis of cases; and (e) to determine what limitations exist in regard to the disability.

Planning

In planning for medical consultation, the counselor must identify the problems he hopes to resolve with the physician and, in general, should do his planning with respect to the face-to-face interview. Proper planning for medical consultation will aid in accomplishing the counselor's objectives and save time. Recording all significant facts in advance will decrease wasted motion in the conferring time. Comprehensive planning should insure that: Significant questions will be asked; case record material will be arranged in an orderly system; presentation will be made in brief, concise, understandable language; and as a result the counselor should project a high degree of professionalism during the face-to-face interview with the physician. The following suggestions are made to assist the counselor in planning for the use of a medical consultant:

- (a) Arrange a schedule for the interview. This is necessary to insure that the counselor, the medical consultant, and any others who might be involved will be available.

- (b) Arrange a place for the interview that is free from the distractions of telephones ringing, traffic, typewriter noises, etc.
- (c) Review the nonmedical factors in the case record. This review should enable the counselor to answer intelligently any questions which may arise during the discussion. Information from the social, environmental, educational, and vocational background that may relate to the medical problems should be readily available.

Counselor Responsibility

The counselor is the principal recipient of medical consultation services. All medical consultation services, whether administrative, educational, or local, have the effect of refining the counselor's role in relationships with clients. He can clarify, expedite, interpret, and make decisions with greater effectiveness through the use of medical consultation.

The counselor could not expect to develop all the skills necessary to solve the complex problems presented by disabled persons. Regular medical consultation can be of assistance to the clients and to the counselor in overcoming some of the barriers to successful rehabilitation. It should cover the variety of disabling conditions brought to the attention of the counselor and be available to him as needed.

The counselor can expect to more effectively utilize medical consultation services by better understanding the following:

- (1) The medical terminology, physical findings, diagnoses, and recommendations contained in medical reports.
- (2) How disabling the client interprets his condition to be and how he relates it to employability.
- (3) How physical restoration may improve the client's employability.
- (4) The skills of specialists in the diagnostic study and treatment programs.
- (5) The residuals of a disabling condition, the limiting effects, the physical stability of the client, and the progress of a client under treatment.
- (6) How the regulations regarding eligibility, services, training, and employment are both related to, and effected by, medical evaluation and interpretation.

In preparing cases for the services of a medical consultant, the counselor should:

- (1) Review all cases to determine the need for

- medical consultation and select those cases presenting problems for presentation to the consultant.
- (2) Select cases recommended for treatment, surgery, prosthesis, and cases presenting multiple disabilities.
 - (3) Present cases where a conflict of information has occurred. This could be between physician and patient, counselor and client, physician and physician, or physician and consultant.
 - (4) Prepare his material so he can be brief and to the point in presenting cases to the consultant.

Responsibilities of the Medical Consultant

The medical consultation Study Group of the Institute on Rehabilitation Services (1963, p. 12) listed the following responsibilities of the medical consultant in his relationship with the counselor. However, these responsibilities are not intended to be interpreted as a job description for medical consultants.

- (a) In personal and group conferences, the medical consultant, utilizing his special knowledge, has the major duty of interpreting to the counselor the medical data available in individual cases.
- (b) In interpreting the medical findings to the counselor, he assists in determining vocational and medical implications, and, if necessary, recommends other medical diagnostic procedures required for this determination.
- (c) The medical consultant alerts the counselor to the needs for further medical care in cases in which it has not been provided, and continues as an active advisor in such problems.
- (d) The interpretative functions of the medical consultant should be balanced by a recognition of his teaching role. In the interpersonal relationship between counselor and consultant centered about a clinical problem, there is constant opportunity for teaching the nature of the disease, diagnosis, and treatment.
- (e) The medical consultant informs himself on the available rehabilitation facilities, helps evaluate their medical components, and assists the counselor in determining the suitability of a facility to meet the client's medical needs.
- (f) The medical consultant, from a wide knowledge of the medical resources and various medical specialists and their ability to contribute to rehabilitation, recommends to the counselor the resource or specialist to be used.

- (g) The medical consultant with a good understanding of the rehabilitation process can eliminate useless medical studies and focus the medical evaluation on the medical aspects of rehabilitation. Also, he should expedite the medical evaluation by helping the counselor plan for specialists' studies concurrently, instead of piecemeal.

THE MEDICAL DIAGNOSTIC STUDY

All individuals involved in the medical study of a rehabilitation client should be aware of the goal of rehabilitation; i.e., the best obtainable vocational adjustment for the client. Their reports and work should reflect this awareness, and the medical evaluation of a client should not become so involved with the diagnosis and treatment of a specific pathology that the goal of rehabilitation becomes overshadowed or secondary. The client's perception of himself as a vocationally and socially productive individual should be constantly reinforced except when it is obviously contraindicated.

Range of Medical Diagnostic Services

The counselor, on the advice of his medical consultant, should arrange for all the medical diagnostic services that are required for an adequate understanding of the individual in terms of his present, and probable future health status; his needs for medical care or other rehabilitation services; and his capacities or limitations, for employment.

Included in the broad range of such diagnostic services are:

- (1) Medical and surgical examinations.
- (2) Psychiatric evaluations.
- (3) Dental examinations.
- (4) Consultation with and examinations by specialists in all medical specialty fields.
- (5) Inpatient hospitalization for study or exploration.
- (6) Clinical laboratory tests.
- (7) Diagnostic X-ray procedures.
- (8) Trial treatment (especially in cases of epilepsy, diabetes mellitus, emotional disturbances, or for differential diagnosis in other conditions).

- (9) Hearing evaluation in cases of blindness to evaluate substitute sensory perception.
- (10) Other medically recognized diagnostic services.

Preparation for Medical Diagnostic Study

At the point of initial contact with his client, the counselor, in conjunction with his medical consultant, should begin to make careful plans for the medical diagnostic study. In the initial interview, the counselor should secure from the client all pertinent information about his disability, including information concerning its onset, its symptoms, its remissions (if any), the treatment he had had for it, and other significant past illnesses.

Particularly important is adequate information about the client's current medical supervision. If he is under the continuing care of his own physician, the counselor needs to know the nature of the treatment being provided, the recency of the contacts, and the nature of the doctor-patient relationship. If the physician knows the client well, he can contribute information relative to the social and psychological aspects, as well as the medical aspects, of the client's situation.

The counselor needs to know if the client is receiving medical supervision from a hospital or clinic in the community. This information should be taken into consideration by the counselor in planning and arranging for medical diagnosis or physical restoration. In many instances, the medical data included in referrals from physicians or health agencies should be supplemented by more detailed résumés of medical services that have been previously provided.

The counselor is responsible for informing the client of the procedures involved in the medical diagnostic study. Adequate interpretation of the agency's requirements and reasons for the diagnostic procedures is essential in enlisting the client's cooperation in following through on medical recommendations. The client will need to understand: (1) Why he is being referred for medical examinations; (2) the amount of time they may require; (3) what he can and cannot expect to learn from the examining physician; and (4) what use the agency will make of reports of his medical condition.

The General Medical Examination

The medical examination is completed by a physician who, insofar as he is able, takes an overall look at

the total medical problem of the individual. The purpose of the general medical examination is to begin an evaluation of the individual's total medical problem and to establish his current health status. It is necessary that a general medical examination be obtained in all cases, though the State plan may specify the conditions under which a medical abstract will be accepted in lieu of a new examination. Examinations by medical specialists will be obtained as needed. The regulations provide that in all cases of behavioral disorders a psychiatric or psychological evaluation will be obtained, as appropriate.

Regardless of the type of impairment, it is necessary to secure complete data regarding the individual's sight, hearing, muscle tone, skin, heart, lungs, and other factors that might have a bearing on the choice of an occupational objective.

Clients who have been treated in mental hospitals, tuberculosis sanatoriums, or specialized outpatient clinics are often in need of a comprehensive general medical review. There is a particular need for visually impaired persons to have their eye examinations supplemented with a complete medical workup. Regulations also require that in all cases of blindness, an adequate hearing evaluation will be obtained.

Choice of the Examining Physician

Many clients who come to the agency are already under the care of a physician, hospital, or clinic. If the client has his own physician, the counselor should encourage the continuance of this relationship. Often, more valid medical data may be obtained from the family doctor than from a new medical examiner. Any consideration of change of examiners in the interest of a fresh appraisal of the client, or of the desirability of supplementary specialist's examinations should be discussed with the family physician. In some instances, it will be advisable to discuss the client's rehabilitation plan with the individual's family physician.

A medical résumé which provides a history of past and continuing medical care can be helpful in planning the diagnostic services that the counselor should secure. Frequently, a résumé from a hospital or clinic will report the results of elaborate diagnostic procedures already performed and thus make it unnecessary for the State agency to have such tests administered.

In spite of the emphasis in the preceding paragraph upon the importance of résumés of past medical care, the present medical condition of the individual needs to be considered in its relation to the purposes of the vocational rehabilitation program. This information

can be attained only through new and thorough examinations. A comprehensive medical examination can often reveal medical reasons for a client's difficulties that have been previously overlooked. Since many rehabilitation clients have not been helped through the usual channels of medicine, education, or employment, the counselor often must be prepared to provide *more and better services* than have been available to the client before. Through a new medical evaluation, it may be possible to uncover an error in diagnosis or an overlooked clue.

In cases where a current medical examination is considered necessary but cannot be secured, rehabilitation services should not be initiated until the medical problem has been satisfactorily settled. Difficulties in securing a current medical evaluation may arise when the client refuses further examination or when the examining physician is reluctant to share medical information. Such difficulties seriously hamper sound rehabilitation planning by the counselor and the client. The medical consultant can be extremely helpful in securing cooperation from the client's physician.

Both the counselor and his medical consultant can help interpret to examining physicians what kind of medical information is needed by the agency as a basis for rehabilitation planning. The examining physician can use this information in appraisal of the individual's physical capacities and thus provide facts which more directly can be related to employment potential.

Scope of the General Medical Examination

The general medical examination should consist of a medical history and a complete physical examination. The examination should cover the individual's general appearance, weight, height, posture, blood pressure, pulse, respiration, hearing, vision, blood vessels, lymph nodes, extremities, heart, lungs, pelvis, nervous system, and other parts of the body specifically mentioned on the State agency's examination form.

Certain clinical laboratory tests are considered an indispensable part of any general physical examination. A urinalysis should be required. A serological test for syphilis and a chest X-ray are now also widely accepted as a part of the general medical examination. Other laboratory tests recommended for inclusion in the general medical examination are a blood count, consisting of at least a red and white cell count and a hemoglobin determination, and an electrocardiogram for clients over 40 years of age. In most instances, these tests would involve additional fees beyond the rate for the general medical examination.

The simple urinalysis for sugar or albumin has been most useful in discovering unsuspected cases of diabetes or kidney disease. Serology is indispensable in serving persons with longstanding chronic illness. Chest X-rays are valuable in revealing heart pathology, as well as the presence of tuberculosis, tumors, and other pathological conditions of the lungs and chest. The medical examination should not be limited to a report of the technical presence of a disability but should give equal consideration to the client's ability to function within the limitations of his disability.

Recency of the General Medical Examination

The general medical examination should be recent enough to provide an adequate basis for evaluating the individual's present state of health and for planning what he should appropriately undertake by way of training or work activity. In most cases, new examinations should be obtained if medical data are older than 3 months. This suggested time period may vary from one disease to another. It may be lengthened for certain individuals; but in some cases, such as diabetes, anemia, or certain heart conditions, it is important to have current (no older than 1 month) information. In all cases, it is desirable that the medical consultant evaluate both the content and adequacy of the medical information secured.

Acceptance of Medical Résumé

If a medical abstract (i.e., a résumé of medical care and examination) is available to the counselor, the following conditions should be met if it is to be considered the equivalent of a new general medical:

- (1) The client's total condition should be reported upon, rather than merely a portion of his anatomy. The data requested in the general medical examination report form should be covered in the résumé.
- (2) The résumé should indicate the date on which the examination was done—when the blood pressure readings were taken, etc. A report which merely summarizes treatment of a series of acute illnesses, or one which is merely filled in from the physician's records without evidence of a complete examination, is not an acceptable substitute.
- (3) The medical findings and conclusions should be of sufficiently recent date to warrant their use in planning for the individual's rehabilitation.

Specialty Examinations

An examination by a specialist should be secured in all cases where there is need for a more thorough study of the particular impairment. These should usually be done upon recommendation of the medical consultant or family physician. Whether medical specialty examinations are recommended by the general medical examiner or not, it is good practice to secure them in cases where more thorough study is needed for better understanding of the client's condition. This would include, for example, all cases where the disability is obscure or hard to diagnose, and where the impairments are such that the medical profession has determined a need for a specialist; i.e., otologist, ophthalmologist, orthopedist, dentist, urologist, etc.

At times it may be desirable to obtain a specialist examination before sending the client for a general medical examination. If there is considerable doubt that he has sufficient disability to be eligible for the program, it may be more expedient to first secure an evaluation by a medical specialist. This procedure is recommended in certain cases of visual or hearing losses, cardiac disabilities, and mental or emotional problems where the severity is not apparent. If the disability is severe enough to qualify the client for further consideration for rehabilitation services, the general medical examination should follow.

The medical specialist can provide more exact information regarding how a client can best utilize his remaining physical resources. When it is possible, the counselor should inform the specialist of the client's tentative vocational goal. This will enable the specialist to plan his evaluation in light of the proposed objective and make specific recommendations relative to the vocational plan.

Hospitalization for Diagnostic Study

Inpatient hospitalization for diagnostic purposes should be provided those clients for whom the required diagnostic study cannot be satisfactorily done on an outpatient basis. In order to minimize unnecessary costs of hospital care, the counselor should plan carefully the timing of the client's admission to the hospital. For example, a hospital's clinical laboratories and other supporting diagnostic services rarely provide the full services for intensive study of a patient over a weekend. Therefore, it is desirable that the client be admitted to the hospital when its full resources can be most effectively and economically utilized.

The Use of Medical Information

It is important for rehabilitation counselors to be aware of their professional responsibilities in handling medical reports and information. The findings of a medical examiner for a client *should not* be discussed with anyone except other qualified professional individuals who need this information to perform their role in that client's rehabilitation program. Even then, care should be taken to insure that the data are not misinterpreted and that the client's right to privacy is respected.

The rehabilitation counselor should *not*, under any circumstances, attempt to interpret the specific technical medical findings to his clients. He is not qualified to perform this function. This is the responsibility of the physician, and the counselor should make it clear to insistent clients that he cannot and will not attempt to explain technical medical reports. The client should *never* be allowed to examine the medical reports himself. Such a practice could be harmful to a client, and would rarely be of any assistance.

Generally, the counselor has two uses for medical information. First, to determine eligibility, and second, to help the client make realistic vocational plans for the best use of his residual capacity.

In summary, the counselor has the following responsibilities in the medical phase of the client-study process:

- (1) Identifying the disability problem.
- (2) Determining the nature of the diagnostic study.
- (3) Understanding the meaning of the medical findings.
- (4) Determining the possibility of alleviating or removing the disability.
- (5) Determining eligibility or potential for rehabilitation.
- (6) Determining the feasibility of services in reaching a goal of employment.
- (7) Determining how and in what way services would best be provided.
- (8) Interpreting residual limitations, to the client and those relating to him.
- (9) Appraising the results of services through continual evaluation.
- (10) Appraising the capacities and limitations of the client with regard to participation in training.
- (11) Appraising the capacities and limitations of the client with regard to employment.

The psychological, social, and vocational concomitants of physical disability are discussed in the following sections. Often what the impairment means to the client in terms of his total adjustment is more troublesome than the diagnosis and treatment of the impair-

ment per se. It is these residual or side effects of disability that rehabilitation counselors should be uniquely prepared to handle. The counselor's role in the medical evaluation process consists chiefly of coordinating and expediting medical services for his clients.

Section 8

CLIENT STUDY: PSYCHOLOGICAL

THE psychological evaluation of a client forms an integral part of the client-study process. Evaluation involves more than mere psychological testing. It includes the study of the client's past behavior as well as conclusions drawn from observations of his current behavior during the initial interview and all other contacts. During the initial phase of the case study, the psychological evaluation provides valuable information in the determination of eligibility and feasibility. However, the evaluation of the client's behavior is in no way limited to the preliminary phase of the study but continues during the entire rehabilitation process. The professionally trained rehabilitation counselor is continually checking his observations and predictions against the client's overt behavior. On the basis of these observations of the client's behavior, he modifies his counseling technique and tentative client job objectives. By remembering the various psychological aspects, effects, and methods of adjustment to disability, the rehabilitation counselor is assured of a sturdy foundation for all his psychological evaluations.

PSYCHOLOGICAL ASPECTS OF PHYSICAL DISABILITY

Often the most pressing problems of the physically disabled person arise not from the disability itself, but from its psychological and social-psychological ramifications. These so-called somatopsychological effects of disability are crucial to both the client's motivation and his response to rehabilitation measures. Psychological problems are often interwoven with the disabling condition to the extent that they often are the most significant barriers to the client's rehabilitation objective (Garrett, 1953). The disabled person is struggling with the socially devaluating effects

of his disability as well as with changes in his self-concept. Because of their excessive concern with self, the physically disabled present many problems to the staff working in a rehabilitation setting. Since there appears to be a greater variation in the physical and psychological needs of disabled individuals, counseling disabled clients is often more difficult than counseling the nondisabled. For more effective counseling, the rehabilitation counselor should have an especially sound understanding of the psychological aspects of physical disability.

A large number of rehabilitation clients are handicapped by emotional problems related directly or indirectly to their physical disability. Because of the limits imposed on them by their disability, many avenues of normal relationships are closed. Socially, physically, and economically, they have encountered frustrating circumstances that have led to conflict. These frustrations and conflicts may have resulted either from their disability, from their attitude toward their disability, or from social pressures. Hostility, aggressive behavior, submissiveness, dependency, and withdrawal symptoms are often a result of these frustrations.

Certainly not all physically disabled clients counseled by rehabilitation counselors are handicapped by emotional conflicts. Many are quite well adjusted individuals, and their major objective in the rehabilitation process is physical restoration and/or vocational counseling, training, or placement. However, more often than not, there are psychological aspects that influence the direction the rehabilitation process will take. For this reason, the rehabilitation counselor should understand how and why physically disabled individuals react the way they often do in their attempts to maintain their psychological equilibrium. He should notice client behavior to ascertain whether specific psychological effects of disability are present.

Psychological Effects of Disability

The psychological effects of physical disability may be classified under the following headings:

1. *Psychological Effects Arising Directly From the Disability.*—With many disability groups (the cerebral palsied, the poliomyelitis victim, etc.) the central nervous system has been damaged in some manner, giving rise to a variety of behavior disorders. In other cases, organic brain damage is present but undiagnosed. Where there is no damage to the central nervous system, the physical limitations imposed on the physically disabled person can cause excessive frustration and this sometimes leads to behavior disorders. The paraplegic, the cerebral palsied, and the orthopedically handicapped generally have difficulty with psychological problems arising *directly* from their physical limitations.

2. *Psychological Effects Arising From the Client's Attitude Toward His Disability.*—The rehabilitation counselor can never be sure what psychological effects a disability will have on a client. The client's attitude will depend largely on: (1) His experiences prior to his disability; (2) the amount of fear he has experienced during the onset and duration of the illness or accident leading up to the disability; (3) the information he has regarding his disability; (4) how he has been treated by his family and friends; and (5) his hopes for regaining or attaining independence and security. Furthermore, if the disabled person is unsure of the future, anxiety is almost certain to be present.

3. *Psychological Effects Arising From the Attitudes and Behavior of Others Toward the Disabled Person.*—The attitude of the general public toward disability is possibly the greatest single determinant of the psychological effects a disability will have on the individual. Our society places a great deal of emphasis on perfection, whether it be economic, social, financial, or physical. This worship of the ideal has resulted in ridicule, discrimination, and avoidance of the different and strange. It would seem that the more visible the disability, the greater is the discrimination and avoidance. As an example, those with facial disfigurements and those with bodily deformities are frequently the victims of unwholesome social attitudes. The deaf, the cardiac victim, and those with other disabilities that are not so readily noticeable do not encounter the social rejection that is the fate of the visibly disfigured.

These negative attitudes are responsible in large part for the poor self-concept many disabled individuals have. It would seem only natural for the disabled to

devalue themselves, for often they cannot measure up to the perfectionistic demands of their society.

Methods of Adjustment to Disability

In their adjustment to disability, the physically disabled either compensate for their limitations, succumb to social expectations, or idolize normal standards and utilize what Wright (1960) terms "as if" behavior. These three methods of adjustment to disability are discussed below:

Compensation.—Compensation can be good or bad, depending on whether the individual strives for constructive achievements or strives to make up for an undesirable trait. Compensation, when carried to extremes, results in neurotic striving for superiority. When the disabled person recognizes realistic limitations and engages in constructive undertakings that he can do, this is positive compensation.

Succumbing to Social Expectations.—In succumbing, the disabled person plays the role expected of a person with a particular handicap. They become ashamed of their disability and react in ways which are consistent with society's concept of them. The "requirement of mourning" (Wright, 1960) is one example of the succumbing aspects of physical disability and, as discussed in section 9, requires the disabled person to feel inferior to meet society's expectations.

"As if" Behavior.—In his efforts to adjust, the disabled person attempts to conceal his disability. He views his disability as devaluating and does not want others to know of it. The need to appear normal may be so strong that the devices utilized by the disabled person fool no one except himself. This desire to hide a disability may become so powerful that actual repression is employed. This "as if" behavior is prevalent among individuals with disabilities that are partial, such as moderate hearing losses or reduced vision.

Referral and Testing Problems

Many of the clients who are referred for vocational rehabilitation have recently experienced traumatic disability. The majority of them are men or women who have been self-sustaining for a number of years. Often, almost overnight, they find themselves unable to work and desperately in need of help and assistance. In seeking help, they frequently overreact and sometimes strike out quite desperately at the person or agency attempting to help them. When the need for a series of psycho-

logical tests is mentioned, such clients tend to react to the negative implications of testing and are unable to see how it can make any positive contribution to their rehabilitation.

The rehabilitation counselor working in the area of psychological evaluation must realize that much of the hostility that the client is expressing is directed against the situation and not against him personally. Some people with very limited knowledge of the aims of psychological testing will be quite suspicious of the process and oftentimes feel that the counselor is trying to find out "if they are nuts." In order to overcome this, the counselor must have a very clear understanding of the specific aims of testing and psychological evaluation. He must establish rapport with the client so that he is able to explain to him the positive results which can come about as a result of the information which will be obtained. While he should certainly not attempt to "sell" the client on the value of the tests, he should present the material realistically and objectively, and in such a manner that the client himself can come to see the values of the testing procedure.

PSYCHOLOGICAL EVALUATION

DiMichael (1959), in a pamphlet entitled "Psychological Services in Vocational Rehabilitation," conceptualizes the potential values of psychological evaluation in terms of client learning. He feels the client can profit from the psychological evaluation through the counseling process by: (1) Helping the client in understanding himself; (2) aiding the client in making reasonable plans and decisions; (3) helping the client in identifying problems; and (4) assisting the client in gaining a better understanding of his relative strengths and limitations.

In the majority of cases, the money spent on psychological evaluation represents a sound investment to the rehabilitation agency. It is much easier to spend a few dollars on adequate evaluation than it is to waste a great deal of time and money as the result of an unrealistic vocational plan. Adequate evaluation should result in an increased number of successfully rehabilitated cases. Psychological evaluation will help both the counselor and the client to identify special skills and aptitudes and to supplement the subjective information which has been gathered during the initial phase of the client-study process. It should help the counselor identify those clients who will need extensive counseling services as opposed to those clients who are relatively

intact psychologically, or are adjusting well to their disability, and who, therefore, will need only minimal counseling services during rehabilitation. This means that the rehabilitation counselor can devote his time to the client who needs it most and thereby increase an individual client's chances for successfully completing a rehabilitation program. Besides recognizing the value of psychological evaluation, the rehabilitation counselor should be aware of the problems it poses.

Recommended Standards for Psychological Evaluation of Rehabilitation Clients

The rehabilitation counselor bears the responsibility for determining both the need and extent of psychological evaluation, except in the case of mental retardation or behavioral disorders when such an evaluation is required. It is his job either to perform the evaluation himself, if trained to do so, or else to secure the evaluation from other sources. In most rehabilitation agencies, psychological evaluation is provided by the counselor himself, by psychologists on the State staff, by consulting psychologists on the State staff, or by outside psychologists if they have special training in the area of diagnostic work with the handicapped. Nevertheless the ultimate responsibility for the application of the information obtained lies with the counselor. He is professionally obligated to use the information gained during the psychological evaluation in order to help the client know and understand himself and to help him in arriving at a reasonable vocational objective. The following lists tell respectively when psychological testing services are needed, and when they may not necessarily be required.

Psychological testing services *are needed* when:

- (1) Mental retardation has to be determined, and testing will include a valid test of intelligence and an assessment of social functioning and educational progress and achievement as provided in the regulations (1966, sec. 401.22(e)), for example:
 - (a) The applicant's eligibility for rehabilitation is based on mental retardation as the primary disability.
 - (b) The applicant is suspected of having subnormal intelligence as a secondary disability.
- (2) Behavioral disorders are suspected and a determination has to be made whether psychological evaluation, as an alternative to psychiatric

evaluation, is appropriate as provided in the regulations (1966, sec. 401.22(e)), for example:

- (a) The applicant's eligibility for rehabilitation is based on behavioral disorder as the primary disability.
 - (b) The applicant's behavior deviates from what is considered normal, or his ability to carry on normal relationships appears to be impaired.
- (3) Long-term or expensive training is involved in a rehabilitation, for example:
- (a) The job objective under consideration involves college or university training.
 - (b) The job objective involves more than 3 months apprentice or on-the-job training.
 - (c) The client's vocational background is not in the field of the skilled work for which he is being considered.
- (4) Client or counselor needs information or confirmation of the client's abilities, aptitudes, achievements, interests, and personality patterns, for example:
- (a) The counselor or client is undecided about a vocational choice and desires information about the client's abilities, aptitudes, achievements, interests, and personality.
 - (b) A tentative job choice has been made, which the counselor or client wishes to confirm through psychological evaluation.
 - (c) The job choice of the client is considered unsuitable by the counselor, who then seeks objective data to confirm the tentative decision.
- (5) Data on the client's capacities and abilities are lacking, are ambiguous, or are contradictory, for example:
- (a) There is no educational or work record available on the client.
 - (b) The case history shows serious contradictory data in regard to the client's capacities and abilities, and his expressed vocational interests.
- (6) Important talents, capacities, abilities, or disabilities are suspected by the counselor or client, for example:
- (a) A special talent or capacity is suspected, but the case history shows no reliable evidence of its existence, and psychological

tests are available for measuring such talent.

- (b) The counselor or client suspect the latter has a specific disability which will materially affect his successful pursuit of the vocational objective, for example, a reading disability, arithmetical disability, a deficiency in English and grammar, etc.
 - (c) The client or counselor seeks to establish the equivalent of a certain level of education for the client, but the client does not have the formal credits necessary to substantiate his claim. In this instance, psychological tests are necessary to determine the client's level of educational achievement and thereby attain the job objective in the most expeditious way.
- (7) An individual is known or suspected of having certain disabilities that require specialized evaluations of his capacities, abilities, skills, interests, and personality, for example:
- (a) Persons with actual or suspected brain or head injuries, cerebral palsy, epilepsy, or other conditions involving neuromuscular disorders.
 - (b) Persons who have emotional disturbances, or for whom it is desirable to determine whether a psychiatric consultation is indicated.
 - (c) Persons who have or are suspected of having damage to the central nervous system.
 - (d) Persons with other disabilities which require specialized individual testing, such as the blind, the totally deaf and seriously hard of hearing, the aphasics, those with severe reading disability, problem cases and individuals whose employment record indicates they are "accident prone."

However, there are occasions when psychological testing is not needed. Psychological diagnosis and evaluation *may not necessarily* be required when the client falls into any of the following categories:

- (1) The person has very recently been successfully employed and intends to return to his work as soon as physical restoration services have been rendered.
- (2) The person has been successfully employed, is now unable to find similar work because of the prejudice of employers toward the handicapped, and it is necessary for the counselor to

convince the employer that the client has the abilities required for the position.

- (3) The person has been successfully employed, and only a minor shift is contemplated in the type of work that he will do in the future.
- (4) The person has a long and rich background of information on the jobs he held, the jobs are in related types of work, and the individual has changed jobs for reasons beyond his control.
- (5) The individual has a long and rich background of educational information, the caliber of the school in which he matriculated is well established, the caliber of the teachers in important subjects is well established, and the client does not plan to study or work in areas unrelated to his background.
- (6) The individual is not cooperative and does not desire to be tested. In such cases, testing occasionally may be contraindicated until the reasons for such an uncooperative attitude are understood and dealt with in counseling. If the client becomes willing to see the psychologist, the latter may be able to evaluate his abilities and his personality patterns.

Ethical Problems Involved in Testing and Psychological Evaluation

In the provision or purchase of psychological evaluations, the rehabilitation counselor should be aware of the principles and ethical problems associated with this service, not only to protect the welfare of his clients but also to eliminate the possibility of putting himself in an embarrassing situation.

Both the American Psychological Association (1963) and the American Personnel and Guidance Association (1961) have established specific ethical standards for the use of tests and the provision of psychological evaluations. An attempt will not be made in this manual to discuss these recommendations in detail, however, a few of the more general points of the APA and APGA codes are given below:

(a) American Psychological Association

Principle 2. Competence.—The psychologist recognizes the boundaries of his competence and the limitations of his techniques and does not offer services or use techniques that fail to meet professional standards established in particular fields.

Principle 4. Misrepresentation.—A psychologist does not claim, either directly or by implication, professional qualifications that differ from his actual qualifications * * *

Principle 7. Client Welfare.—The psychologist who asks that an individual reveal personal information in the course of interviewing, testing, or evaluation, or who allows such information to be divulged to him, does so only after making certain that the responsible person is fully aware of the purposes of the interview, testing, or evaluation and of the ways in which the information may be used.

(b) American Personnel and Guidance Association.

General. Number 6.—The member should not claim or imply professional qualifications exceeding those possessed and is responsible for correcting any misrepresentations of his qualifications by others.

Testing. Number 4.—Different tests demand different levels of competence for administration, scoring, and interpretation. It is therefore the responsibility of the member to recognize the limits of his competence and to perform only those functions which fall within his preparation and competence.

The rehabilitation counselor should keep the above principles in mind when preparing to evaluate a client. In the rehabilitation process, it is the counselor's responsibility to secure competent assistance in formulating a vocational plan for his clients.

Content of a Psychological Evaluation

In addition to using psychological tests, there are many other things that the counselor can do to gather information for the total psychological evaluation of each client. These include the following:

1. *Review of Educational Experiences.*—The counselor should secure as much information as he can in regard to the client's previous educational experience. Remembering that the best single indicator of what a student will do academically in the future is his previous grade point average, the counselor should contact the client's schools for high school and college grades and any other information that the school has in regard to his rank in class and his scores on psychological tests administered during the time he was in school. Information on his social adjustment to the school, as well as information on his participation in athletics and other social events, is of help.

2. *Assessment and Personality.*—In addition to the use of paper and pencil tests, or even projective personality tests, the counselor should be able to gather information about the client by observing his behavior during the counseling interview and other contacts. He should evaluate the following variables: The cli-

ent's reaction to his disability; his feelings in regard to adjusting to disability; the effect of the disability upon his social adjustment in the community; his attitude towards exposing himself to the physician for the general medical, specialist's report, and other medical examinations.

It would also be well to observe any marked deviations in personal appearance and changes in behavior during the interview, as well as general impressions in regard to tension, hostility, passivity, etc. During the interview, he should look for signs of excessive nervousness, such as rapid talking, blocking of speech, giggling, excessive perspiration and overt anxiety, and fear out of proportion to the situation. During the interview, he should also be able to get some idea of the client's general ability level as indicated by his verbal functioning. He should be able to evaluate his general ability in terms of his skill in expressing himself adequately and in terms of the amount of realistic thinking that is reflected in his current vocational planning.

The psychological evaluation is in no way an isolated process but involves *all* of the variables mentioned above. The job of the rehabilitation counselor is to understand all of the information that he gained during the psychological evaluation, to integrate it into a reasonable vocational plan, and to provide psychological services that will allow the final objective to be reached. In addition to using tests for diagnosis and prediction, they can also be used to provide valuable information for ongoing research within the agency itself.

Counselor's Use of Tests

The amount of psychological testing that an individual counselor will perform depends upon the following factors: His training and experience; the amount of time he has available for testing; and the policy of the agency that employs him. As mentioned in a previous section of this manual, the training and work experience of rehabilitation counselors who are now employed by State and private rehabilitation agencies varies greatly from State to State. In many States nearly every counselor on the staff would be qualified to use tests as outlined above, while in other States very few counselors would have sufficient training either to administer or score psychological tests.

The policy of the agency is extremely variable from State to State, and often even within districts of the same State. Some agencies expect their counselors to do nearly all the psychological testing that may be

involved in any particular case, while other agencies feel that these services should be purchased in the same way that medical or any other necessary services are purchased. In the majority of States it would seem that the rehabilitation counselor is expected to be qualified to administer and evaluate tests of mental capacities, interests, and tests for personality traits within the normal range.

The committee on psychological testing, at the First Annual Workshop of Supervisors of Guidance, Training and Placement sponsored by the Vocational Rehabilitation Administration in 1947, emphasized that the counselor should be qualified to administer and evaluate tests, when they specified "a recommended minimum basic testing kit for each rehabilitation counselor." In regard to this kit, DiMichael (1959) has the following to say: "the use of the counselor as a service resource for clients where the counseling testing kit is suitable has several advantages. The counselor is able to test a small group of clients at one time in such places as schools, outlying area offices, and other referral agencies. Some of the homebound may be served by the counselor on a scheduled visit. Some clients in far outlying areas may be tested without the difficulty of arranging travel and overnight lodging. We may also expect that more clients in need of psychological testing and evaluation will be provided the services."

While recognizing that the rehabilitation counselor in most State agencies is certainly not trained at the doctoral level, and is not skilled in the use of tests as clinical diagnostic instruments, the fact remains that in the majority of cases the burden for the selection, use, and administration of psychological tests falls upon his shoulders. In many areas throughout the country, psychological services are not available except in the larger cities. In these areas, when a psychological evaluation is needed, the rehabilitation counselor in the field is expected to provide at least minimal testing services.

The Use of Tests With Handicapped Individuals

The use of tests and test information for formulating a specific plan of action must always be on an individual basis. This is especially true in rehabilitation settings. The specific limitations imposed by each client's disability need to be considered in relation to both his ability to perform on a test, and his vocational objective. For example, the client who writes slowly because of his disability should not be given tests which

place a premium on speed, particularly if success in his occupational objective does not require a rapid rate of manipulation or finger dexterity.

There are many testing situations where special consideration cannot and should not be given a handicapped individual. Such testing situations are determined by the nature of the disability and the vocational objective; e.g., for the client with a below-knee amputation who is interested in attending college, there is no reason to make an allowance for his disability, you use his score on a college aptitude test to help predict his future academic success. His particular limitation of activity does not interfere with his possessing those traits which are measured by the test and which are relative to his vocational objective.

Implicit in the use of a standardized test is the assumption that all the individuals in a particular group have had an equal opportunity to learn the material in question. The imposition a disability has on a handicapped client's opportunity to accumulate the expected experiences and knowledge will vary widely among and within disability groups. Some of the variables which can affect his experiences are: Severity of disability, age at onset, limitation of movement, sensory limitations, degree of withdrawal from the environment—physical or psychological, and family attitudes. In spite of these real limitations, the fact still remains that most handicapped individuals will be competing for employment with nonhandicapped persons. On the question of what norms should be used with the handicapped, C. H. Patterson (1958) made the following observations:

* * * there is the question I would like to raise in terms of testing the handicapped. When is it justifiable to make departures from standardized testing procedures with handicapped clients? The basis of using tests is to get an objective comparison of the individual with a standardized group. This is the norm group. Then insofar as one departs from the standardized procedure of administering the test, to that extent the norms are not useful, and decisions are affected. They are not based upon the research information that is available. We should avoid departing from standardized procedures insofar as possible. What does this raise in terms of the question about the difference between the actual functioning level and the potential level? This is sometimes over-emphasized. We are interested in potential functioning of a client only when we have some reason to believe that the client will at some time in the foreseeable future function at the level, or be able to function when the blocks or whatever it is that is preventing him from functioning at highest level can be removed, or when there is some feeling that they can be removed. So potential is only potential; it may never become actuality. A knowledge of his potential alone is of little use in the actual decisions the client has to make or that the counselor has to make.

What norms should be used? We should use the most appropriate norms. There is a lot of discussion about getting norms of handicapped people, norms for C. P.'s, and various other disability groups. But these are not the kind of norms that we need. Certainly we need many more norm groups than we have. We can't depend upon general population norms. But the norms needed are not in terms of disability, the norms are in terms of the kind of people with whom the client is going to be competing in the future. The most appropriate norms are for the group which the client is going to enter; the occupation, the competitive field. These can be broken down into local norms, and industrial norms of various kinds. These are some of the questions that we ought to consider when we are talking about the adaption of the testing to the individual and the use of norms (p. 159).

Another point needs to be made here: Although a handicap may penalize an individual on a performance or work sample test, it may not affect his ability to be a competitive producer on the job. This would be true with handicapped individuals who have mechanically or otherwise made compensations for their disability. Also, some machinery can be adapted and modified so as to enable a handicapped worker to compete with nonhandicapped coworkers.

An attempt will not be made to cover specific tests and the technical information needed for their use in this manual. There are a number of excellent books that cover this topic; i.e., Anastasi (1961), Cronbach (1960), and Freeman (1962). The exact reference to these and other related texts may be found in the "Suggested Readings" for this part of the manual.

In summary, psychological testing may not be needed in all cases, however psychological evaluation is certainly involved in the planning of every rehabilitation program. In the rehabilitation process, the counselor is responsible for orienting the client to the purpose of tests and for providing an accurate interpretation of test results during the counseling process. The effective use of tests by the counselor is dependent upon the adequacy and the thoroughness of his training in this field. The counselor should be aware of his professional competencies in the area of evaluating a client's behavior and should abide by the code of ethics proposed by the American Psychological Association. The general points of this code were outlined in this section. For a complete writeup on psychological services in vocational rehabilitation refer to the manual by DiMichael (1959). Many of the specific topics touched on here are reported in detail in DiMichael's manual; this detailed coverage should answer most of the questions which rehabilitation counselors can raise in regard to psychological services.

Section 9

CLIENT STUDY: SOCIOCULTURAL

PHYSICAL AND SOCIOCULTURAL ENVIRONMENT

NO HUMAN trait is so exclusively dependent on heredity as not to require certain environmental conditions for its development. This is true of physical traits and certainly much more so of social, intellectual, and emotional traits. At any given moment, an individual is the product of countless interactions between his genetic endowment and his physical and sociocultural environment. By physical environment we refer to the natural world surrounding the individual: Climate, terrain, food supplies, disease germs, etc. By sociocultural environment we mean the world of people, customs, values, and manmade objects (Coleman, 1960, p. 52).

The physical and sociocultural environment of the handicapped individual runs inevitably and inexorably through his personality and self-concept. Those who have worked with the physically handicapped know that adjustment to a disability is closely related to how the attitudes and values of the disabled person interact with the attitudes and reactions of significant people in his environment.

The crucial importance of environmental factors in shaping personality development has been well summarized by anthropologist Margaret Mead (1953):

* * * the functioning of every part of the human body is moulded by the culture within which the individual has been reared—not only in terms of diet, sunlight, exposure to contagious and infectious diseases, overstrain, occupational hazards, catastrophes, and traumatic experiences, but also by the way he, born into a society with a definite culture, has been fed and disciplined, fondled and put to sleep, punished and rewarded * * *

Culture is seen * * * as a principal element in the development of the individual, which will result in his having a structure, a type of functioning, and a pattern of irritability different in kind from that of individuals who have been socialized within another culture * * * (p. 377)

The divergence of attitudes toward the handicapped in various cultures was previously mentioned in section 1. These attitudes are taught and learned in a social context. Both deliberately and unconsciously, each society manages to convey its concepts, values, and accept behavior to its children. To clarify what is expected of a person with a given position and status within a society, that society establishes various *roles* for its members, each associated with a certain pattern of anticipated behavior. The individual's basic personality structure is affected not only by society in general but also by the various subgroups to which he belongs—groups based upon his family membership, religion, occupation, social class, age, sex, etc. Each subgroup tends to foster certain values, beliefs, and approved behavior patterns which may in turn be subject to the restrictions imposed by society as a whole. The fact that each individual belongs to a somewhat different pattern of subgroups tends to produce individual differences, just as common membership in the larger cultural group makes everyone somewhat alike.

Sociocultural factors have such a great influence on both the handicapped individual's personality and adjustment and on the rehabilitation process itself that these factors must be considered in *all* phases of a client's rehabilitation. Though the adjustment problems of the disabled are in many respects unique to each particular individual, there are certain characteristics of the psychological environment of disabled persons in America that have general implications for their adjustment. Roger G. Barker and Beatrice A. Wright present theoretical explanations of the two deterrents to adjustment i.e., the *social devaluation* and the *insecurity* of the disabled, which they feel are inherent within our culture (Garrett, Rehabilitation

Service series No. 210). It should be emphasized that the rehabilitation counselor should remain cognizant of the pitfall of overgeneralization, since all variables affecting client behavior must be considered in light of the individual as he is here and now with his own unique repertoire of capacities and experiences.

Barker and Wright (1959) offer the following explanations for the social devaluation and the insecurity of some disabled individuals in America. Material from their writing is quoted in some detail since it seems to so precisely reflect the dynamics involved.

Devaluation of the disabled: Because of the value which society places on "body-whole" and "body-beautiful" a disabled person has to adjust to certain generally prevalent social-psychological facts. Probably the most far reaching of these is his social status. Often he is regarded by himself and others as inferior, not only with respect to his specific limitations, but as a total person. He may feel shame, inferiority, even worthlessness.

This general devaluation has some parallels with that of racial and religious groups. The Negro or the Jew, for example, are considered by some to be unworthy as human beings, or not acceptable as "100 percent Americans." The disabled too, are seen as an underprivileged minority by many (Barker, 1948).

Not only is the disabled person often considered inferior, but it is also felt that he "ought" to feel inferior, that he "ought to know and feel his place" much in the manner of other underprivileged minority members. This hypothesis, known as the "requirement of mourning," was originally elaborated by Dembo (1948) and her coworkers in a general theory of misfortune. It may not at first seem valid. For one thing, the requirement of mourning implies that men want others to suffer, and this is ethically objectionable. However, if we consider the following example, we can perhaps get some "feeling-insight" into the probable validity of this hypothesis:

A man takes great pride in being an outstanding community member. He owns the best car, belongs to exclusive social clubs and abides by the most proper social amenities. These are the things he values most highly. It follows, therefore, that he must consider as unfortunate those who lack material possessions and are omitted from positions of prestige. Furthermore, if these unfortunates do not act the part, for example, if they do not envy him and regret their misfortune he must reject and devalue them, for otherwise his own security is threatened.

Similarly, a person who places a high value on physical beauty, strength and skill is under strong pressure to demand that the disabled person mourn his lack of these, depreciate himself, and envy the nondisabled. Such a person must do this in order to maintain physical beauty, strength, and skill as central values upon which his security depends. And, paradoxically, the disabled person may also feel that he "ought" to feel inferior. This will occur as long as his value system remains that of the nondisabled majority, the group to which he wishes to belong and in many cases at one time did belong.

We see that the disabled are confronted with a serious

situation because two basic psychological needs of man are the need for self esteem; i.e., for high self-evaluation, and the need for social status; i.e., for high evaluation by others. For optimal adjustment these needs must be satisfied in some degree.

Whether or not a disabled person devaluates himself, he still has to cope with another important aspect of his psychological situation; namely, insecurity. Many areas of his life may be characterized by a lack of definiteness as to what may happen, an uncertainty as to where he stands with respect to the world about him. The following are three important sources of insecurity:

1. *Physical Insecurity:* The cultural world of houses, jobs, automobiles and cities is devised with the requirements of a broad group of relatively "normal" people in view. For this group, society goes far to structure and define the physical conditions of life. Only if this is done, are people free to make plans with the expectation of carrying them out. When a physically normal person starts to work he generally knows what is possible and what is impossible for him in the way of perception, physical locomotions, and manipulations, and he knows that within the limits of what is possible he can usually accomplish the day's tasks. He knows that the steps of the bus will be of a convenient height, that the seats will fit him, that the walk from the bus stop will not exhaust him, that the controls of the elevator will be within reach and that his employer's instructions will be understandable. He knows, in short, that the world of cars, towns, and offices, which society has constructed, is made for his convenience. One can easily imagine the changed outlook of a physically normal person as he started to work if he knew that the steps of the bus might be 5 feet high, that the seats might be without backs, that his office might turn out to be 10 miles from the bus station, that the controls of the elevator might be 10 feet above the floor, and that he might be unable to hear his employer.

This is, in some degree, the position of the physically handicapped person in a "normal" world. In many situations he is faced with a much greater uncertainty than are normal persons as to whether he will be able to carry out the locomotions, manipulations, and perceptions necessary to achieve his purposes. This can be very frustrating and anxiety producing as the following incident, related by Raymond Leslie Goldman (1947) who was hard of hearing indicates: "I am in a classroom. The class is a Latin recitation. We hold our books open at a certain page and one by one, as the teacher calls our names, we rise and translate the text, the bidden student taking up where his predecessor left off. I studied conscientiously the night before; I am thoroughly prepared. Yet, agony fills me. I am cold with terror, wretched with desperation, stricken by a sense of impending disaster.

I do what I can to avoid the horror of catastrophe. I try to save myself with my eyes. But I ask too much of my perceptive wits. My eyes must be on the teacher's lips whenever she happens to call my name. Even so, shall I know whether she says Goldman, or Goldsmith, or Gorham, or Bowman? I must be careful not to rise if it is one of the others whose names has been called.

And how shall I know where to begin, granting that I rise at the correct time? I know with what page we began; I made certain of it by looking over the shoulder of the student in front of me. I turn a page whenever the others turn theirs. But where, on two pages, are they? I watch the reciting stu-

dent. If he is behind me, I turn and see his face, but I cannot read Latin from his lips. If he is in front of me, I watch the back of his head. I can tell whether we are on the left-hand or right-hand page. The head is turned slightly to the left; the chin slowly sinks, then suddenly the chin goes up and the head turns a little to the right. The right-hand page! But what paragraph? What sentence? My classmate sits down. Look at the teacher! Oh, God, why does she hold down her head that way, looking at the recitation cards! What did she say? Gorman, Goldman, Bowman?

In spite of my desperate efforts I wasn't always successful. There were times when I didn't rise when the teacher called my name, and sometimes I rose when she called on someone else. On one occasion I thought she spoke my name and I got up and began to recite. The class broke into laughter. Behind me, the boy whose name had been called, had risen and begun to recite before I got to my feet. When I got up and joined in, like a second alto coming into a musical round, the teacher had every right to look startled."

2. *Social Insecurity*: In addition to the increased hazards and uncertainties arising from his physical situation, the handicapped person is faced with a similar state of affairs in his social world. The conflicting attitudes of normal persons toward the handicapped have been thoroughly established (Barker, et al., 1946). Acceptance and rejection, sympathy and pity, trust and fear, valuation and devaluation are the rule. This is due partly to ambiguous, unstable perception. The disabled person is seen now as good, now as evil; now as able, now as unable; now as childish, now as adult. The consequence of this is that the handicapped person is inevitably unsure of his reception by others and uncertain of the stability of their attitudes.

3. *Uncertainty Regarding Self*: Finally, the physically handicapped person is faced with greater uncertainty in building a consistent attitude toward himself. He meets the same difficulties others have in forming a stable, consistent attitude toward him. He receives the same ambiguous stimuli as others do when he views his own physique. He, too, must separate his perception of his imperfect body from the stimuli that reveal his less imperfect person. He is also faced with a conflict between the cultural values concerning physique and those relating the dignity of the individual. He fluctuates between feeling ashamed when the physical values are high and feeling an inner strength when the human dignity values are most potent. Moreover, in the case of acquired disability, his new body image conflicts with that of his former self. The anguish that can arise from this uncertainty and conflict about the self is effectively described by Katharine Butler Hathaway (1942) who suffered from a tubercular infection of the spine and was bedridden throughout her middle childhood. She says:

When I got up at last * * * and had learned to walk again, one day I took a hand glass and went to a long mirror to look at myself, and I went alone. I didn't want anyone * * * to know how I felt when I saw myself for the first time. But there was no noise, no outcry; I didn't scream with rage when I saw myself. I just felt numb. That person in the mirror couldn't be me. I felt inside like a healthy, ordinary, lucky person—oh, not like the one in the mirror! Yet when I turned my face to the mirror there were my own eyes looking back, hot with shame * * * when I did not cry or make any sound, it became impossible that I should speak of it to anyone, and the confusion and the

panic of my discovery were locked inside me then and there, to be faced alone, for a very long time to come (p. 41).

Over and over I forgot what I had seen in the mirror. It could not penetrate into the interior of my mind and become an integral part of me. I felt as if it had nothing to do with me; it was only a disguise. But it was not the kind of disguise which is put on voluntarily by the person who wears it, and which is intended to confuse other people as to one's identity. My disguise had been put on me without my consent or knowledge like the ones in fairytales, and it was I myself who was confused by it, as to my own identity. I looked in the mirror, and was horror-struck because I did not recognize myself. In the place where I was standing, with that persistent romantic elation in me, as if I were a favored fortunate person to whom everything was possible, I saw a stranger, a little, pitiable, hideous figure, and a face that became, as I stared at it, painful and blushing with shame. It was only a disguise, but it was on me, for life. It was there, it was there, it was real. Every one of those encounters was like a blow on the head. They left me dazed and dumb and senseless every time, until slowly and stubbornly my robust persistent illusion of well-being and of personal beauty spread all through me again, and I forgot the irrelevant reality and was all unprepared and vulnerable again (pp. 46, 47).

We come to the conclusion that, without question, the world of the physically handicapped tends to be less clear and secure than the world of nonhandicapped persons and that in consequence the freedom of the handicapped person is more limited. Insecurity is not, of course, peculiar to physically handicapped individuals. An important fact about all men is that they are weak relative to many physical and social forces that surround them. The forces that drive men and those that resist them are strong and greatly restrict men's freedom of action (Garrett, Rehabilitation Service series No. 210, pp. 18, 19, 24-27).

SOCIAL FORCES AFFECTING THE HANDICAPPED'S SELF-CONCEPT

The individual's self-concept or sense of identity is shaped in part by the social roles he plays. We are a combination of what we would like to be, and of what significant others will allow us to be. If the group regards a person as a leader, a solid citizen, or a menial, he tends to regard himself in the same way. He also tends to adopt the values and attitudes that are expected of one of his position, as well as those fostered by the groups to which he belongs or would like to belong. These attitudes, often adopted quite unconsciously, make him different from others who had the same original potential but happened to be cast in other roles.

The social role of the physically handicapped individual is often adversely affected by the reaction of others to him. Frequently others do not realize either

the dynamics underlying their penalizing behavior or that they are making manifest their unconscious rejection in devious and subtle ways. The result is that the disabled person is often cast into a role of being personally and socially inferior.

In an experiment to determine the reaction of subjects to mutilated figures, Wittreich and Radcliffe (1955) had subjects wear aniseikonic lenses of varying strengths when viewing two figures, one normal and one mutilated. On a scale purporting to measure resistance to induced aniseikonic distortion, they found that the threshold for the mutilated figure was significantly higher than for the normal figure. A plausible interpretation of these findings is that perceptual defenses are utilized to reject the threatening aspects of an abnormal figure.

Gilder, et al. (1954), achieved similar results to those of the foregoing investigation when they utilized full-sized mannequins as well as adult amputees as stimuli. One of their findings was that the perception of the amputee, and even the mutilated mannequin, was apt to provoke strong emotions of anxiety and even of anger. They interpret these reactions as a function of the threat that actual (or even simulated) amputation has on the integrity of body image of the normal person who identifies with the person viewed. The type of emotional response they encountered is seemingly dependent on the meaning the body image has for the subject, and on his particular way of dealing with such stress.

If persons unrelated to amputees experience such threat and manifest such emotional reactions, then it would be much more likely that persons in direct contact with an amputee will experience threat and manifest their defensiveness by anger and rejection. It is this type phenomenon that plays a major role in determining the social position and self-concept of the handicapped individual.

Smits (1964) designed a study to investigate the effect that the obviousness and the severity of physical disability can have on the way a person perceives himself, how accepting he is of himself, and how others view him. He reasoned that severe physical disabilities, because of the intrinsic limitations they imposed, are different from mild physical disabilities in their effect on how a person feels about himself. Furthermore, differences in severity of disability were expected to cause differences in the way others reacted to disabled persons. Smits felt that more severely disabled individuals, because of self-degradation, would present themselves negatively to others, who in turn would

react negatively to the disabled individual. The subjects for Smits' study were selected from a group of physically disabled high school students in a large urban area. There were 125 male and 76 female adolescents in the study. By use of: (1) A student self-assessment scale, (2) a teachers' assessment scale, (3) a mothers' assessment scale, and (4) a classmates' assessment scale, Smits found that:

- (1) Severely disabled adolescents have significantly lower self-concept than adolescents whose physical disabilities are mild.
- (2) Severely disabled female adolescents have significantly lower self-concept and significantly lower self-acceptance scores than mildly disabled female adolescents.
- (3) Teachers rate female disabled adolescent students significantly higher than male disabled adolescent students regardless of whether the physical disability is obvious or subtle, severe or mild.
- (4) The interaction between the obviousness and the severity of physical disability affects the rating that teachers and mothers give to disabled adolescents regardless of the age or sex of the adolescent.

A second purpose of Smits' study was to test the validity of several ideas found in the literature which either dealt directly with the physically disabled, or which dealt with related areas that had important implications for the disabled group. From his findings he concluded that:

- (1) Physically disabled adolescents, as a group, are rated lower than physically normal adolescents on a sociometric device where students rate each other as friends, coworkers and leaders.
- (2) Obviously disabled adolescents receive more extreme ratings from their classmates than subtly disabled adolescents.
- (3) The statements in the literature emphasizing the psychosocial importance of physical beauty for the female, and physical strength for the male, are not supported by the data gathered in this study.

The Smits study emphasizes that the rehabilitation counselor should be aware of the significance of even the most minute factors in his client's sociocultural field, since these factors often are affecting and have contributed to the client's present status. It is equally imperative that rehabilitation plans and counseling efforts should reflect an awareness of these factors.

PROS AND CONS TO HISTORY TAKING

In the rehabilitation process, case histories, and anecdotal records are vitally important. They are necessary to fulfill legal requirements and to insure clients of the best possible integration of services. A discussion of the pros and cons of history taking may be of interest and may assist the counselor in developing an effective technique of data gathering. The securing of actual information can be a dry, meaningless process that overstructures the counselor-client relationship, or it may be a dynamic learning experience for both the client and the counselor.

Wolberg (1954, pp. 207-208) presents a brief discussion of both sides of the argument. He states that those in favor of formal history taking insist that great gaps in information are present where reliance is placed solely on the spontaneous unfolding of historical material. Only a careful inquiry into the various areas of somatic, psychologic, interpersonal, and community functioning is said to reveal a complete picture of what has been happening to the client. Where adequate historical data is lacking, it may be months before the client gets around to talking about an aspect of his problem which may give the counselor an entirely different perspective of the situation.

There are also many reasons why interviewers hesitate to take complete case histories. *First*, exhaustive histories are not considered absolutely necessary in formulating a plan from a diagnostic point of view. *Second*, they are not believed to be therapeutically valuable. Therapy is regarded as a process of helping the client to develop a new outlook on life and not as a process of merely collecting information. Background material is felt to be unimportant in promoting this goal. *Third*, it is argued that when the client is asked to give a schematic account of his history and of himself, he may appear to be talking freely of his past while, in actuality, he may use this as resistance to conceal the truly significant facts of his problem. *Fourth*, he may assume that once he has made a report of his history, he can sit back and expect that a solution for his problems will automatically be forthcoming. In discussing the objections to the use of case records, Leona Tyler (1961, p. 83) states, "The most serious way in which they may interfere with the counseling process is by encouraging categorizations and snap judgements. Because they are made up of bits of factual information, it is easy for the person reading them to adopt the external frame of reference. It is then natural for him

to classify the case according to his own psychological theories." Tyler's main objection here is to counselors assuming that the case record can be used for prejudging an individual.

GUIDELINES FOR HISTORY TAKING

A resolution of the divergent points of view regarding the value of a case history will not be attempted. However, a few suggestions for gathering data in the rehabilitation setting follow:

- (1) Do not let completion of the survey form or social history become a goal. Remember that the client is the main concern of the rehabilitation process, not the paperwork.
- (2) Don't divert the client from discussing some aspect of his history because you already have the information necessary for the form and are anxious to move on to the next topic. Important clues to understanding a client may be gained by his spontaneous discussion of the aspects of his history that he considers significant.
- (3) Be sure the client understands the reasons for the history and can see where he may be benefited from it.
- (4) If a client resists a part or all of the data gathering, or feels threatened by what he perceives as an invasion of his privacy, do not become defensive and punitive.
- (5) When it is deemed necessary for additional information, secure the client's permission to contact relatives, employers, friends, etc.
- (6) Do not let the client ramble on endlessly on all aspects of his history; maintain control of the interview.

CLIENT STUDY—SOCIAL

A well-worn, but unreputed postulate in the social sciences states "Past behavior is the best predictor of future performance." With this and the above material in mind, perhaps the study of a client's social history and present environmental stimuli may be viewed as an integral part of the rehabilitation process.

The full understanding of a client's disability requires complete and carefully selected information concerning the extent of his disability and the nature of his response to this and other life experiences. A social

history is necessary for a diagnosis of the *total problem* and is the background against which a probable solution to the disabled person's problem is formulated. The social evaluation should be as thorough as possible. It reflects the life and the individual characteristics of the client (Browning, 1958).

Characteristics of Social Evaluation

Pertinent information is secured in relation to what appears to be the client's problem(s). Some of the content included in the history may be contained in the routine survey. However, this may be supplemented in narrative recording as additional problems are identified or further information is obtained. The history should not be cluttered with irrelevant information. The client is encouraged to tell his own story in his own way, but the counselor guides the interview, keeping in mind the information that is desired. Notetaking or recording should be kept to a minimum if an easy relaxed atmosphere is to be maintained. If the client gets the impression that the counselor is asking questions and then recording the answer, he will soon learn to wait for the next question.

In recording the history, the primary source of information is the client. If the agency is a member of a local Social Service Exchange then the counselor can obtain a record of the social agencies that know the client. Reports from these agencies should be obtained and significant material incorporated under the appropriate headings in the psychosocial history. Information not obtained from the client may be incorporated in appropriate sections of the history with the particular source identified.

The techniques of history taking and writing are developed through practice. It is necessary for the counselor to hear as well as listen. He must bear in mind the importance of the sequence of events, associating the appearance of certain reactions with particular experiences. For example, was there any change in the health picture following divorce or trouble on the job? The counselor should explain that, in order to plan for successful rehabilitation, he must know the client as a person which means he should know about his health history; how and where he has lived; his education; his interests; etc. There is no set form or procedure for the taking of a history, but usually the major disability is a logical beginning point. If the counselor simply asks the client to tell about the trouble he is having, he will generally have little difficulty in getting a detailed description of the current disability.

Suggested Procedure for Obtaining and Organizing Social History

The following are suggested items to be included in systematically recording social information:

Identifying Data.—Name; address; date and place of birth; citizenship; social security number; military service; name and address of parents; nationality; marital status; number, ages, and sex of children; religion. It is helpful to list sources of information from which social history is obtained.

Referral.—Source and reason.

Present Illness.—History of present illness; date of injury or onset of illness; client's description of disability. What was client's personal situation at the time—married, working, in school? How has it affected him? His family? What has he done about it? Has it increased in severity? What does he think could be done about it?

Previous Medical History.—Identify and give dates of previous illness or injuries; client's account of disabling effects and treatment. Secure dates of previous hospitalizations and names of hospitals as well as names of physicians to whom client has previously been known. Counselor should secure the client's written permission for release of information from each of the medical sources. This information should be obtained as early as possible in order that it may be shared with the examining physician and medical consultant of the vocational rehabilitation agency.

Personal and Family History.—This information should be more detailed and written in narrative.

Early Life and Cultural Climate of Home.—The counselor should secure information regarding the client's childhood and early family relationships. This may be approached by asking client where he lived as a child. Such things as the parents' background, occupation of father, number of brothers and sisters, client's place in numerical order, family relationships, indications of social deprivation and chronic poverty, living in a ghetto area and belonging to a disadvantaged group, etc. may be revealed quite naturally in discussing some of his early life experience. Then the information may be organized under the proper heading when recorded.

Education.—What was the highest grade completed? How old was he when he left school? Is there a family history of illiteracy and educational deficit? Did he have any vocational or prevocational courses or training? Did his disability or any previous illnesses affect his school progress? How did he do in school? A record of school grades should be obtained whenever possible.

A report of psychological tests given at school and elsewhere may make an important contribution in completing an appropriate vocational plan, and may prevent needless duplication of psychological testing. How does the client describe his social activities at school? Was he a member of clubs? Did he participate in school athletics? Was the school in a generally disadvantaged area? While the psychological findings together with school progress may give evidence of intellectual capacity, it should be born in mind that other factors such as physical and mental health, cultural influences, and geographical location may also play an important part in educational achievement. Is the client's educational attainment commensurate with that of other members of his family, with the community pattern, and with his work history?

Work History.—What kinds of work has the client done and how long has he worked at each? What is his own estimation of how well he got along with his employers and with the other employees? In what kind of work did he excel? What kind did he like best? Does he express hostility in regard to some of his work experiences or supervisors? Is he skilled at a specific trade? Has he done skilled or unskilled work? How have local employment opportunities affected his work history? What ambitions does he express for the future? Does he have an unstable work record and a poor attitude toward work?

Present Family Relationships and Economic Situations.—Throughout the client's life, the nature and quality of family relationships exert a strong influence on his reaction to each new experience. It is as important to understand as much as possible about these adult relationships as it is to understand those which occurred during his early formative years. How close has he remained to his parents, brothers and sisters? The counselor will want to know many things about the client's current home situation including such things as: What persons make up the immediate household, sources and adequacy of support, client's position in the home, and how does his handicap affect relations among family members? What are the standards of living of the family and what is their position in the community? Is there a long history of dependency or public offense? Do members of the family share in social activities? Are there evidences of harmony or discord which might significantly affect the outcome of vocational rehabilitation efforts? Are members of his family willing to help him overcome the handicapping effects of his disability? If client is married, what is the attitude of his spouse at this time? Were they ever separated? What are the evidences of

strengths and weaknesses as they affect the client's potential for rehabilitation? If there are children in the family, how do parents and children get along together? What is known of the physical and mental condition of the children? What are client's ambitions for them?

Personality and Habits.—Here the counselor attempts to gain some description of the client as a person both prior to the onset of the disability and as he is at present. This requires obtaining information about his disposition, interests, reactions, and personal habits. Does he show particular concern about his situation? What social activities does he take part in? Has he been a leader or a follower? What is his personal appearance and manner? Is there any evidence of a severe emotional problem? Describe behavior which indicates this.

NOTE.—The questions listed above are only a few suggestions to be used in obtaining the detailed history and information which are necessary for the social evaluation. The counselor will usually receive more helpful information from the examining physician, psychologist, or social agency if pertinent and relevant personal and health history are shared in advance of any examinations. At this same time, the counselor may present questions for special consideration that can be of help in subsequent vocational planning.

By way of summary, it was pointed out in this section that the sociocultural study should show the client within the framework of his social environment. Therefore, the sociocultural study should represent not only his strengths and weaknesses, but should also individualize the meaning of his disability to himself and his family. The social study should reveal the circumstances around which the handicap or disability occurred, and the particular meaning it had for the client and his family when it first occurred. The study of the total family structure and the impact of the sociocultural environment are important in all phases of helping a person to rehabilitate himself.

Some of the characteristics of social evaluation were identified such as: Collection of pertinent identifying data, referral source, history, present family relationships, economic situation, personality and habits. This social information, when taken as a whole, should bring the client into focus as an individual distinct from others. It should point up his potential for benefiting from the rehabilitation process.

A thorough social evaluation is vital both for the counselor's professional helping relationship with the client and his family, and also for assisting other members of the rehabilitation team. There is no set procedure for taking the social history, although the major

disability may be a logical beginning point. It is necessary for the counselor to both hear and listen. When this is done, he will have little difficulty in getting a detailed description of the current problems of the client.

A suggested outline for social evaluation is included. The rehabilitation counselor can usually receive helpful information from physicians, psychologists, and

social workers, if pertinent personal and health information is shared in advance of the interview. In this way, the other members of the rehabilitation team have some guideposts in terms of their own individual efforts on behalf of the client. As Elledge (1957, p. 426) has aptly stated, "the better we understand people within their social reality, the less likelihood there will be of uncooperative cases."

Section 10

CLIENT STUDY: VOCATIONAL

THE IMPORTANCE of a thorough vocational evaluation in the client-study process cannot be overemphasized. It is here that medical, social, and psychological information are united with specific vocational data in an attempt to arrive at the ultimate goal of the rehabilitation process—vocational success. Vocational evaluation is the process of gathering, interpreting, analyzing, and synthesizing all the vocationally significant data (the medical, social, and psychological data) that have been collected regarding an individual, and relating it to occupational requirements and opportunities.

THE MEANING OF WORK

Why do people work? A reasonable answer to this question is of vital interest to the vocational rehabilitation counselor whose goal is the vocational adjustment of his clients, and whose entire activities are directed toward this goal. If, as it would appear to some writers, the sole purpose of working is to earn money, then why does the counselor need to bother with such factors as the client's interests, aptitudes, and job satisfaction? Why not merely create jobs that the handicapped are capable of doing, that will provide them with the essentials of existing, and not be bothered with their emotional needs or personal satisfaction? Such an approach is occasionally supported by classical economists and by their emphasis on "economic man." However, most counselors are not willing to accept such a restricted picture of the meaning of work. They know of many people who do not need to work in order to have money for necessities, or even luxuries, and who still choose to work. They know of many others who are working at jobs which provide less pay, but more personal satisfaction than other jobs they might have.

In the area of human relations, we know that people are happiest when their activities both satisfy them

and fulfill their psychological and/or physiological needs. Maslow (1954) describes five general levels of needs and arranges them in a hierarchy reflecting their developmental emergence and prepotency. They are: (1) Physiological needs, (2) safety needs, (3) belongingness and love needs, (4) esteem needs (need for personal recognition), and (5) need for self-actualization (enjoyment of beautiful things, creative expression, the wish to understand oneself and the world, and the seeking of philosophical and religious meanings are all self-actualizing needs). These needs can be even more pronounced for the handicapped individual whose self-concept and intrapersonal development may have suffered because of an impaired ability to satisfy them.

Disability does not necessarily change the handicapped person's perception of activities that are satisfying to him, but often the jobs which will meet his needs are *inaccessible* to him without modification of physical facilities. Two functions of the counselor are to aid the client in choosing a vocation where he will find satisfaction, and to arrange for services which will make him employable in his appropriately chosen field.

The need to earn a living is obvious, but with the handicapped it carries other implications. Self-support engenders self-respect. The person who is paying his own way feels more like a contributing citizen; e.g., he can complain about taxes like other people while justifiably taking pride in his community and Nation.

The Minnesota Studies in Vocational Rehabilitation, a series of studies sponsored by the University of Minnesota's Industrial Relations Center and supported in large measure by grants from the Vocational Rehabilitation Administration, were initially designed to conduct: (1) A community survey of physically handicapped individuals, and (2) an experimental study of the effectiveness of various job placement procedures. From June 1958 through April 1964, 16 separate reports have been published. An exact reference to these excellent studies is provided in the Suggested Readings

at the end of this part of the manual. The scope of these studies has broadened to include such topics as study numbers: II. A Study of Referral Information; V. Methodological Problems in Rehabilitation Research; VII. Factors related to Employment Success; and XV. A Theory of Work Adjustment. In study number X. A Definition of Work Adjustment (1960), there appears the following conceptualization of work adjustment:

Work adjustment is inferred from two primary sets of indicators: "satisfaction" and "satisfactoriness." "Satisfaction" includes overall job satisfaction and satisfaction with various aspects of the individual's work environment (his supervisor, his coworking conditions, his hours of work, his pay, and the type of work in which he is engaged). It includes the satisfaction of his needs and the fulfillment of his aspirations and expectations. It includes the congruence of his vocational interests with the interest of most "successful" people working in his occupation. "Satisfactoriness" is indicated by his productivity and efficiency, and by the way he is regarded by his supervisor, coworkers, and the company or institution for which he works. It is negatively indicated by his absence and tardiness, by the accidents that he has, and by his ability to stay on the job for a satisfactory period of time. It is also indicated by the congruence of his abilities and skills with those demanded by the job (p. 1).

The function of the Federal-State vocational rehabilitation program is to provide services to handicapped individuals which will assist them in attaining the best possible work adjustment. The handicapped individual and society should both profit from the individual achieving work adjustment as conceptualized above.

PSYCHOMETRIC ASSESSMENT OF VOCATIONAL TRAITS

The information on testing presented in "Client Study: Psychological" had to do with some aspects of the psychometric assessment of vocational traits. Specific data on this topic will not be presented here since the detailed information regarding vocational testing may be found in the texts listed in the Suggested Readings section for this part of the manual. There are, however, characteristics of a handicapped population that present *unique problems* in the administration and interpretation of tests. Some of these characteristics and problems will be discussed here.

In dealing with a certain percentage of his clients, one of the problems that the rehabilitation counselor must face is that it is difficult to use tests in identifying the vocational interests of handicapped individuals

who have been *limited in their activities* and thus in their opportunities to acquire a variety of experiences. The authors of interest tests assume that the individuals who take the tests have acquired a comparable repertoire of environmental experiences and the items on most interest tests require the testee to show a degree of preference for a specific activity. Therefore, the handicapped individual who has *no experiential basis* for making a choice between a variety of activities will often tend to show either a dislike or an absence of preference for any particular field of interest, or else will show high scores in areas about which he has little or no real knowledge. In some instances the affective reaction of such people to vocational preferences scales results in a "flattened" interest inventory. This "flatness" of interest is commonly associated with individuals from lower socioeconomic groups, persons doing menial labor, assembly work, public service work, police or protective work, and other occupations that are of a "routine" nature. For those individuals who are not psychologically committed to a field of work, it appears that their job choices are not guided by the personal satisfaction of participating in an activity or by the altruistic gratification it affords, but that one job takes precedence over another simply because it offers the least resistance and/or is more convenient.

Occupations which attract these individuals (mainly labor and service) are comprised chiefly of workers who have dabbled at several other jobs before finding steady employment. As a rule, such jobs are fairly structured and require that the workers have no particular interest commitment in what they are doing. The workers' predominant source of gratification often lies in avocational interests and their work is perceived primarily as a source of support. While the workers may possess strong values regarding work, promptness, and achievement, they derive little personal intrinsic satisfaction from their work. Adherence and dedication to a job is uncommon and job changes are always a possibility (they are always "thinking" about doing something else) for such people.

Vocational counseling with these individuals presents a serious problem to the rehabilitation counselor because such clients can never find anything they really *like* to do; they just want or need a job. Vocational counseling thus consists mostly of finding something they can and will do rather than aiding the individual in matching his personality and skills to a satisfying occupation. Unfortunately, there is little a counselor can do to alter the prior experiences of his client which influence vocational choice. He can only operate within

the framework of the client's needs and help him discover the occupations that may meet these needs.

As mentioned in the section on Client Study: Psychological, the rehabilitation counselor receives a substantial number of referrals from welfare offices, etc., of clients who exhibit marked character disorders of a passive-dependent nature. These clients are very resistant to change and extremely difficult to motivate toward accepting the goal of work. Nevertheless, they are often under considerable pressure from welfare to accept rehabilitation services and often feel they must appear to cooperate. Clients of this type can prove very frustrating for the beginning counselor since they look and talk so encouragingly yet perform so inadequately.

Additional material on this subject will be found in the section on Problems and Techniques of Counseling.

VOCATIONAL HISTORY

Through recording and studying a client's vocational history, the counselor can begin to acquire an understanding of the client's vocational aptitudes, his occupational skills and work habits developed through past employment, as well as his vocational interests, ambitions, and incentives. A review of these aspects of the client's prior vocational adjustment can provide the best indication of the type worker he will be after rehabilitation. *Past performance is still the best measure of future behavior.*

The basic items of information listed below should be secured in all cases. These items are usually recorded on the survey interview form, though they can be recorded equally well in the narrative part of the case record. This topic is discussed in more detail in the Case Recording section of this manual.

It is important to list jobs held by the client, starting with the present job and recording all previous employment. For clients who have held many jobs over a long period of time it may not be necessary to list each job separately, but enough information should be given to indicate clearly the nature and length of his experiences. Included in the list should be the name and address of the employer, the kind of business, name of job held by the client, the wages, the dates on which he began and left each job, and his reason for leaving each job.

The counselor needs to know both the degree of skill which the client had in the various jobs he held and also whether this skill is now sufficient to meet current

employer requirements. The extent to which the client "gets along" with his foreman and fellow workers, his punctuality and reliability, and his overall work habits are important factors to consider. The counselor should further evaluate reasons for any frequent changes in employment, and for any unusual shifts from one occupational area to another, particularly any changes or shifts that seem inconsistent with the client's vocational training or his expressed vocational interests.

Counselors frequently want to know how detailed the vocational history should be. The amount and kind of the client's work experience indicates how thorough to make the vocational study. A few guides for determining extent of study are presented below:

Clients with *no* work experience need not be investigated so extensively as others. However, in such cases a careful validation of vocational interests may be especially important to insure suitable vocational plans.

Clients with *varied* employment should be studied carefully, especially if most of their experience is on unskilled jobs. In these cases, measured and/or expressed interest may not be important while other factors; e.g., specific skills developed, may be quite useful. Attitudes toward employment (willingness to work) and physical capacity for work merit detailed exploration.

Clients with *substantial* work history should be thoroughly studied from the standpoint of finding a job objective in which their past work experience and training can be used. The following information is pertinent: Does he retain the good will of past employers? Can he be placed on a new or different job at the same plant? Is there a related type of employment or self-employment in which he can use his past experience?

Other aspects of the case history may suggest the need for an intensive study of the vocational history. For example, a client whose intelligence tests and school grades suggest less than average intelligence may express an interest in professional or other high-level work that appears to be incompatible with his ability. Because of this apparent discrepancy, his expressed interests and his capacity should be carefully studied and validated. As another example, a client who has a record of poor interpersonal relationships with the members of his family, or who has made a poor social adjustment at school, is likely to be socially maladjusted on the job. As a result, his personal and social adjustment on past jobs and his attitudes toward employment should be carefully evaluated.

Present Vocational Interests and Assets

The client should be encouraged to state his vocational interests. However, consideration should not be limited solely to his expressed choice of occupations. It is suggested that the counselor *explore the client's work preference in terms of his desire to either work with people, with things, or with ideas*. He should also consider the client's description of his aptitudes for work, that is whether the client says that his aptitudes are artistic, commercial, social, or musical, etc., in nature. The counselor should further explore the interests, hobbies, and part-time activities of the client, as well as his stated preference as to his first and second choices of vocations.

The source of the client's interests is of special concern to the counselor. He should determine if they are based on actual job experiences, reading, observation, influence of family and friends, or other factors. The counselor should evaluate how long the expressed interest has existed; whether the client at each interview professes interest in a new field; and how much he knows about the work in which he expresses an interest. He should further determine if the client believes his vocational interests are consistent with his abilities; if the client thinks his interests are permanent; and whether his hobbies and recreational activities have any bearing on his occupational interests.

The client's expressed interests should be evaluated to see if they are consistent with the client's measured abilities. Along the same line, the counselor needs to know if the client's experiences substantiate his expressed interests such as by hobbies, reading and summer jobs, and if the client's interests are reasonable from the standpoint of available opportunities for training and employment.

All special vocational assets that the client may have should be considered. These may include, for example: Ownership of an automobile, membership in a union, friends and acquaintances who can help him secure or train for employment, or a license to engage in a trade. Other special assets include a good speaking voice or good manual dexterity. Both permit the client to work at home if necessary. The ability to type and/or to speak foreign languages are often vocational assets. It should not be overlooked that proficiency at hobbies might enable a client to enter competitive work; e.g., the ham radio operator can work in electronics assembly while the home photography expert can work in developing and enlarging photos.

Occupational Choice

In evaluating the vocational potential of rehabilitation clients, the counselor is frequently confronted with the question of how or why a client arrived at a particular occupational choice. There are many different theories related to this subject and it may prove helpful here to briefly review several major theoretical positions.

Hoppock (1957) hypothesizes: (1) That occupations are chosen to meet our needs, whether these are intellectually perceived or only vaguely felt, (2) occupational choice begins when we first become aware that an occupation can help meet our needs, (3) having information about ourselves and occupations facilitates successful choice, (4) job satisfaction depends on the extent to which the job we hold meets the needs that we feel it should meet, (5) satisfaction can result from a job which meets our needs today or promises to do so in the future, (6) occupational choice is always subject to change if we feel that a change will better meet our needs.

Brill (1949) in his "Basic Principles of Psychoanalysis" suggests that: (1) Normal individuals need no advice in the selection of a vocation; they are able to sense the best activity to follow, (2) there is always some psychic determinant which lays the foundation for a later vocation, and (3) a sensible person neither needs nor wants advice in choosing a mate or vocation, and fools will fail in spite of the best guidance.

Caplow (1954) after reviewing sociological research concluded that: (1) Error and accident play a larger part in occupational choice than we like to admit, (2) occupational choices are made when we are still remote from the world of work. Often choice is dependent on the impersonal pressure of the school curriculum which is remote from the realities of the working situation, (3) typically, realistic choices required the abandonment of old aspirations in favor of more limited objectives, and (4) it is not until late in the average person's career that he is able to compare his expectations with his aspirations and arrive at a permanent sense of frustration, a glow of complacency, or an irregular fluctuation between the two.

Maslow's (1954) hierarchy of needs; i.e., (1) Physiological needs, (2) safety needs, (3) belongingness needs, (4) esteem needs, and (5) need for self-actualization, were mentioned earlier in this section. This hierarchy may be related to an individual's occupational choice. That is, he will choose a vocation commensurable with his own personal need structure. The physiological and safety needs are generally satis-

fied by the material compensation received from working. Food, clothing, protection, etc., can be obtained either directly or indirectly and, when the elements and hunger are a constant threat to the individual, his motivation to work is to survive. The protection that American society provides its citizens (welfare, unemployment insurance, disability benefits, etc.), for the most part, precludes an individual's occupational choice being based solely on these "lower order" needs. The application of the "higher order" needs to an individual's occupational choice is obvious. For example: A person who needs to belong will seek a job or vocation which will satisfy this need. Generally, his satisfaction will come from the acceptance given him by his coworkers or supervisors. The nature of the work is not as important as the interpersonal climate of the surroundings in which the work is performed. The individual whose need for esteem and recognition is predominant will be drawn to an occupation where he can receive praise or recognition which will reinforce his feelings of worth and adequacy. Individuals whose most pressing need is for self-actualization will gravitate toward the arts of philosophical endeavors. According to Maslow's theory, when environment conditions will not allow an individual to choose a vocation which fits his needs, he is usually dissatisfied with his work and seeks avocational outlets to satisfy his needs.

Ginzberg's (1951) general theory is: (1) Occupational choice is a process which takes place over a 6- to 10-year period, (2) each decision during adolescence is related to prior experience, and has influence on the next decision, but the process of decisionmaking is basically irreversible, and (3) occupational choice is the result of combining subjective elements with the opportunities and limitations of reality; occupational choice inevitably has the quality of a compromise.

Super (1957) has proposed a "theory of vocational development" which can be summarized as follows: (1) People differ in their abilities, interests, and personalities, and each person is qualified for a number of occupations, (2) requirements for an occupation allow some variety of individuals in each occupation, (3) change with time and experience make choice and adjustment a continuous process, (4) the process of vocational choice may be stated in a series of life stages; growth, exploration, establishment, maintenance, and decline, which may be subdivided into— (a) the fantasy, tentative, and realistic phases of the exploratory stage, and (b) the trial and stable phases of the establishment stage, (c) parental socioeconomic level, mental abilities, and personality characteristics

affect the nature of career patterns, (d) the process of compromise between individual and social factors, between self-concept and reality, is one of role playing which may take place in fantasy, counseling, or real life activities, (e) satisfaction depends on the extent an individual finds adequate outlets for abilities, interests, personality traits, and values.

Though none of the theories presented mention specifically the physically handicapped, there are few who would deny the influence of a physical disability on occupational choice. For different clients, certain theories of occupational choice are more applicable than others. In many cases, a client might cut across several theories in his evaluation of occupational choice. The rehabilitation counselor should be aware of the dynamics in the occupational choice of a client and utilize all possible resources in assisting him to make the correct choice.

Evaluation of Client Capacities in Rehabilitation Facilities

There is a wide range of rehabilitation facilities, each offering different types of programs of service. Rehabilitation centers, sheltered workshops, halfway houses for the mentally ill, cardiac classification centers, and optical aids clinics are a few of the better known facilities in operation today. Each type of facility has developed a program to provide one or more services to aid the handicapped individual.

In the comprehensive rehabilitation center, several evaluative and therapeutic services are found. Here, one finds an integrated program of medical, psychological, social, and vocational evaluations and services under competent professional supervision. Centers vary as to primary emphasis. The majority of centers have a heavy medical emphasis, but nevertheless provide all other rehabilitation services as part of the total program. Some rehabilitation centers are vocationally oriented and concentrate on vocational evaluation and vocational training. In these vocationally oriented centers, medical service is available, but of course it is not provided to the degree found in the medically oriented center.

Centers are particularly helpful in assessing the needs of severely handicapped persons and in the provision of corrective and therapeutic services. The counselor should be familiar with the various centers which may be utilized for evaluation of client capacities, and select the one which best seems to fit the needs of the individual client.

The workshop is another facility receiving increased attention as a place to secure an evaluation of the client. Again there is wide range as to size and professional service available. Today more emphasis is placed on the workshop as a diagnostic and therapeutic tool in meeting the work and work-related needs of the handicapped. Beginning after June 30, 1965, Federal Law (Public Law 89-533) authorizes the Health, Education, and Welfare Secretary to make grants to assist in meeting the costs of constructing public or other nonprofit rehabilitation facilities and workshops. A project for construction of a workshop may include residential accommodations for use in connection with the rehabilitation of mentally retarded individuals. The law also provides weekly allowances to be paid to the handicapped individuals receiving training services on a project basis in these public or nonprofit rehabilitation facilities and workshops.

(For a more detailed account of the structure and use of prevocational and work-adjustment units, see sec. 13 of this manual.)

VOCATIONAL CONSIDERATIONS FOR FIVE SPECIAL DISABILITY GROUPS

The Older Age Group

Definition and Description.—The older age group is generally considered to include persons 45 years of age and above. There is no physiological reason for this classification. It is purely arbitrary.

Certainly many of these people have special problems, social as well as medical. There is the question of social and employer acceptance as well as the problems of reduced function. This is even more apparent for the disabled older worker. The counselor needs to be careful not to confuse age with disability, for physical disability may occur before or during old age. These are two separate problems and the following comments apply to people who become disabled after age 45.

The reduction of function is often compensated for by responsibility, practical knowledge, and stability. These are valuable and irreplaceable traits, acquired through years of work. The importance of these acquisitions makes it imperative that older workers not be lumped together in one group. The necessity for individual evaluation is perhaps greater in this area

than for younger persons. Experience has proven that capable persons should not be forced to retire.

In general, older workers have more experience, are more stable and responsible. There is less absenteeism and they have a good record in regard to on-the-job injuries. Older workers make fewer medical visits for minor aches and pains not directly related to work accidents. Even if they do have disabilities, or if their work capacity has declined, they should not be considered unemployable. There are many jobs where experience and stability are more important than speed and vitality.

Evaluation of the Severely Disabled and Paraplegic Persons

The evaluation of severely disabled persons should be made by a team of interested professional persons, including some of the following: The rehabilitation counselor; physicians; psychiatrists; social workers; occupational and physical therapists; psychologists; vocational educators; and others. The amended law (Public Law 89-333) makes it possible for State agencies to provide vocational rehabilitation services to severely disabled individuals in order to evaluate their effect on the individual, thus facilitating making a determination that there is or is not a reasonable expectation that vocational rehabilitation services will render the individual fit to engage in a gainful occupation. Extended evaluation up to 18 months can be provided to individuals whose disability is paraplegia and other spinal cord injuries or diseases, epilepsy, mental retardation, mental illness, or others listed in the regulations (1966 sec. 401.21(c)).

The individual's school and work history should be reviewed in order to determine his methods of adjustment prior to his accident; this often reveals the basis for his reactions and attitudes towards his disability.

Social factors in each case, including the client's family and community relationships, should be thoroughly studied. It is important to uncover any factors that encourage an attitude of dependency on the part of the client, and to recognize any atmosphere of overprotection that may exist in the family. Such potential assets as the family's desire to help and the availability of other sources of income in the family should be utilized to motivate the client, rather than to encourage dependency.

At the proper time, the client should be helped to face reality, to accept the limitations imposed by his disability, and to restrict his social activities. At the same time he should be helped to establish compensa-

tory social contacts and activities that are within his abilities. He should make full use of what he has, in order to establish a feeling of normalcy in those work and social situations where his disability is minimized.

The Epileptic Client

Basically, the evaluative procedures given above for the severely disabled also apply to clients who are subject to epileptic seizures. In addition, it is necessary to arrange that the epileptic client has a complete neurological examination and that he receives adequate medication. The rehabilitation counselor should always know certain things about his client's epileptic seizures; i.e., whether the client has a warning, whether this warning always precedes a seizure, and the time interval between the warning and the start of unconsciousness.

A controlled epileptic, when properly placed, is able to earn a good livelihood. An epileptic can be expected to do any job he is mentally and physically capable of doing (this means physically able to do when the seizures are not present), with the exception of certain occupations where the life of the client or the life of others might be endangered if he would suddenly become unconscious. This would eliminate jobs which require driving vehicles or operating dangerous equipment and/or machinery.

A basic premise in epilepsy is that the employer should be informed either by the client, the counselor, or the physician involved, of the nature and extent of the client's disability.

The counselor should be certain the epileptic client has the abilities and skills necessary to do the job for which he is applying and then emphasize those abilities in the placement process.

The Mentally Retarded

A complete social and psychological evaluation is mandatory, with special emphasis being given to parental and community attitudes toward the retarded client. The counselor can probably best evaluate the vocational readiness of these individuals through interviewing and counseling.

Since retardates represent a range of varying personalities, the kind of interviewing which most aptly applies is the one that is geared to the individual. Directive interviewing, applied with dignity and sympathy, would apparently be the most appropriate type in most circumstances. If a retardate has come to re-

habilitation from an authoritarian setting, it seems sensible to initially employ a directive approach to be followed in time by a temporary supportive one, so that he may ultimately develop maximum self-direction. Initially, the counselor conveys desirable vocational goals based on a careful case analysis. By means of questions, praise, warm feeling tones, and other supportive measures in interviewing, the client is helped to feel that he has formulated his own decisions. In the supportive method, the counselor acts as a parent—or big brother—figure who is helpful and encouraging.

The end goal of counseling needs to consider the interviewing process as one of weaning away the client from dependency to gradual self-adjusting independence. The process of conditioning the client for independent adjustment is best accomplished towards the end of the rehabilitation process. The rehabilitation counselor facilitates the client's independent adjustment by: (1) Encouraging independent problem solving, (2) encouraging the client to make active use of other community resources, and (3) gradually decreasing the number of interviews as the client assumes greater self-responsibility.

The Emotionally Disturbed

Counseling the emotionally disturbed is similar to all counseling in that the entire approach to the problem must be centered around the strengths of the individual client. The client must be considered as an individual with his own assets and liabilities unlike those of any other. Every action should be directed toward obtaining and keeping his confidence since only in this way can the client-counselor relationship be maintained on an even keel.

Early referral is most desirable to permit the counselor to know the case better. If the referral is from a hospital, he can sit in on their case conference and hear his new client described by such members of the hospital staff as the social worker, psychologist, occupational therapist, and psychiatrist. Problem areas can be more readily identified, and with this increased knowledge he will be in a much better position to plan with the client toward the time when his discharge becomes effective.

The rehabilitation counselor must have a complete picture of the emotionally disturbed client before he will be able to assist him with his choice of a vocational objective. In addition to possessing knowledge about the client's emotional disturbance and physical condition, the counselor must investigate other areas of the

client such as his vocational interests, economic status and social, educational, and family background. For hospital referrals, the rehabilitation counselor is able to obtain much of this information from the hospital staff. Other types of referral will require more effort on the part of the counselor and he will need the services of other professionals to obtain a thorough evaluation of the client. When his client is emotionally disturbed, the counselor should enlist the aid of a psychiatrist. It is the function of the psychiatrist to help the counselor understand the patient's behavior patterns as these relate to his work activities. In the team approach to rehabilitation, reaching an understanding of the client, and developing a course of action for his eventual job adjustment should be a shared responsibility.

The selection of a vocational objective is dependent upon so many factors that it is impossible to set any hard and fast rules. Many emotionally disturbed people break down for reasons other than their job. For these, it is well to consider reemployment in their same field of work or some related employment. Others may have broken down because of the pressure brought to bear on them in their job performance and might be best employed in a different field. For all cases involving emotional disturbance, the counselor must rely on a thorough psychiatric evaluation in which the psychiatrist both identifies the cause and type of mental illness

and suggests, insofar as possible, general areas of employment possibilities.

(The vocational rehabilitation counselor in State hospital settings is discussed in another section of this manual.)

In summary, the counselor helps the client through counseling to use medical, psychological, and social data to form a realistic appraisal of his present capacities, his personal characteristics, and his job potentialities; to obtain information on job requirements and opportunities; and on the basis of such information and understanding to select a job objective and to carry through a vocational plan that will lead to his vocational rehabilitation. This choice of one's lifework is a decision in which a client is called upon to state rather definitely his self-concept, to say, "I am willing to be this kind of person." Similarly, holding and adjusting to a job is for the client a process of determining whether that job lets him play the kind of role he wants to play, and whether the role the job forces him to portray is compatible with his self-concept. Work provides an opportunity for the client to test his self-concept with reality; i.e., a chance to determine whether he can measure up to his perception of himself. Therefore, the rehabilitation counselor must always remember that *the job must be acceptable to the client's self-concept if the entire rehabilitation process is to succeed.*

Section 11

BASIC PRINCIPLES FOR DETERMINING ELIGIBILITY

THIS SECTION is concerned with the specific requirement and the basic principles used in determining the eligibility of individuals applying for vocational rehabilitation services. A thorough understanding of the client-study material which has been presented in previous sections should permit the counselor to use that material for accurate evaluation of eligibility. As soon as he has enough information, the counselor is faced with the immediate problem of using all of the material that he has gathered to arrive at a decision as to whether or not any particular client is eligible for vocational rehabilitation services. In order to determine eligibility, he must select the most significant data that he has compiled from the interviews, examinations, and all the other reports obtained through the client study.

Except for very complicated or severely disabled clients, tentative hypotheses about the client's eligibility and his potential for successful vocational rehabilitation are made quite early in the client-study process. These tentative hypotheses are then checked and reevaluated as additional data are accumulated. The final vocational rehabilitation diagnosis is based on the total study and upon the availability of required services. As significant facts come out, and as the counselor integrates them into the total diagnosis, a picture of the client's assets and liabilities becomes evident. As a rule, the relationship of the client's strengths and weaknesses to the selected job objective and to the rehabilitation plan should be clearly indicated at this point in the rehabilitation process.

The new legislation, Public Law 89-333, recognizes that the counselor often cannot readily obtain enough data to predict reasonable expectation of becoming employable, in order to determine eligibility of certain applicants who have complicated problems or severe disabilities. It authorizes that full vocational goods and services may be provided during a period of extended evaluation. The regulations governing the vo-

ational rehabilitation program (1966, sec. 401.21(c)) state that necessary services

* * * may be provided during a period not in excess of 18 months in the case of an individual whose disability is: (1) Mental retardation, (2) deafness, (3) blindness, (4) paraplegia, quadriplegia, and other spinal cord injuries or diseases, (5) heart disease, (6) cancer, (7) stroke, (8) epilepsy, (9) mental illness, (10) cerebral palsy, or (11) brain damage, and not in excess of 6 months in the case of an individual with any other disability.

Within this 6- or 18-month period, the counselor can observe actual response to services and thereby be better able to predict whether further services would probably make the applicant employable.

The term eligibility is not to be confused with factors which may cause an otherwise eligible case to be rejected or not accepted for services. The regulations (1966, sec. 401.26) state: "The State plan shall set forth the criteria to be used in selecting eligible individuals for services when services cannot be provided to all eligible persons who apply. Such criteria shall be designed to achieve the objectives of the vocational rehabilitation program to the fullest extent possible with available funds." As an example, while a person requiring extensive medical restoration may meet the eligibility requirements, because of the criteria used by the State when funds are limited, he may legally be refused vocational rehabilitation services, or the services may be delayed.

While economic need was not a factor in eligibility prior to Public Law 89-333, the provision of certain services at agency expense was conditioned by the client's inability to secure them for himself. The new regulations (1966, sec. 401.29) prohibit a needs test as a condition for furnishing diagnostic and related services, counseling, and placement, and provide that a State need not condition the provision of any vocational rehabilitation services on the client's ability to pay for them. However, the new legislation gives each State the freedom to retain (or introduce) a needs test

as it deems necessary for some types of services. The intent of the new law is to encourage States to eliminate tests of economic need in an effort to see whether this will improve services to a greater number of the handicapped.

In practice, the rehabilitation counselor should have little difficulty in determining eligibility, particularly with the availability of extended evaluation. He then utilizes the client-study material which he has gathered about the applicant and relates it to three conditions which must exist for every individual who is given further services.

ELIGIBILITY REQUIREMENTS

The counselor is required to show that all three of the following conditions exist for each individual determined eligible for vocational rehabilitation services:

- (1) The presence of a physical or mental disability;
- (2) The existence of a substantial handicap to employment; and
- (3) A reasonable expectation that vocational rehabilitation services may render the individual fit to engage in a gainful occupation.

A detailed discussion for each of these three conditions is given below. The rehabilitation counselor should familiarize himself with this information since it is his responsibility to properly determine the eligibility of each applicant who is assigned to him.

Physical or Mental Disability

The counselor must determine in each case the presence of a physical or mental condition which materially limits, contributes to limiting or, if not corrected, will probably result in limiting an individual's activities or functioning. It includes behavioral disorders characterized by deviant social behavior or impaired ability to carry out normal relationships with family and community, which may result from vocational, educational, cultural, social, environmental, or other factors (1966, sec. 401.1(o)).

The disability must be evaluated through diagnostic study which is adequate to provide the basis for establishing that a physical or mental disability is present. In all cases of mental illness, a psychiatric evaluation must be obtained; in all cases of mental retardation, a psychological evaluation must be obtained; in all cases of behavioral disorders, either a psychiatric or psycho-

logical evaluation must be obtained, whichever is appropriate. Examinations by other specialists must be obtained, as needed.

Behavioral disorders may be, but are not necessarily, medically diagnosable conditions. An individual with a behavioral disorder exhibits abnormal behavior which persists over a period of time and manifests itself in various settings such as in school, on the job, before the courts, and in the family. Factors such as cultural and social deprivation, chronic poverty, public offense, illiteracy and educational deficit, and long-term unemployment do not, in themselves, constitute behavioral disorders, but may contribute to the formation of a behavioral disorder.

Although additional diagnostic study may or may not be applicable for establishing the existence of a disability, it will include a complete general medical examination to provide an appraisal of the current medical status of the individual. Reports of medical examinations, which the counselor secures as a part of the diagnostic study, constitute a practical basis for determining disability and for formulating the individual plan of vocational rehabilitation.

Substantial Employment Handicap

In the determination of eligibility for vocational rehabilitation services, the counselor must establish the existence of an employment handicap. Substantial handicap to employment means that a physical or mental disability (in the light of attendant medical, psychological, vocational, educational, cultural, social, or environmental factors) impedes an individual's occupational performance, by preventing his obtaining, retaining, or preparing for a gainful occupation consistent with his capacities and abilities (1966, sec. 401.1(w)).

A disability may constitute an employment handicap in either of two ways. In one, the employment handicap may be the direct result of the disability. In the other, the employment handicap may be related to the disability in the light of attendant medical, psychological, vocational, educational, cultural, social, or other environmental factors. Examples of attendant factors are a lack of marketable skills, low-educational level, community and employer prejudices and attitudes concerning disability, long-term unemployment, unstable work record, belonging to a disadvantaged group, residence in ghetto areas or pockets of poverty, long history of dependency, and poor attitudes toward work, family, and community.

A substantial employment handicap may also exist

when a disabled person is employed but cannot obtain a gainful occupation consistent with his capacities and abilities. Disabled individuals who are working substantially below their potentialities should be provided with vocational rehabilitation services to help them engage in occupations more consistent with their capacities and abilities. Their potential, interests, and desires should be determined and then programs developed which will help them reach suitable employment goals.

Expectations That the Outcome of Vocational Rehabilitation Services Will Be a Gainful Occupation

As a part of the eligibility determination for each client, the counselor must establish that there is a reasonable expectation that vocational rehabilitation services, when completed, will enable the individual to engage in a gainful occupation. This requires the counselor to evaluate and ascertain potential capacity of the individual for employment, taking into consideration the effect the agency's services may have on reducing or correcting the disability or on lessening the employment handicap and providing greater opportunity for employment. The extent of the evaluation may vary greatly from one individual to another, depending on the nature and severity of the problem. Consideration should be given to the probable effectiveness of the services that can be made available, rather than to anticipated length of services, extent of need for services, or nature of severity of the disability. Also, factors such as anticipated earnings or the period of work expectancy should not control the determination of the individual's likelihood of engaging in a gainful occupation.

"Reasonable expectation" is a determination made by the counselor based upon adequate, sound, and appropriate information about each individual, including extended evaluations where appropriate. "Fit to engage" refers to an expected achievement level for a given individual to undertake a gainful occupation consistent with his capacities and abilities. This level will vary greatly from individual to individual, and in some instances may be extremely low when compared to competitive standards. "Gainful occupation" includes employment in the competitive labor market; practice of profession; self-employment; homemaking, farm or family work (including work for which payment is in kind rather than in cash); sheltered em-

ployment; and home industries or other gainful homebound work (1966, sec. 401.1(h)).

The provisions for extended evaluation described earlier in this section allow for a broader range of services for handicapped clients with severe disabilities and/or complicated problems to assess their potential. The counselor will have an opportunity to evaluate the effect of such services on the individual before determining that there is or is not a reasonable expectation that vocational rehabilitation services will render the individual fit to engage in a gainful occupation.

CERTIFICATION OF ELIGIBILITY

The counselor is required to include a statement in the case record for each handicapped individual accepted for extended evaluation or for vocational rehabilitation services, certifying that he has met the basic acceptability or eligibility requirements as the case may be. This statement must be completed prior to, or simultaneously with, the acceptance of the client for either extended evaluation or rehabilitation services, and must be dated and signed. In case of ineligibility, a statement of this finding is also required. The individual must also be informed of his right to an administrative review and fair hearing. An applicant for or recipient of vocational rehabilitation services who is dissatisfied with any agency decision with regard to the furnishing or denial of services may file a request for review and redetermination of that decision by a member of the supervisory staff; he may also be granted a fair hearing before the State agency or the State administrator if his application for services is denied or is not acted upon with reasonable promptness.

Certification of the applicant's eligibility does not imply that the full range of services has been determined for the individual. There may be need for further diagnostic evaluation to determine specific services the individual requires or may benefit from in accomplishing his vocational rehabilitation.

By the way of summary, establishing eligibility for vocational rehabilitation services requires a series of decisions which involve: Identifying the physical or mental disability, explaining how it and attendant factors interfere with occupational performance, evaluating need for vocational rehabilitation services which will overcome or reduce these interferences, and predicting the probable outcome of the vocational rehabilitation services.

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PART THREE
CLIENT SERVICES

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Section 12

PLANNING AND PROVISIONS OF SERVICES

THE GOAL of vocational rehabilitation is the suitable placement of the vocationally handicapped client. In this section, it is assumed that a thorough client study has been completed. The client is now ready, with the continued assistance of the counselor, to carry out a plan of action leading to placement in a suitable position.

ACTIVATION OF PLAN

By the process of synthesizing the data obtained through the methods previously outlined in the sections covering medical, psychological, social, and vocational client study, the client and counselor can now plan the rehabilitation services needed to effect the client's preparation for, entrance into, and adjustment in employment. It should be noted that planning is evident throughout the client-study process and is often initiated by the client prior to contact with the counselor. However, the specific activities involved in making the necessary arrangements are shared as much as possible by both the client and counselor.

All services needed by the client are incorporated into the rehabilitation plan. Sometimes the counselor may take advantage of financial support and/or services from outside resources, including the client and his family. This is of particular importance when providing services based upon economic need. Such contributions and services are integrated by the counselor into the overall plan of rehabilitation.

UTILIZATION OF CLIENT'S RESOURCES

Evaluating the client's financial circumstances is an integral part of rehabilitation planning. Generally it

serves two basic purposes: (1) As a basis for counseling and planning a program of rehabilitation services, and (2) to establish economic need for services conditioned on need.

An assessment of the client's total economic situation should precede the planning of a rehabilitation program. Without knowledge of the socioeconomic background of the client, rehabilitation plans often break down. From this point of view, evaluation of the applicant's economic situation becomes a basic process in rehabilitation and is generally undertaken whether or not the rehabilitation plan is to include services based on need. Every individual, without regard to sex, race, creed, color, or national origin, who applies for vocational rehabilitation services may have his vocational potential evaluated at the expense of the Federal-State rehabilitation program without consideration of his personal finances. Also, every handicapped individual who meets the eligibility requirements may receive guidance and placement services without payment. Until the passage of Public Law 89-333, an individual was required to show "need" before certain other services could be provided. As mentioned previously, the determination of need as a requirement for the provision of certain services has been deleted from the Federal legislation. However, a State may retain a need requirement and many States will undoubtedly do so.

The services which have been traditionally contingent on economic need are: Physical restoration; maintenance; transportation (except for diagnosis); occupational licenses; books and training materials; tools, equipment, initial stocks, and supplies; other goods and services. Some States also condition training on economic need.

When an agency's provision of services to an individual depends upon whether he is able to pay for them, standards for making this determination are essential. In public programs, it is necessary to recognize and respect the equality of individuals under the

law. This does not mean that all persons must be treated identically. On the contrary, the concept of equitability recognizes that individual needs differ and that equitable treatment is afforded by use of objective ways of measuring those needs. Fairness to the individual, to the taxpayer, and to the staff member who makes the decision on an individual's ability to pay, all necessitate some objective standard by which to measure "financial need."

While vocational rehabilitation is a program of highly individualized services, some needs are common to all people; e.g., basic needs for the ordinary requirements of living such as food, clothing, shelter. It is possible and necessary to measure such needs as these by objective standards, so that like treatment is given all clients who are in similar circumstances. Individual needs cannot be measured equitably without objective criteria. According to provisions of Public Law 89-333, State agencies can either establish their own specific criteria for determining economic need or they can delete economic need requirements.

The following broad concepts apply in the processes and standards for determining the client's ability to pay for vocational rehabilitation services.

- (1) *Vocational Rehabilitation Is a Temporary Service of Value.*—The specific objective of providing vocational rehabilitation services to the handicapped individual is to enable him to engage in a gainful occupation. It follows that standards, policies, and procedures developed by the State agency should be based on the concept of assisting the individual as necessary for a temporary period at the end of which he can take his place among his neighbors as a working member of the community.
- (2) *Processes and Standards Should Assist to Preserve and Strengthen the Individual's Self-Reliance.*—It is important that all standards, policies, and procedures, and methods of work with the individual are designed to help him become self-reliant and achieve his maximum independence.
- (3) *The Individual Should Understand His Responsibilities and the Basis for Services.*—Federal and State rehabilitation laws and regulations establish the basis upon which individuals are provided services through the program. In dealing with the disabled individual the vocational rehabilitation counselor is obligated to acquaint him with the services available through the agency and the condi-

tions under which individuals qualify for them, and to provide services in accordance with those conditions. The counselor also has an obligation to acquaint the client with the responsibilities and obligations he incurs by accepting the agency's services.

- (4) *Equitable Treatment of Individuals Is Essential in a Public Program.*—It is essential that individuals in similar circumstances be given similar consideration on an objective reasonable basis and be accorded equitable treatment under the laws.
- (5) *The Individual's Need Under State Standards Is the Basis for Planning and Providing Services.*—The individual's need for services is the basis for planning and providing the specific services necessary for his rehabilitation in accordance with State standards and policy.
- (6) *Quality and Quantity of Services Are Sufficient To Accomplish the Individual's Rehabilitation.*—When rehabilitation services are undertaken for an individual, they must be sufficient in quality and quantity if he is to reach the goal of becoming a working member of the community. To only half rehabilitate an individual would not be economical.
- (7) *Constructive and Adequate Processes Are Necessary for Effective and Economical Administration.*—In common with all programs it is important that State vocational rehabilitation agencies maintain standards and methods of operation that are effective and economical in the light of the program objective.

JUSTIFICATION OF SERVICES

In order to justify services the counselor should prepare an individual plan written to cover the services needed by the client. The plans should show there is a good possibility that the services will meet the client's needs as disclosed by the case study and will lead to the client's vocational rehabilitation. The plan should indicate that the provision of services will entail a "substantial service" enabling the counselor to terminate the case as "closed employed," when satisfactory job adjustment has been made. State agency standards and policy should be met if a plan of services is to be acceptable.

In those instances in which counseling is the *only* rehabilitation service other than placement provided a

client, it should be assured that the counseling was *substantial* and contributed to the client's job adjustment. Subsequent to a complete medical and vocational diagnosis, counseling usually includes the following counselor activities:

- (1) Acquainting the client with the advantages of not making an occupational choice until after a careful study of his vocational assets and liabilities.
- (2) Assisting the client in cultivating a self-understanding of his capacities, aptitudes, and interests, based on the data secured during the case study.
- (3) Providing the client with information about occupations, education, health, and other community services and facilities.
- (4) Assisting the client in selecting suitable and realistic vocational goals.
- (5) Planning with the client a program for the attainment of selected vocational goals.

The counselor should recognize that not all of these activities may be present in every counseling situation. They are descriptive, however, of the framework within which counseling may be considered as *substantial*.

PROVISION OF SERVICES

Throughout this manual, the premise that each client's needs must be considered individually has been emphasized; i.e., the rehabilitation process is an individual process. This is especially true in the provision of rehabilitation services. The rehabilitation counselor has a great amount of freedom and flexibility in formulating a plan of services for each client, however, this freedom should be exercised with discretion and foresight. The services provided a client should not only meet his present needs, but insofar as possible encompass future needs. A capacity to derive adequate plans of service for disabled individuals is one of the necessary and unique qualifications for rehabilitation counseling.

Generally, the rehabilitation counselor can provide whatever services are reasonable and necessary to insure the best obtainable vocational adjustment for his client. Vocational rehabilitation legislation has authorized the utilization of a wide range of services in the rehabilitation process (these are itemized later). There is also a great deal of latitude within each service; i.e.,

the counselor and the client may select a training facility from several possible colleges or vocational schools.

In most States, a planned program of services is generally approved prior to actually authorizing any vendor to begin providing services. A written authorization is sent to the vendor with a description of the type of service, proposed expenditures, method of reporting and billing. If the cost of a portion of the services is to be paid by the client or other resource, the vendor is informed.

The client is informed of the services, starting date, conditions of contract, and regulations of the agency pertaining to the services. If release forms, receipts, or other signed statements are required prior to initiation of services, they are secured by the counselor. A written statement is sent to the client confirming the plan of service prior to the starting date. Sufficient time is allowed between approval and starting date so that the client can reasonably be expected to meet the schedule. The client is also informed of his right to file a request for review and redetermination by a member of the supervisory staff or for a fair hearing before the State administrator, if he is dissatisfied with any agency decision with regard to the furnishing or denial of services.

The counseling relationship continues during the entire period of service. In cases where the client is from out of the district or State, and is under the supervision of another person during the period of services, complete information needs to be sent to the supervising office. The client is then informed of the availability of counseling services in the district or State where he is presently residing and the supervising office arranges for continual counseling.

Description of Services

Services which may be included in a rehabilitation plan are: Physical restoration, training, maintenance, transportation, placement, provision of tools, equipment and licenses, establishment of and management services for small business enterprises, and other goods and services necessary to render a handicapped individual fit to engage in a gainful occupation.

(A) *Physical restoration services* are defined as "medical and medically related services which are necessary to correct or substantially modify within a reasonable period of time a physical or mental condition which is stable or slowly progressive." More specifically, physical restoration services include:

- (1) Medical or surgical treatment by general practitioners or medical specialists,
- (2) psychiatric treatment,
- (3) dentis-

try, (4) nursing services, (5) hospitalization (either inpatient or outpatient care) and clinic services, (6) convalescent, nursing, or rest home care, (7) drugs and supplies, (8) prosthetic devices essential to obtaining or retaining employment, (9) physical therapy, (10) occupational therapy, (11) medically directed speech or hearing therapy, (12) physical rehabilitation in a rehabilitation facility, (13) treatment of medical complications and emergencies, either acute or chronic, which are associated with or arise out of the provision of physical restoration services, or are inherent in the condition under treatment, and (14) other medical or medically related rehabilitation services. The provision that the condition is stable or slowly progressive does not apply when physical restoration services are provided in order to determine the rehabilitation potential (Regulations, 1966, sec. 401.1(p)).

(B) *Training* is only one of a comprehensive list of vocational rehabilitation services. However, it takes on special significance because of its contribution to the individual's job adjustment. Through training, the individual not only prepares for employment but is better able to compete for jobs, and in periods of declining employment is better able to hold the job he has. Training provides an individual with marketable knowledge and skills which are especially desirable when it is necessary to overcome employer prejudice toward physically or mentally handicapped persons. Training gives to the disabled individual something which can assist him significantly in competing with others who are seeking employment. During periods of fluctuation in the labor market, the fact that a handicapped person has had training may very well spell the difference between job security and a long period of idleness.

Training also contributes in other ways to the individual's total adjustment. Many clients are enabled through their successful performance in training to develop the self-confidence that is vital to their personal and vocational adjustment. The training program is often a strong motivational experience in helping the disabled individual to establish a satisfactory vocational role for the first time, or to rediscover his place in the community.

In order for the disabled person to attain optimum benefit from his training it is important that the conditions under which it is given are satisfactory and that the client recognizes his obligations in insuring the success of the training program.

Rehabilitation training includes any type of training that may be necessary in order to rehabilitate a disabled individual. This definition recognizes that a State agency may utilize public and private training facilities; or may provide such services directly by assigning staff members to this function, by employing

instructors, or by operating training facilities. Books and training materials (including tools) are included.

The training authorized by a counselor may be classified into three broad categories; vocational, prevocational, or personal-adjustment training. These terms have reference to the training provided in the State-Federal vocational rehabilitation program, and are not intended for general use in other professional fields.

(a) "Vocational training" includes any organized form of instruction which provides the knowledge and skills that are essential for performing the tasks involved in an occupation. Such knowledge and skills may be acquired through training in an institution, on the job, by correspondence, by tutors, or through a combination of any or all of these methods. Vocational training may be given for any occupation—professional, semiprofessional, technical, clerical, agricultural—or for any of the skilled or semiskilled trades.

(b) "Prevocational training" includes any form of basic training given for the acquisition of background knowledge or skill prerequisite or preparatory to vocational training, or to employment where the primary occupational knowledge and skills are learned on the job. It includes training which is related to vocational courses or to employment, by complementing or facilitating the acquisition of the knowledge and skills required for entry into an occupation. In vocational rehabilitation, prevocational training may also include training given for the purpose of removing an educational deficiency which interferes with the fullest utilization of the occupational knowledge or skills already possessed by a disabled individual.

(c) "Personal-adjustment training" includes any training given for any one or a combination of the following reasons:

- (1) To assist the individual to acquire personal habits, attitudes, and skills that will enable him to function effectively in spite of his disability.
- (2) To develop or increase work tolerance prior to engaging in prevocational or vocational training, or in employment.
- (3) To develop work habits and to orient the individual to the world of work.
- (4) To provide skills or techniques for the specific purpose of enabling the individual to compensate for the loss of a member of the body or the loss of a sensory function.

(C) *Maintenance* payments are supplementary to the other vocational rehabilitation services. Maintenance means "payments to cover the handicapped

individual's basic living expenses, such as food, shelter, clothing, health maintenance, and other subsistence expenses essential to achieving the individual's rehabilitation potential or to achievement of his vocational rehabilitation objective" (regulations, 1966, sec. 401.1(k)). Maintenance is furnished only when required in order to enable an individual to derive full benefit of other vocational rehabilitation services being provided. It may be provided at any time, in connection with vocational rehabilitation services, from date of initiation of such services, including diagnostic services, up to a reasonable period following placement. Maintenance may be provided only for the disabled person's needs and not for those of his dependents. The State plan may also provide that the agency will assume, as part of maintenance, amounts to cover the cost of short periods of medical care for acute conditions arising in the course of vocational rehabilitation.

(D) *Transportation* is another of the supplementary services in vocational rehabilitation. "Transportation is considered to mean the necessary travel and related costs in connection with transporting handicapped individuals for the purpose of providing diagnostic or other vocational rehabilitation services under the State plan. Transportation includes costs of travel and subsistence during travel (or per diem allowances in lieu of subsistence) for handicapped individuals and their attendants or escorts, where such assistance is needed" (regulations, 1966, sec. 401.38).

(E) *Placement* responsibility is assumed by the State or local rehabilitation agency for individuals accepted for service. The agency sets standards for determining if the client is suitably employed and provides for a reasonable period of followup after placement to assure that the vocational rehabilitation of the client has been successfully achieved (regulations, 1966, sec. 401.40). This topic is discussed in detail in a following section.

(F) *Tools, equipment, and initial stocks (including livestock) and supplies* may be provided when necessary to the client's vocational rehabilitation. Equipment and initial stock and supplies for vending stands and necessary shelters in connection with the foregoing items may be provided (regulations, 1966, sec. 401.41). These services may be supplied to the client, if needed, in connection with employment by others or in the establishment of a small business enterprise whether operated by the client directly or under the management and supervision of the rehabilitation agency.

(G) *Occupational licenses* are provided when the job objective requires it. An occupational license is

"any license, permit, or other written authority required by a State, city, or other governmental unit to be obtained in order to enter an occupation" (regulations, 1966, sec. 401.1(n)).

(H) *Small business enterprises* (including vending stands) may be operated by blind or other severely handicapped persons under the management and supervision of the State agency or its nominee. State plans describe "the types of enterprises that can be established; the policies for the acquisition of the stands, equipment and supplies; and the policies for their management and supervision" (regulations, 1966, sec. 401.44).

(I) *Other goods and services* necessary to render a handicapped individual fit to engage in a gainful occupation or to determine his rehabilitation potential may be provided, but Federal financial participation is not available in any expenditure made either directly or indirectly on behalf of the handicapped individual for the purchase of any land or for the purchase and erection of any building or buildings. Reader services for the blind and interpreter services for the deaf may also be provided (regulations, 1966, sec. 401.43).

Utilization of Community Resources

The rehabilitation counselor should recognize that the vocational rehabilitation program is only one part of the total array of services provided by the community to meet the needs of the handicapped. It is his responsibility to acquaint the community with the State agency program and to effectively utilize the resources available. Reciprocal relationships should be developed with all agencies that can assist in the rehabilitation of disabled individuals.

The productive use of related programs and professions by the counselor depends upon the following: The counselor's knowledge of the principles and fields of service of related professions and agencies; awareness of the specific and potential resources for services to the disabled; and adoption of effective ways of developing and working with the resources in the community.

Services and other assistance through the vocational rehabilitation agency fall into three general categories. These are: (1) Services which the State agency furnishes directly through its own staff, (2) services which it obtains from physicians, schools, rehabilitation centers, hospitals, and others, and (3) assistance obtained from cooperating agencies and individuals.

Services from community resources may be furnished directly to the client, his family or others involved in

his rehabilitation or they may involve consultation with the counselor or participation through advisory committees. The rehabilitation process is composed of many elements in addition to those within the immediate province of the counselor.

Some of the types of community resources which the rehabilitation counselor might need to utilize in providing actual case services are: Government agencies, civic and service clubs, voluntary agencies and services, institutions for public service, professional persons, and advisory committees.

The effective counselor recognizes that many of the services upon which the rehabilitation of the individual depends, must be provided by nonrehabilitation agencies. However, before seeking these services, the counselor *needs to know enough about the resource to have confidence that it can actually assist his client*. Conversely, in order for the personnel of other agencies to use their time most profitably, they need to be given a thorough explanation of the client's problem. The counselor needs to maintain professional relationships with appropriate personnel of other agencies and keep himself posted on their programs. Lines of communication need to be kept open. The counselor should bring participating resources into the planning stages to make them more closely aware of the developments by which the rehabilitation objective is chosen. The counselor should also keep the participating resources informed about the client's progress and the outcome of their services.

In summary, planning and providing services with and to vocationally handicapped individuals is a joint activity requiring the cooperative participation of client, counselor, and community. The extent and manner in which community resources are used is a reflection of the counselor's concept of his role in serving the needs of the handicapped and relating himself to other programs in the community. It is of utmost importance that he become an active leader in community planning.

The effective counselor recognizes that many services upon which rehabilitation of the individual depends must be provided by nonrehabilitation sources. However, the facilities which the counselor utilizes must meet the standards set up in the individual State plan. He should prepare a written plan showing the services required by the client and how such services will meet his individual needs and lead to the chosen vocational objective. In those instances where counseling is the only rehabilitation service provided to the client, other than placement, it should be assured that the counseling was "substantial" and contributed to his job adjustment. The planned program of services is usually approved prior to actually authorizing any vendor to begin providing services. The client is informed of the services and the date they are to start.

The counselor's responsibility does not end with the client's placement on a job, but is continued until his followup contacts reveal that both client and employer feel he is an adjusted, satisfied employee.

Section 13

PREVOCATIONAL EVALUATION SERVICES

THE DECISION to place this section with "Client Services" was an arbitrary one, since a rehabilitation facility, where prevocational services are often provided, may perform a service or a diagnostic function, or both. Diagnostically, special facilities can be used in the preliminary study of more severely disabled clients who fall in the "gray" area, that is, to determine if a client has the residual capacity to make a satisfactory vocational adjustment. Another diagnostic service provided by these facilities is to establish parameters of physical or mental capacity within which an occupational choice can be made. The Service function of rehabilitation facilities entails such services as prevocational training, a therapeutic environment for the adjustment to disability, gait training, physical therapy, etc.

In order to clarify the two functions of rehabilitation facilities and prevocational units the following definitions are presented.

1. *Rehabilitation Facilities.*—In the past decade professional organizations of administrative personnel in rehabilitation centers and the Public Health Service in connection with programs under the amended Hill-Burton Act have defined rehabilitation center and facility. The regulations governing the vocational rehabilitation program now include the following definition:

"Rehabilitation facility" means a facility, operated for the primary purpose of assisting in the rehabilitation of handicapped individuals: (1) Which provides one or more of the following types of services: Testing, fitting, or training in the use of prosthetic devices; prevocational or conditioning therapy; physical or occupational therapy; adjustment training; evaluation, treatment, or control of special disabilities; or (2) through which is provided an integrated program of medical, psychological, social and vocational evaluation and services, under competent professional supervision: *Provided*, That the major portion of such evaluation and services is furnished within the facility, and that all medical and related health services are prescribed by, or are under the formal supervision of, persons licensed to practice medicine or surgery in the State (1966, sec. 401.1(r)).

2. *Prevocational Units.*—A statement issued by the division of hospital and medical facilities of the Public Health Service and the Office of Vocational Rehabilitation (1954) on the development of rehabilitation facilities under the Hill-Burton program outlines prevocational experience as follows:

Prevocational experiences may be defined as those experiences offered in the facility which simulate conditions in employment, but do not include definitive vocational training. They are of value to the patient in determining the relationship of his capacities and disabilities to a given occupation and are designed to build up his confidence in his ability to overcome the vocational handicap inherent in his disability (p. 5).

A publication by White and Redkey entitled "The Prevocational Unit in a Rehabilitation Center" (1956) summarizes the nature and purpose of such a unit as follows:

The prevocational unit is a vocational evaluation laboratory. For a specific period of time, the patient has a trial in the performance of a wide variety of work experiences. The period of time the patient is assigned to the unit should be for a period of not less than 3 weeks. To achieve the best vocational evaluation of the patient, his condition should warrant his spending a full day in the program. This will vary with the individual, and the program must be planned on an individual basis, taking into consideration the medical aspects of the patient's condition, his mental outlook, emotional adjustment, and his concurrent programs. For the majority of cases an initial period of anything less than a day is considered impracticable.

The work experiences in which he will engage should be provided in actual work situations or in environments which simulate work situations. Obviously, sampling in all occupations which offer possible employment opportunities for physically handicapped persons cannot be offered in the prevocational unit. The basic skills and job operations evaluated in the unit nevertheless should be fundamental to occupational areas such as clerical, skilled, semiskilled, subprofessional, agricultural, and service occupations. The evaluation made must be based on standards which have direct relationship to employment requirements.

Specific activities within these areas should take into consideration placement opportunities in the community and in the area served by the facility. This will be particularly true in reference to light industrial and agricultural activities.

In some instances, community resources can be utilized to implement the facilities of the center and to provide more realistic work situations. Whenever possible, opportunities of this kind should be developed (p. 2).

In the early history of rehabilitation, vocational training was the primary method involved in restoration of employability. Later, psychosocial services led to drastic changes in the methods and titles of rehabilitation facilities. In the course of the advances of the past decade, there have developed not only changing concepts but confusion in terminology used to describe these facilities. Names of agencies generally do not indicate what services an agency or facility offers, or its purpose. Some of the various designations by which workshops refer to themselves are: Rehabilitation workshops, special workshops, industrial rehabilitation workshops, vocational adjustment centers, industries, work classification units, and training centers. A number of types of programs and philosophies are represented by these workshop designations and thus in a sense there is justification for the variety of terms. On the other hand, two workshops of essentially the same type may be known by two entirely different generic titles, such as training center and sheltered workshop.

The confusion is not confined to workshops, but extends over the entire range of rehabilitation facilities. Terms such as "Physical Medicine and Rehabilitation" and "Rehabilitation Workshop" do not mean that the entire rehabilitation process (physical, vocational, etc.) takes place within the facility. Similar confusion of terms is caused by the fact that a workshop is occasionally contained within a rehabilitation center and that a curative workshop is not necessarily a workshop at all (Chouinard and Garrett, Rehabilitation Service Series No. 371).

The regulations governing the vocational rehabilitation program state:

"Workshop" means a place where any manufacture or handiwork is carried on, and which is operated for the primary purpose of providing gainful employment to the severely handicapped: (1) As an interim step in the rehabilitation process for those who cannot be readily absorbed in the competitive labor market; or (2) during such time as employment opportunities for them in the competitive labor market do not exist (1966, sec. 401.1(y)).

A report by the Association of Rehabilitation Centers, Inc. (1964), states that there are about 2,000 facilities that vary widely in emphasis and size which identify themselves as rehabilitation facilities. Therefore, the rehabilitation counselor has a problem of matching the best facility to the needs of his client. This must be accomplished through a thorough under-

standing of the services available from all the rehabilitation facilities in his geographic area.

PURPOSE OF PREVOCATIONAL EVALUATION

Prevocational evaluation programs are designed to facilitate the entry into the labor market of the individual whose capabilities cannot be assessed by traditional techniques. They are designed to develop the work tolerance and skills that will permit the client to function on a job. Their emphasis is upon assessing and removing barriers to normal vocational development and functioning. A prevocational facility provides a controlled situation which permits modifying work behavior, work environment, and factors contributing to the individual's functioning in a work situation setting.

Development of Prevocational Programs

The growth of rehabilitation facilities can be attributed to two factors: (1) The recognition that rehabilitation, particularly of the severely disabled, requires teamwork among many medical and related specialties if it is to be successful, and (2) greater public acceptance of the rehabilitation program which has resulted in the demand that services be made available to larger numbers of disabled, many of whom are severely disabled (Redkey, 1957). Thus, the severely disabled who presented impossible rehabilitation problems in the past can often be served in today's comprehensive rehabilitation centers.

In 1964, over 200 rehabilitation facilities reported being able to provide prevocational experience for their patients (Association of Rehabilitation Centers, 1964). Of these, 135 reported having an identifiable prevocational unit. A "unit" is described as a vocational diagnostic laboratory in which patients try out various job samples taken directly from industry.

Services Provided by Prevocational Programs

Prevocational evaluation programs may be located in primarily medically oriented or vocationally oriented centers. In the former, the first concern may be with developing work tolerance, while the latter concentrates upon developing or measuring job skills. Medically oriented centers are usually staffed by occupational therapists while the vocationally oriented

centers are staffed by industrial arts teachers, vocational counselors, or persons with general industrial experiences (Mott, 1960).

Some of the diagnostic or ameliorative services offered in prevocational evaluation programs are: Work experience, personal adjustment, work adjustment, counseling, physical conditioning, training in the basic academic skills of reading, arithmetic, and writing, work training, evaluative procedures, and development of production speed sufficient to meet the demands of competitive industry.

METHODS OF PREVOCATIONAL EVALUATION

Although the techniques and procedures used in prevocational evaluation may vary, the methods used in most rehabilitation centers may be classified as:

Work Sample Method: Actual employment conditions are produced in the prevocational unit. This enables the evaluator to compare the performance of the disabled person with that of a successfully employed person. These conditions range from the general (i.e., general employment situations which determine whether or not a person is employable) to the specific (i.e., specific jobs, such as watch repairing). The main problem with this method is that it is often difficult to reproduce actual industrial conditions.

Sheltered Workshop Work: Here the severely disabled work at tasks specifically related to a job in industry with the industrial rate set by the firm giving the contract to the workshop. This method of evaluation is especially suitable for those disabled by severe emotional or psychiatric illnesses. This is essentially a wage-earning situation, while the work sample method is not.

Psychological Assessment: Intelligence, mechanical aptitude, finger dexterity, and personality tests are administered to assess the individual's abilities and capabilities. This method has been somewhat limited in application as it is difficult to devise suitable assessment instruments that are valid predictors with the severely disabled. Research is being conducted in this area and there are several measurement instruments specially designed for use with the severely disabled. One such instrument is the THOMASAT (Thomas, et al., 1960), an experimental technique designed to appraise cognitive-

motor functions relevant to jobs performed in the sheltered workshop.

Engineering Approach: This is a recent development, and is a work sample system based on the most common physical motions involved in typical semi-skilled jobs, industrial and clerical work. The levels of difficulty of the jobs are described in physical and engineering terms mostly related to the amount of force or physical pressure necessary for performance of the job (Mott, 1960).

Patient-Employee Evaluation: This approach is employed primarily in hospitals, where the patient is assigned work with the various nonprofessional services of the hospital. After a week or so of occupational therapy, the patient works in accounting, bakery, maintenance, etc., and his performance on each is appraised by supervisors (Mott, 1960).

SELECTION OF CLIENTS AND THE APPROPRIATE FACILITY

The place of the facility in the total rehabilitation program is determined by the practices and procedures of the State agencies. Before a counselor can make an adequate decision as to whether or not to engage the special services offered by a facility, he must know of the purpose of the facility, as well as the specific services it can provide for his client. Bulletins, year-books, annual reports, and other sources of information regarding these special facilities should be examined before purchasing their services. Visits by agency staff members to various facilities are an excellent means of acquainting them with the services provided. Other practical matters that influence the agency's selection and utilization of special facilities are cost of services, distance from client's home, and the availability of domiciliary and other custodial services to meet special needs of homebound and severely disabled clients.

In regard to the selection of a facility, the agency should ascertain that:

- (1) The facility meets standards as set up in the State Plan.
- (2) All facility staff members are qualified in their specialty.
- (3) The physical plant is adequate for the services required.
- (4) The facility is one that keeps the agency properly informed on client's progress.
- (5) The facility is reliable and ethical.

- (6) The facility can provide services at the time needed.
- (7) The facility has a reputation of establishing satisfactory relationships with counselors and clients.
- (8) The facility has a fairly consistent record of obtaining effective results.
- (9) The cost of services are in line with the cost of similar services at other facilities.

"The Standards for Rehabilitation Facilities and Sheltered Workshops" (1967) published by the Vocational Rehabilitation Administration, primarily for use in the conduct of grant programs for training services and workshop improvement, can serve as a measure of quality in evaluating both the facility and its program.

In the selection of clients for such facilities, the procedures vary. Selection can be determined by the counselor's judgment, screening teams, facility evaluation of case records, by prior client experience, by the agency, etc. It would seem that the ideal procedure for selection should be an adequate appraisal of the client's total situation. Careful case evaluation and competent consultive assistance should be a standard procedure. Clients that receive facility services should be those who:

- (1) Need multiple-integrated services or a specific service which can best be obtained at the facility.
- (2) Can probably benefit by the service.
- (3) May be undergoing evaluation or extended evaluation to determine whether there is a reasonable expectation that vocational rehabilitation services may render them fit to engage in a gainful occupation.
- (4) If sent for services other than evaluation, the case study indicates there is a reasonable chance that they may, as a result of the services of the facility, become gainfully occupied.
- (5) Understand the services being made available and have indicated a "readiness" to accept such services.

OBTAINING APPROPRIATE SERVICES FROM THE FACILITY

Rehabilitation facilities have broadened their function to include: Improved physical functioning of the severely disabled, inducing latent motivation for voca-

tional rehabilitation from clients who have almost lost hope, prevocational adjustment services, and integration of the various services toward the single goal of the vocational rehabilitation of the client. To avoid unrealistic expectations on the part of the counselor, he should develop a useful understanding of the function, limitations, and scope of service of the rehabilitation facility.

Some of the factors that hinder obtaining proper services from the rehabilitation facility are: Inadequacies of facilities' staff and services provided; indefinite lines of authority and communication within the facility; misuse of facility by rehabilitation counselor (dumping ground); inadequate information on services expected for client; inability or unwillingness of the State agency and the facility to come to a common agreement on a definition of diagnosis as opposed to other case services; and misunderstanding on the part of the facility of the legal and administrative limitation imposed on the State agency in the purchase of services.

In obtaining appropriate services for their clients, the State agency should establish the following procedures:

- (1) Provide the facility with complete background information on all clients referred to the center.
- (2) Brief each client on the services to be expected, the ultimate goals to be achieved, and the procedures employed at the rehabilitation center for achieving these goals.
- (3) Encourage State agency counselors to visit available rehabilitation facilities to further their knowledge and understanding of the rehabilitation services so they may better interpret these services to clients.
- (4) Request that a specific member of the rehabilitation center's staff be designated as contact person.
- (5) Instruct State agency counselors not to attempt to refer all difficult cases to the rehabilitation center. Only those who can be aided by the available service should be considered.
- (6) Formalize State agency authorization policies and make these available to the facility.
- (7) Request from the rehabilitation center a formalized statement of its policies and requirements for the referral and acceptance of clients.
- (8) Formalize State agency definition of diagnostic services as differentiated from treatment services.

COUNSELOR-CLIENT-FACILITY RELATIONSHIPS

Traditionally, only two persons have been involved in the rehabilitation counseling relationship—the client and the counselor. Within the past few years, however, a third party has entered this relationship—the staff of the rehabilitation facility. This poses a problem for the counselor, since the influence of the center on the client may equal or surpass that of the counselor. Since the counselor is charged with the primary responsibility of providing counseling and placement services, the efforts of a third party must be dealt with on a positive basis, with the counselor regarding the center's work not as a substitute for his counseling service, but rather a supplementary service to enrich the client's rehabilitation program.

The problem of client-counselor-facility relationships can be divided into two related problem areas:

- (a) Client-counselor-facility relationships while the client is in the facility.
- (b) Relationship after the client has left the rehabilitation facility.

In regard to the first, the greatest problem appears to be distance. The lack of opportunity on the part of the State agency counselor for personal contact with the client in the rehabilitation facility due to distance, expense, and travel time involved presents a serious obstacle in counselor-client-facility relationships. This problem is minimized when the facility is close to the agency counselor's home territory, but there are not enough facilities at this time. A possible solution for this problem would be to assign a State agency counselor to the center to work with vocational rehabilitation agency clients while they are in the facility, or there might be more written communica-

tion with the client and the center staff, with an occasional visit to the center to meet with the client when a particular problem necessitates a trip.

The relationship of the client and his counselor after the client has left the rehabilitation facility is dependent on their relationship while he was there.

In order to fulfill his responsibilities to the client sent to a rehabilitation facility, the rehabilitation counselor must be regarded by the facility personnel as a key factor in the rehabilitation process. The rehabilitation counselor needs to be the person to whom they look to get a "perspective" of the client they will be serving—his family, his community, his vocational opportunities, and other pertinent information. Some facilities seem to constantly overlook the professional skills of the rehabilitation counselor and the value of his contribution to the successful rehabilitation of a disabled person.

Some suggestions for improving State agency facility relationships are:

- (1) Joint staff meetings to promote a better understanding of the program, interpretation of policies, and procedures for referrals and reporting.
- (2) The State agency can provide an opportunity for the counselor to visit the facility for his orientation at an appropriate time.
- (3) The State agency can provide an opportunity for its counseling staff, and encourage the facility staff to participate in State, district, and regional workshops.
- (4) A State agency counselor might be assigned to the larger facilities, and a liaison man to smaller facilities.
- (5) The State agency can provide a program of orientation training for the professional staff of the facility.

Section 14

COUNSELING: DEFINITIONS AND THEORIES

THE PURPOSE of this section is to present data on identifying characteristics and/or differences between schools of counseling, counseling theories, approaches to counseling, or whatever other labels are used to identify the writings of authoritative and influential people. This should help the rehabilitation counselor develop the background knowledge he needs in order to read and evaluate the different books that have been written on the counseling process. An attempt has been made to avoid reopening or resurrecting the old "nondirective versus directive" controversy.

The plan for the section is: (1) To identify what we mean by counseling by presenting a number of definitions of the term, (2) to identify the exact frame of reference from which the writers view the counseling process, (3) to briefly review the contributions of Rogers, Williamson, and Thorne and the influence of their writings on the development of theoretical positions, and (4) to draw some conclusions regarding the application of theory to the work of the counselor in a rehabilitation setting.

DEFINITIONS

Leona Tyler (1961): It is a process designed to help a person answer the question, "What shall I do?" * * * A helping process the aim of which is not to change the person but to enable him to utilize the resources he now has for coping with life. The outcome we could then expect from counseling is that the client do something, take some constructive action on his own behalf. Whether the need that brings him to counseling grows out of his arrival at a point in his life where an important decision must be made or out of an emotional conflict that is paralyzing his ability to act, the counselor will attempt to make forward movement possible (pp. 1, 12).

C. H. Patterson (1962): A professional relationship, established voluntarily by an individual who feels the need of psychological help, with a person trained to provide that help (p. 112).

C. Gilbert Wrenn (1951): A personal and dynamic relationship between two people who approach a mutually defined problem with mutual consideration for each other to the end that the younger, or less mature, or more troubled of the two is aided to a self-determined resolution of his problems (p. 59).

Dugald S. Arbuckle (1961): * * * a warm relationship in which the counselor, fully and completely, without any ifs or buts, accepts the client as a worthy person. In this relationship of complete acceptance, the client can grow and develop, and come to use the strengths and capacities that are his, and to make decisions and choices that will be satisfactory to him, and thus to his fellows. Such decisions will be rational and logical in that they will bear some relationship to the assets and the liabilities that are possessed by the individual (p. 137).

Edward S. Bordin (1955): Counseling and psychotherapy are terms which have been used to apply to interactions where one person, referred to as the counselor or the therapist, has taken responsibility for making his role in the interaction process contribute positively to the other person's personality developments (p. 6).

Carl Rogers (1942): Effective counseling consists of a definitely structured permissive relationship which allows the client to gain an understanding of himself to a degree which enables him to make positive steps in the light of his new orientation (p. 3).

Pepinsky and Pepinsky (1954): * * * A process by which help is given, is referred to as counseling. Here the client and counselor interact in an interview or series of interviews * * *. And the function of the interaction is to help the client change his behavior so that he may obtain a satisfactory resolution of his needs (p. 3).

E. G. Williamson (1958): Counseling is a peculiar type of relatively short-term human relationship between a mentor with some considerable experience in problems of human development, and in ways of facilitating that development, on the one hand, and a learner, on the other hand, who forces certain clearly or dimly perceived difficulties in his efforts to achieve self-controlled and self-manipulated forward moving development (p. 521).

J. W. Gustad (1955): Counseling is a learning-oriented process, carried on in a simple, one-to-one social environment, in which a counselor, professionally competent in relevant psychological skills and knowledge, seeks to assist the client by methods appropriate to the latter's needs and within the context of the total personnel program, to learn more about himself, to learn how to put such understanding into effect in relation to more clearly perceived, realistically defined goals to the end that the client may become a happier and more productive member of his society (McGowan and Schmidt, 1962, p. 3).

A FRAME OF REFERENCE

In a previous publication, McGowan and Porter (1964) expressed the assumptions they feel form the foundation for the process of counseling. They are reproduced here so that the counselor using this manual can better understand their position on counseling in the total rehabilitation process.

The Client

We believe:

(1) That clients differ both in their perceived needs for counseling and in their capacity to profit from counseling. That some clients have developed traits or learned skills which will allow them to benefit from a counseling relationship, while others are not able to verbalize their problems and cannot enter into a relationship requiring any degree of psychological closeness.

(2) That the majority of clients perceive vocational counseling as a basically informational process during which something will be done for them, rather than with them. That they do not, at least initially, perceive themselves as being part of the process, nor do they expect any major changes in their self-concept to come about as an end product. As Seeman stated back in 1948 at the conclusion of a study of counselees who

received counseling at the University of Minnesota Counseling Bureau, " * * * the facts lead to the permissible inference that on the whole clients both begin with and maintain a concept of vocational counseling as a basically informational process, with little indication that personal reorientation will take place within the interview."

(3) That a certain percentage of the clients who are seen in a rehabilitation setting, who have requested counseling themselves, or who are sent to the counselor on the basis of obvious need, either lack the necessary motivation for counseling, and/or exhibit certain character disorders that preclude successful outcomes.

(4) That clients have different kinds of problems which require different kinds of help.

(5) That serious problems of communication can and usually do exist when there is any marked discrepancy between the socioeconomic, sociocultural level of the counselee and the counselor.

The Counselor

We believe:

(1) That counselors manipulate and/or control behavior. That they may do so consciously and by design, or unconsciously and by accident. But in either case they do influence and manipulate the behavior of their clients. That they need to recognize and accept the fact that they do so through the responses they choose to reinforce, the goals they set, the settings in which they choose to operate, and the general personal or public image they project.

(2) That they need to establish commonly agreed upon goals in regard to desirable outcomes of counseling, from the frame of reference of the client, and then to actively help the client reach these goals.

(3) That a counselor's basic beliefs as to the nature of man influence his choice of counseling techniques, his goals, his choice of setting in which to operate, and his interest in a process versus a product orientation to counseling. That he is incapable of giving to his clients more freedom than he allows himself. That if he believes in a humanistic explanation of man's nature, he will tend toward techniques that encourage the "emergence" of feelings, attitudes, and beliefs from within his clients, with full confidence that the counselee would make a "good" or correct decision. That if he believes in a naturalistic or scientific explanation for man's nature, he will prefer techniques of counseling which encourage reeducation and a general "containment" approach. By the same token if he believes man can best

be explained in terms of culturalism, theism, or any other philosophical belief, that he will adopt a compatible philosophy of counseling, and then implement the philosophy with techniques which are consistent with it.

(4) That each counselor enters into the counseling relationship with a learned predisposition (on the basis of home, school, religion, and social training) toward certain counseling techniques. Research would indicate that counselors tend to divide themselves consistently into two groups: One group tends to hear and respond to affect or feeling material; the other to cognitive or factual material. And, while they do vary their responses somewhat according to the material that the client is presenting, they tend to hold to a familiar or established pattern of responses from interview to interview and from client to client.

(5) That a counselor's need for status may be exaggerated rather than reduced by formal training in counseling. That the cultural atmosphere in which a counselor is raised has a direct influence upon how high up in the "pecking order" of the fields of counseling he wants and needs to advance. That Vocational Rehabilitation and Employment Service counselors occupy the bottom of the prestige ladder as a result of: The general lack of high social status of their clientele; the physical settings in which they operate; and the absence of training standards which have permitted untrained personnel direct entry into the field with the consequent assignment of the title "counselor."

The Process

We believe:

(1.a) In a client-need oriented approach to counseling in which the counselor allows the counselee freedom to grow and develop at his own pace and according to the method of his own choosing.

(1.b) That all good counseling should be "client-centered" on the basis of client needs, not on the basis of a counselor's personal preference for a specific counseling technique.

(1.c) That each client has a right to grow and develop in the manner that he chooses and that fits his general patterns of reaction and adjustment to people and situations. That the counseling interview and the client's behavior during the interview represents a sample of how he reacts, and that the counselor is obligated professionally to take his cues from the behavior of the client. That some clients will prefer a rational, cognitive approach to their problems and life, some will deal

more in affect and feeling, and some with a combination of both approaches.

(2) That counseling represents a growth process, with the counselor and client both working toward common goals. That the goal or goals are subject to review and reevaluation, but that common agreement on overall aims and objectives early in the process can prevent misunderstandings and also help to speed up the process.

(3) That general or accepted counseling responses (e.g., reflection, clarification, information giving, etc.) are common to all schools of counseling. That differences between approaches are based on differences in basic beliefs as to the nature of man, his final goals, etc., and are not determined by the verbal techniques that have traditionally been associated with any one "school of counseling." That process and product are mutually dependent, but that some counselors prefer to emphasize the process while most clients are interested in product.

(4) That empathic listening and the communication of true interest in the counselee are essential characteristics of counseling.

(5) That clients present different kinds of problems and need different kinds of help. That as Callis (1960, p. 5) has expressed it: "* * * (a) lack of experience is most effectively dealt with by the method of counselor discovery and interpretation; and (b) distortion in perception is most effectively dealt with by the method of client self-discovery."

(6) That changes in a client's behavior will occur only when he perceives, either cognitively or conatively, that a modification of his behavior will be personally rewarding or self-enhancing. The reward may be either tangible, or in terms of reducing his anxiety; i.e., a tension state that has resulted from unmet needs.

THEORETICAL POSITIONS

This unit will attempt to briefly review some of the identifying ideas and viewpoints about "schools" of counseling as they have been expressed in the writings of authoritative and influential writers. As mentioned earlier, we have tried to avoid reopening the old "directive" versus "nondirective" controversy. This topic is still being discussed and rediscussed by students as well as by some experienced counselors. When pressed to explain what they mean by the two terms, the majority of beginning counselors end up by defining "directive" counseling as a form of counsel-

ing in which you do most of the talking and give advice; and "nondirective" counseling as a form of counseling in which you listen and reflect. Unfortunately, the issues involved are not so easily defined. In reality, *all* counseling must be for the good of the client and thus "client-centered," regardless of the verbal techniques that are used. If a counselor is able to convey feelings of genuine respect, acceptance, and complete concentration on the needs and problems of the individual, whether he does so verbally or nonverbally, how much he talks or does not talk, or even how he talks, are often relatively insignificant details.

The presentation of material which follows will only briefly outline the main points found in three theoretical approaches to counseling. For a more extended coverage of these and other approaches, the reader is urged to read the basic books on the counseling process that are listed in the Selected Bibliography at the end of part III.

Due to space limitations, the review of theoretical positions which follows is restricted to a consideration of the contribution of Rogers, Williamson, and Thorne. The works of Rogers, Williamson, and Thorne were selected because: The three men have all made significant contribution to the development of theory through their extensive writings; they are highly respected; and, they present three overlapping but significantly different viewpoints from which to study the counseling process.

The Contributions and Influence of Carl R. Rogers

Rogers published his first major book, "The Clinical Treatment of the Problem Child," in 1939. This book was followed in 1942 by "Counseling and Psychotherapy." Since that time he has published three additional books and an almost continual series of articles. He writes with clarity and force and has been a person of great influence in the development of current counseling theory. His writings have resulted in the development of a theory of counseling referred to as "Rogerian" or more commonly as, "client-centered" or "nondirective" counseling, after the general methods used.

His approach to counseling is based upon the belief that people's problems are primarily of an emotional etiology and that most clients already possess the objective information that they need to make a decision about a problem. The philosophical foundations for his theory rest upon a humanistic explanation of

man's nature which can best be illustrated by several short quotes from his writing:

(1) The innermost core of man's nature, the deepest layer of his personality is positive in nature—he is basically socialized, forward-moving, rational, and realistic (1961, p. 91).

(2) The organism has one basic tendency and striving to actualize, maintain, and enhance the experiencing organism (1951, p. 487).

(3) In my experience, I have discovered man to have characteristics which seem inherent in his species, and the terms which have at different times seemed to me descriptive of these characteristics are such terms as positive, forward-moving, constructive, realistic, and trustworthy (1957, p. 199).

The above quotes clearly illustrate Rogers' belief that man has the basic capacity to choose the correct goal and make correct choices if he is able to see his problems in an objective manner in a situation free from threat. The job of the counselor therefore is to establish a relationship which is characterized by feelings of warmth, understanding, acceptance, lack of evaluation, and lack of threat. In order to do so, the counselor must share the internal frame of reference the individual, since, as Rogers says: "The best vantage point for understanding behavior is from the internal frame of reference of the individual himself." To do this the counselor must be able to convey to his client an attitude of genuine liking, the complete absence of value judgments, the ability to concentrate completely on the client's problems, and finally, he must be able to share this perceptual framework without losing his own personal identity. He elects to serve, primarily as an agent of the client, and not as a representative of society. His primary concern is with the counseling *process* rather than *product*, although he would feel that success in the process area would logically lead to an application in the product area. As Rogers (1951) states:

It is the counselor's function to assume, insofar as he is able, the internal frame of reference of the client, to perceive the world as the client sees it, to lay aside all perceptions from the external frame of reference while doing so, and to communicate something of this empathic understanding to the client (p. 29).

In order for a counselor to be able to share the internal frame of reference of his clients, and particularly that of anxious and disturbed clients, it is necessary that he have a broad knowledge of personality growth and development, abnormal psychology, a capacity to hear dynamics, not merely words, and be secure enough in his own adjustment that he is able to share the individual's perceptual framework without

any serious challenge to his own sense of reality and personal adjustment. In Rogers' (1951) terms:

* * * it is the counselor's aim to perceive as sensitively and accurately as possible all of the perceptual field as it is being experienced by the client * * * to the full perceptual field * * * to indicate to the client the extent to which he is seeing through the client's eyes (p. 34).

Perhaps Rogerian counseling can best be described as a form of release or emergence counseling. The counselor believes basically that "good" will emerge from within the individual and this process is facilitated by the use of counseling techniques that include: (1) Listening in depth, (2) reflection of attitudes and feelings, and (3) clarification. A portion of the counselor responses are open-ended or nonstructured leads which allow the client the opportunity to develop and understand his own problems and to express the emotional feeling or affect that accompanies them. In his 1942 book, Rogers stated that several *conditions* must be met before this type of counseling is practical: (1) The individual must be under a degree of tension, (2) he must have some capacity to cope with life, (3) there must be an opportunity for him to express his tensions in planned contacts with a counselor, (4) he must be reasonably independent of family control, (5) he must be reasonably free from excessive instabilities, (6) he must possess average intelligence, and finally (7) he must be of suitable age.

In summary, Rogerian counseling is based on the dual conception that people's problems are primarily emotional in nature and that man has the capacity to deal with his problems if given the proper atmosphere in which to consider them. An advantage to this approach is that it does *not* reinforce client dependency through the counselor making decisions for the client. Instead, it places responsibility on the client to find solutions to his problems within himself. In doing so the client's past experiences, which cannot be changed, are minimized, and his present adjustment is the focus of attention. It provides for a depth of emotional release and a more permanent form of self-supporting growth.

In contrast to the advantages of Rogerian counseling the following disadvantages are noted: (1) The basic assumption of emotional causation has the effect of making all clients fit the mold of having emotional problems no matter what their own perception of their problems may be, (2) as a result of this concept and the techniques needed to implement the approach, a series of interviews is usually required. Therefore, the emergence theory of counseling is often considered *too time consuming* to be realistic in terms of the admin-

istration policy of most agencies, (3) Rogers' aversion to diagnosis through the use of tests ignores, or at least minimizes, the improvements in diagnostic instruments and procedures which have occurred in the past few years, (4) the reality factors in the client's life; e.g., job placement, are not stressed, (5) there is no research to support "emergence" techniques as the most appropriate, nor has it been established that the same goals cannot be accomplished through the use of other, less time-consuming counseling methods, finally (6) many counselors do not have the belief in their own capacity to solve problems, which is necessary before they can project these same beliefs onto their clients. As stated earlier, they are unable to allow their clients a freedom of action and responsibility that they themselves do not possess.

The Contributions and Influence of E. G. Williamson

While Rogers writes from the framework of a therapist who is concerned primarily with the counseling process, Williamson writes from the position of a teacher and university personnel administrator who is more interested in the product or outcome of counseling. His philosophical explanation of the nature of man would appear to be most closely identified with Culturalism (i.e., an explanation of man's behavior in terms of his social role). Several quotes from Williamson's writings seem to best illustrate his interest in man as a social being and the importance which Williamson placed upon a rational adjustment to the world of work and to society.

* * * Today personnel workers turn away from such an emphasis upon growth for growth's sake of each individual, to the significance for the growth of each individual in the social context in which he grows * * * (p. 187).

The counselor * * * serves as a consultant in attempting to rehabilitate the student through understanding the why of his behavior and through the development of desirable modes of behavior. The counselor seeks to cultivate the student's desire to conform to group life without destroying desirable traits of individuality (p. 235).

In counseling, he (the client) is turning upon himself his own intelligence or rationality in trying to use certain canons of logic and certain psychological insights so that he approximates, but seldom fully achieves, rationality in controlling his own life (p. 522).

Other things being favorable, an individual faces the best probabilities of achieving both personal happiness and occupational success if and when he is engaged in activities and in work which require the kinds and amounts of aptitude, interest, and personality structures that he possesses (p. 184).

This approach to counseling is based on the concept

that people's problems are often developmental in nature and are the result of conflicts with their external environment. Therefore, the client must learn how to use reality oriented problem solving techniques effectively. Williamson states:

* * * a most essential and distinctive feature of counseling is its problem-solving dimension with respect to objective difficulties in the external world and also with regard to associated, subjective, affect disturbances. In our culture, man not only is trying to "feel good" but he also seeks to become and to maintain himself as a rational problem-solving being (p. 521).

The two basic assumptions behind such an approach to counseling appear to be: (1) That man is a rational being who is called upon to make many and varied decisions in order to adapt to a society that has a strong influence upon him. That these decisions often call for knowledge and experience which he is capable of acquiring, but has not had the opportunity to acquire up to this point in his life, (2) that as a result the client needs to make use of the knowledge, experience, and technical information that a trained, skilled counselor can provide in order to make and test decisions that will permit him to obtain optimal growth and happiness as a member of society. In discussing the goals of counseling, Williamson (1958) states:

* * * the end goal or objective of counseling is the optimum development of the individual student within the limits of his potentialities * * * The role of the counselor is clear—to teach or help the individual: To learn to understand and accept himself in terms of his capabilities and techniques of living; to appraise them in terms of their implications or consequences, and when appropriate, to substitute more adequate behavior to achieve desired life satisfactions that the individual has set as his personal goal (p. 522).

According to Williamson (1962) man has potentiality for either good or evil and the purpose of counseling is to assist in actualizing the "good" potential of man, particularly in the case of the client who lacks the environmental experiences necessary to foster his "good" drives and impulses. In this respect, good is interpreted in the light of man's relationship and responsibility to society. As Williamson (1950) states, "the nature of man and of counseling are affected by societal obligations." He continues:

* * * in Western culture, man is normally, and at his best development, a social animal and not a social isolate * * * the content of counseling is effected by the societal objective of the maximum utilization and conservation of human resources (p. 188).

Williamson (1939) lists six *steps* in the counseling process: (1) Analysis—collecting data from any sources, (2) synthesis—collating and summarizing of

data, (3) diagnosis—identification of problems, (4) prognosis—judging probable consequence of problems and indicating alternate actions, (5) counseling—cooperative advisement, and (6) followup—assisting with new problems. Emphasis is placed on step three, diagnosis, and thus requires that the counselor be knowledgeable in psychological testing and interviewing techniques.

The counseling relationship is characterized by Williamson as an understanding, acceptive, and secure environment in which the client may receive an objective personal evaluation free from personal and/or class bias.

To be effective in this type of counseling, the counselor must be well trained in counseling techniques, have adequate diagnostic skills, and possess mature judgment. He needs to have objective knowledge of the prediction power of tests and of current occupational information and he must be able to integrate the two so that knowledge can be transferred to the client. The "six-step procedure" would indicate that he should prefer an orderly and rational approach to life's problems himself. Finally, the Williamsonian counselor must not be overly therapeutically ambitious and must be able to accept the fact that he will be of limited use to those clients whose problems are primarily long-term emotional reactions which are best solved by therapeutic help.

In terms of techniques, Williamson indicates that the counseling relationship is primarily a learning situation. That is, its goal is to help the individual to know more about himself and his environment in order that he may attain optimum development. The following quote from Williamson (1950) emphasizes this point in more detail.

* * * counseling is one of the personalized and individualized processes designed to aid the individual to learn school subject matter, citizenship traits, social and personal values and habits, and all other habits, skills, attitudes, and beliefs which go to make up a normally adjusted human being (p. 189).

The counseling techniques generally associated with this school include: (1) Asking factual questions which will develop the problem further, (2) supplying the client with information about himself and his environment, (3) giving suggestions and advice concerning decisions, and (4) proposing alternative courses of action. The use of these techniques does not replace the use of reflective, clarifying, or acceptance responses when they are appropriate. However, the counselor is primarily interested in a reality oriented approach

and makes use of techniques which will tend to produce this type response in his clients.

This type of counseling appears to work best with individuals faced with a choice situation where they need information, understanding, emotional support, and acceptance in order to make the correct decision.

A major *advantage* of this method is that it usually requires a limited number of interviews and therefore is more realistic in terms of the amount of time actually available in most schools and agencies. The active role of the counselor allows the client to benefit from the judgment and experience of a mature, trained, and experienced person that he can use as a "sounding board" for his thinking. This is the type of counseling help most people expect or anticipate when they enter a counseling relationship (McGowan, 1954), and the process can usually proceed with a minimum amount of structuring.

The *disadvantages* of this technique are mostly in relation to the adverse consequences that may occur as the result of poor counselor judgment. For example: A counselee may present a relatively simple choice problem as an entree to discuss a more deep-rooted emotional conflict, or his apparent choice problem may be the symptom of underlying emotional stress. If a counselor does not recognize this responsibility and responds only to the surface problem, then the counselee may continue to have adjustment difficulties and feel that he has encountered another person who does not understand him, and therefore be reluctant to reenter again into a counseling relationship. Counselor judgment is also important in the use of tests. Failure to understand the limitations of a test, or failure to know what trait is actually being measured by a test can result in a faulty diagnosis from which future plans are then formulated and often implemented.

The Contributions and Influence of F. C. Thorne

Frederick C. Thorne is trained in both medicine and psychology. He has a Ph. D. degree in psychology from Columbia University, and an M.D. degree from Cornell. His writings and his approach to counseling clearly reflect the influence of this training and have resulted in what is referred to as an "eclectic" approach to counseling.

The position calls for a scientific study of *all* methods of diagnosis and treatment, and as Thorne expresses it:

To the degree which eclecticism is able to integrate all operational methods and find ways available at time and

place, it appears to us that it must represent the last word concerning what we can validly understand and apply in practice (p. 240).

Thorne holds to a scientific approach and perceives the counselor as a social scientist who has a professional dedication to observe and follow strict scientific procedures in the diagnosis and treatment of problems of human behavior. He feels it is impossible for a counselor to provide the correct form of counseling service (treatment) without first identifying what it is the client needs (diagnosis). Again as Thorne expresses it:

The eclectic approach to scientific case handling basically depends upon adequate diagnosis as the cornerstone of all case handling in order to identify etiologic causes and apply appropriate therapeutic methods according to their indications and contraindications (p. 239).

Our opinion is that advances in psychotherapy must depend on more valid diagnosis, and to this end we have evolved a systematic method for evaluating all factors known to organize personality integration (p. 234).

The ethical justification for making a clinical judgment which does not have complete scientific support and validation is that it only professes to be the best that can be offered at time and place (p. 20).

Thorne's theory attempts to explain man in terms of science and therefore would be most closely identified with a Naturalistic philosophical approach. It seems to proceed from two assumptions: (1) That people differ in their capacity to cope with life and its problems and therefore need different types of assistance. That some people seek counseling for emotional support or reconstruction, while others are looking solely for information. Therefore, each problem should be approached from the counselee's frame of reference, and the counselor should not impose (or project) his own philosophical or theoretical assumptions to the counselee. That as social scientists, counselors have a professional obligation to meet the needs for each particular client as expressed and perceived by the client, (2) that an adequate diagnosis is *essential* to any science which proposes to properly identify causes and then to select and administer appropriate methods of treatment. This "scientific" approach uses case histories, physical and psychometric tests, and clinical interviews for the identification of problems.

The counseling relationship established is characterized by warmth, understanding, and acceptance. In addition, emphasis is placed on reassurance and information-giving in order to promote client learning. For a counselor to operate effectively from an "eclectic" framework, he should hold to a scientific view of man, possess broad diagnostic skills, and enjoy a flexibility of style and technique. To meet these requirements, he

needs to have an extensive knowledge of the literature and technical tools of his field and to be well trained in both emotional and rational approaches to counseling.

The advantages of eclectic counseling include: (1) It uses the best aspects of other approaches, and applies them "scientifically"; i.e., a thorough diagnosis which is followed by the prescribed treatment, (2) it allows the counselor to work with a more diverse clientele, and (3) it makes use of all available data from all systems and all published research.

While Thorne's theories may appear to be the ideal approach to counseling, the eclectic approach has inherent limitations and disadvantages. Some of these are: (1) It is not realistic in terms of most counselors' ability to master several counseling styles. Counselors tend to develop a method suitable to their personality, and when they try to adapt to another technique they tend to become less effective (McGowan, 1956), (2) it is based on an assumption that diagnostic tests and techniques can precisely identify problems. Research related to the diagnostic tools available to counselors does not support this assumption (Patterson, 1962), and (3) it is not realistic to believe that many counselors can have all the academic training necessary to be proficient in this type of counseling.

APPLICATION OF THEORY IN REHABILITATION SETTINGS

Vocational rehabilitation counselors are called upon to work with many different kinds of people who present a wide range of problems. And, there is probably no other group of counselors in America that have as many resources available to assist their clientele as do rehabilitation counselors. It is the counselor's responsibility, and unique contribution to the rehabilitation process, to design a plan of services appropriate to his clients' needs.

Regardless of the emotional needs of some of his clients, the rehabilitation counselor is *not* primarily a psychotherapist, nor is he in a position (at least in the majority of offices) to offer any long-range therapeutic help to his clientele. He lacks the training, time, privacy, physical facilities, and administrative authority to provide therapeutic help. This does not mean that he cannot deal with problems of emotion, affect, and feeling. However, it does mean that he is limited in how far he can go in working with clients who present se-

vere emotional problems and that he has a moral and professional obligation not to imply that he can provide therapeutic help when he is not in position to do so.

Therefore, it would appear that the rehabilitation counselor should *not* communicate to his clients that he is primarily interested in the reconstruction of their psyche or the development of therapeutic insights, when his main concern is with their vocational adjustment; i.e., suitable job placement. This means that the counselor should not deliberately develop a therapeutic relationship that fosters dependency or transference, nor should he make exclusive use of such techniques as reflection, clarification, open-ended affect leads, etc., which tend to produce such a therapeutic relationship.

All of this implies of course, that the counselor accepts the fact that he controls, at least in part, the material that the client produces. As Bandura (1961) expresses it:

The results of these studies show that the therapist (counselor) not only controls the patient by rewarding him with interest and approval when the patient behaves in a fashion the therapist desires, but that he also controls through punishment, in the form of mild disapproval and withdrawal of interest, when the patient behaves in ways that are threatening to the therapist or run counter to his goals (p. 156).

This is not to imply that rehabilitation clients do not have problems of an emotional nature. It is difficult to imagine a much more anxiety-producing situation than that experienced by a disabled father who is out of work and unable to support his family. It would be impossible to counsel with such a person without experiencing and responding to the anxiety and despair that he may feel. Nevertheless, the rehabilitation counselor is primarily responsible for successful job placement and must of necessity limit how far he and the client can proceed in exploring the psychological effects of disability and unemployment upon the client as a person.

As a result it seems that the counselor must attempt to develop a theoretical framework, and then implement it with techniques which are aimed at helping his client make the best possible vocational adjustment. This would seem to suggest that counseling techniques which are reality and product oriented, and which aid the individual to learn more about himself, his interest, his abilities, and the relationship of these traits in the world of work, would be most appropriate for the rehabilitation counselor to use. Suggested techniques are described in section 15.

In actual practice this is a search for the most adequate means of establishing a helping relationship and,

for the professionally oriented counselor, it is a search that never ends. McGowan and Schmidt (1962) state:

In a sense, then, each person perceives and reacts to problems in counseling in relation to his own personal experience, self-awareness, knowledge, level of training, and general research sophistication and, in his own way, theorizes about counseling and develops an approach to it which is consistent

with this. It seems, therefore, that in considering theoretical and personal frames of reference from which to understand the counseling process, it is necessary to keep in mind that such individual differences will be reflected in the person's orientation and that this orientation will affect each person's responses. It is helpful to remember that an individual's most objective view of the process will, at least in part, be a product of his own beliefs, knowledge, and experience (p. 160).

Section 15

REHABILITATION COUNSELING: PROBLEMS AND TECHNIQUES

A GREAT deal of confusion seems to exist whenever rehabilitation counselors, agency administrators, college professors, etc., try to communicate with each other about counseling. The confusion comes about in part as a result of the many different meanings that are assigned to the word. At the present time it would appear that this difficulty will continue since the word counseling is widely used by both professional and nonprofessional groups and is assigned different meanings by each group. Some people within the area of rehabilitation consider that nearly all the counselor's activity with a client involves "counseling," while others feel that the counselor provides a multitude of services, one of which is "counseling." Therefore, it seems logical to try and define what we mean by the term vocational rehabilitation counseling before attempting to discuss it in any detail.

Some previous Guidance Training and Placement Workshops sponsored by the Vocational Rehabilitation Administration have defined vocational rehabilitation counseling as:

A process in which the counselor thinks and works in a face to face relationship with a disabled person in order to help him understand both his problems and potentialities, and to carry through a program of adjustment and self-improvement to the end that he will make the best obtainable vocational, personal, and social adjustment (Thomson and Barrett, 1959, p. 51).

Porter (1964), offers the following definition:

Rehabilitation counseling is a learning oriented contact where the primary activity is discussion with a disabled person in a face to face relationship where it is the counselor's intent to help the client: (1) Understand both his problems and potentialities; (2) mobilize his assets; and (3) carry through a plan of adjustment and self-improvement appropriate to the client's needs—all within the context of the vocational rehabilitation process. The goal being for the client to make the best obtainable vocational, personal, and social adjustment by learning solutions to immediate problems and new techniques for meeting future problems.

Peterson (1963), used the following definition in his study:

Counseling is a learning-oriented, purposeful, process, carried on by means of one-to-one conversation, in which a competent professional person (counselor) seeks to assist the client to learn more about himself and to accept himself; to learn how to put such understanding into effect in relation to more clearly perceived, realistically defined goals so that the client may then react in terms of present realities and demands and be a happier and more productive member of his society.

McGowan (1963) offers the following ideas on rehabilitation counseling and vocational rehabilitation counselor's unique role:

For me, personally, the vocational rehabilitation counselor's unique contribution to handicapped clients consists of his intrinsic interest, special training, and supervised experience, which have prepared him to combine medical data from the physician, psychological data from the psychologist, psychosocial-vocational data based on his own special training in testing and counseling, and information about the world of work obtained from the employment service and other sources, and to transmit these combined data through the counseling process to the client in such a way that together they are able to arrive at a vocational plan which is acceptable to both the client and the counselor, and which promises the client the best possible chance of achieving job satisfaction and vocational success.

The provision of *counseling* as a rehabilitation service is actually specified in the "Regulations Governing the Vocational Rehabilitation Program" (1966). The Regulations state that:

The State plan shall set forth the standards and policies established for the counseling of handicapped individuals which will assure: (a) Adequate counseling services to the individual in connection with his vocational potentialities and the health, personal, and social problems related to his vocational adjustment; and (b) necessary assistance to him in developing an understanding of his capacities and limitations, in selecting a suitable occupational goal, and in using appropriately the medical services, training, and other rehabilitation services needed to achieve the best possible vocational adjustment (sec. 401.28).

A detailed review of opinions regarding the rehabilitation counselor's role and of the significance of counseling in the rehabilitation process is presented in part

IV of this manual. This section will be concerned primarily with the *provision of counseling as a rehabilitation service*.

VOCATIONAL ADJUSTMENT: THE GOAL OF REHABILITATION COUNSELING

Congressional intent since the passage of the first act in 1920 has been to promote the *vocational* rehabilitation of disabled persons. The Vocational Rehabilitation Act as amended in 1965 (Public Law 89-333) states that it is "for the purpose of assisting States in rehabilitating handicapped individuals so that they may prepare for and engage in gainful employment to the extent of their capabilities, thereby increasing not only their social and economic well-being but also the productive capacity of the Nation" (sec. 1(a)). According to the regulations governing the vocational rehabilitation program, it is the *vocational* adjustment of the disabled individual that is the goal of rehabilitation counseling. McGowan (1960, p. 42) has previously stated that the primary concern of vocational rehabilitation counseling is the realistic and permanent *vocational* adjustment of the handicapped individual. And, that it is this objective which differentiates rehabilitation counseling from all other types of counseling. In Lofquist's (1959) operational definition of rehabilitation counseling, he makes this point explicit. He clearly indicates that, while the work of the rehabilitation counselor may involve many different types of problems, he is primarily concerned with vocational planning and problems.

This emphasis on vocational problems does not eliminate the rehabilitation counselor's interest in the personal and social aspects of his client's adjustment. He is responsible for:

(a) Adequate counseling services to the individual in connection with his vocational potentialities and the health, personal, and social problems related to his vocational adjustment; and (b) necessary assistance to him in developing an understanding of his capacities and limitations, in selecting a suitable occupational goal, and in using appropriately the medical services needed to achieve the best possible vocational adjustment (Regulations, 1966, sec. 401.28).

In this manner, the current regulations make it clear that the rehabilitation counselor is concerned with his client's personal and social problems, but only insofar as they affect his vocational adjustment.

In some cases the counselor, by means of counseling

techniques, assists the client to modify basic attitudes that have resulted in social maladjustment. However, this is not the essential duty of the rehabilitation counselor, and he should be careful not to engage in counseling activities of a therapeutic nature which are beyond his training and competencies.

Peterson (1964), in a study of "Counseling in the Rehabilitation Process," utilized a diagnostic category system that included vocational, emotional, or educational problems. From a random sample of 213 rehabilitation clients he found that 91.50 percent of them presented problems of a vocational nature; 8.50 percent had an emotional problem, and none were diagnosed as having an educational problem. He further found that "lack of physical corrective measures" was the causative factor in the problems of over half (54 percent) of the cases. Three other causative factors, "lack of information about self," "lack of skill," and "conflict with rehabilitation goals" were cited for an additional 27.5 percent of the cases. The remaining cases had problems caused by "lack of information about environment," "conflict with others," "lack of financial resources," "lack of opportunity in the environment," or "conflict with self."

From these data it appears that vocational problems are the type of problems that rehabilitation clients most frequently present to their counselors. Porter (1964) found that the vocational problems that come to the attention of rehabilitation counselors are divided fairly equally among problems of vocational choice, vocational change, or vocational adjustment difficulties.

From an analysis of the regulations governing the vocational rehabilitation program, the opinion of authorities in the field of rehabilitation, and the available research, it may be concluded that *vocational* counseling should be the rehabilitation counselor's primary counseling specialty.

PROBLEMS ENCOUNTERED IN VOCATIONAL REHABILITATION COUNSELING

There seem to be some situational, environmental, personal, and personality factors related to the job of the vocational rehabilitation counselor and his clientele that present unusual problems which require research solutions to point the way for the development of more effective counseling techniques. The problems seem to be related to three areas: (i) Special environmental

and situational problems; (2) problems due to the nature of the clientele and the size of the counselor's caseload; and (3) problems due to personal variables related to the counselor himself. A brief discussion of each of these points follows:

Problems Due to Environmental and Situational Factors

The following factors in these areas seem to present unusual problems to the rehabilitation counselor.

- (1) The amount of *time* that he has available for any one client is often related to the size of the counselor's caseload, and to administrative requirements regarding an acceptable number of closed cases for any given period.
- (2) The amount of *travel* involved in some localities imposes a restriction on both how often a counselor can see a client and how much attention he can give him at any one time. Also involved is the matter of finding adequate facilities for counseling out in the field. There seems to be little question that minimally adequate facilities for counseling are generally available, but often times these are inadequate in terms of the privacy required for some of the material that the client needs to discuss.
- (3) Devotion of counselor time and energy to *administrative duties* and arranging for other services also limits the amount of counseling a counselor can realistically be expected to provide. These duties fall into two major areas: Those related to arranging for services; and those related to records and agency forms. While admitting that both duties are essential to the rehabilitation counselor's job, the fact remains that they can often make serious demands on the amount of time that he has available for counseling service.

Problems Due to the Nature of the Case Load

Within this area, the following variables seem to present some unusual problems to the vocational rehabilitation counselor:

- (1) The number of cases referred with problems of a *serious nature*; i.e., multiple disability, long-term psychiatric hospital commitment, etc. This type of case often takes a great deal of time and

money to rehabilitate. As indicated in section 20 of this manual dealing with caseload management, a counselor is limited in the number of such cases that he can carry at any one given time, particularly if both intensive counseling and coordination of services are required.

- (2) The number of cases referred exhibiting *passive-dependent personality traits*. A study by Wilcox (1958) indicates that passive-dependency as a personality trait is much more prevalent among vocational rehabilitation clients than among the general population. This is understandable in the light of the feeling of many writers that dependency is one of the major readjustment problems we face in rehabilitation. Wilcox's study further indicates that passive-dependency is much more prevalent among referrals from welfare agencies than among referrals from other sources. His data would suggest that up to 25 percent of the clients accepted for services who were referred from welfare agencies exhibit passive-dependency traits to such an extent that these traits would seriously interfere with their ability to participate actively in a rehabilitation plan. In terms of self-concept this type client would appear to perceive of himself as being unable to compete in what he feels is a basically hostile and overpowering society. He needs some reason to justify his failure to work and provide for his family, and turns to illness for this justification. However, as he accepts illness and the security and justification it provides, he often has to give up his individual rights to self-assertion and any open expression of hostility against people in authority. As a result he develops passive methods of manipulating those who seek to motivate or change him. Working with cases of this nature, particularly if the counselor is naive as to the real dynamics of the client's behavior, can be discouraging and often result in feelings of disillusionment on the part of the counselor.
- (3) The number of cases who have *withdrawn both physically and psychologically* and who fail to respond to ordinary motivational techniques is often high. It would appear that rehabilitation counseling services need to be offered as close as possible to the onset of disability, in order to be most effective. Many times referrals are delayed, and by the time the counselor makes contact with the client he has already responded to many secondary gains

and begun to withdraw from the world of work. This is particularly true of referrals from mental hospitals. In some cases it means that each day a client remains in the hospital beyond a certain point lessens his chances for rehabilitation. Yet surprisingly enough, a study by Gwaltney (1959) indicated that even the regressed, or so-called "backward" patient, still retains an ideal self-concept of himself as a working, contributing individual. This suggests that their rehabilitation potential might be greater than we are now realizing.

Problems Due to Personal Variables Within the Counselor Himself

- (1) Many of the problems that a rehabilitation counselor encounters in working with clients are serious in nature and challenge the professional skills of all the professions. If a counselor has not received adequate training before attempting to help such individuals and cannot understand the dynamics of their problems, he can often become discouraged and even depressed over the hopelessness of some of the problems that are presented. Counselors need help and constant supervision in this area in order to maintain good mental hygiene on their own part. They need to develop the capacity to help their clients without becoming overidentified personally with their clients' problems.
- (2) In some instances, a relatively low salary schedule may not only prevent a rehabilitation agency from hiring the best qualified counselors but may also be a source of discouragement and poor morale especially when a counselor feels he is not making enough money to adequately support his family. Poor salaries affect both selection and retention of counselors.
- (3) In some areas travel demands are great, and many highly professional counselors may prefer to work for another agency that does not require such extensive traveling, thus allowing more time for counseling and related service activities.
- (4) Rehabilitation has occasionally presented a rather questionable public image in the past and is only now beginning to come into its own as a professional area of work. This trend has been aided both by the training funds that were made available from Public Law 83-565 and

89-333 and the resulting establishment of rehabilitation counselor training programs in universities which already had national reputations and stature in the general area of counselor training. Fortunately, many people who have not previously been interested in rehabilitation counseling as a field of work are now beginning to see it as a field that offers a real professional future and unlimited opportunities to help other people.

COUNSELING TECHNIQUES

Within the past several years well-known authorities in the field of rehabilitation counseling such as Patterson (1958, 1959), Lofquist (1957), Hamilton (1950), Wright (1960), Jacobs, et al. (1961), Rusalem (1962), Muthard (1961), Allan (1958), Kessler (1955), and Soden (1949), have published books on the topic of rehabilitation and rehabilitation counseling. These books provide basic material on counseling within the rehabilitation process. There has also been a series of excellent books in the general area of counseling and counseling techniques by Patterson (1959), Tyler (1961), Brammer and Shostrom (1962), and McGowan (1962). No attempt will be made in this section to review the basic material covered in these fundamental texts and complete references are provided in the Suggested Readings at the end of this part of the manual. The matter of *exactly* what technique or techniques to use in attempting to motivate and counsel a handicapped individual remains relatively unanswered. Nevertheless, we have no reason to assume that basic techniques of counseling that apply to the nonhandicapped would not work equally well with the handicapped. On the other hand, there is no question but that the very nature of a person's disability often limits the type of adjustive techniques that he can use, thus presenting unusual problems for the counselor.

Counseling Suggestions

The next two units of this section of the manual contain suggestions on how to counsel and how to use tests correctly during the counseling process. Admittedly, a how-to-do-it approach to counseling is a dangerous one; nevertheless, the writers are offering some suggestions on the basis of their personal experience derived from supervising counseling practicum. They

again repeat that basic information on the counseling process can be found in the texts mentioned above and in additional books referred to in the Suggested Readings at the end of this part of the manual.

The authors, themselves, believe in a client-need oriented approach to counseling in which the counselor allows the client freedom to grow and develop at his own pace, according to a method of his own choosing. They also believe the counselor needs to be a person first, and a competent technician second.

The content of these two units was modified by the authors from material developed by McGowan (and staff) in the Testing and Counseling Service at the University of Missouri, and by the Counseling and Guidance Staff at Michigan State University.

In a previous article McGowan (1956) stated:

Most people interested in becoming counselors have a background of successful experience in dealing with people. It is often the pleasure that they have experienced in their relationships with people that leads them into counseling where they will work with clients in an even closer relationship. Yet, it seems that many new counselors become so worried about making the correct response to a client in terms of a specific technique that they often lose all the spontaneity and flexibility that has helped them previously in establishing satisfactory interpersonal relationships. In an attempt to counteract this the writer always suggests that beginning counselors "be themselves." The main idea of such an approach is to try to emphasize that counseling style in terms of a specific response may be overemphasized. By attempting to use a response that does not fit in with their own natural response set, counselors may be hindering their own capacity for establishing the close personal relationship for successful counseling. A review of studies dealing with counselor responses and the counseling process would seem to support such an approach (p. 246).

Suggestions for the Initial Interview

- (1) *Be yourself*—do not attempt to play a role or to change your natural style of verbal response to fit any particular counseling technique—rather, adopt a counseling technique to your own personality traits and familiar verbal delivery pattern. If you really want to help him, the client will know it, and this is one of the basic ideas or feelings that you need to communicate. If you are truly able to convey to the person you are working with the impression that you are sincerely interested in him and want to assist him, you can make many technical counseling errors and still have a "good" relationship.
- (2) Don't *tell* the client what counseling is, let him

experience the relationship. Counseling represents a learning experience and he will learn from what *you do* as well as from what you say. In many cases when you attempt definite structuring, particularly later on in the interview, you are telling the client that things are not going the way you want them to and are actually instructing him on how he should act.

- (3) *Relax* and try to *go slow*. Give the client time to interact and to accept his share of the responsibility. Nearly all beginning counselors and many experienced ones, move the interview too fast and as a result work far too hard themselves.
- (4) Learn to *listen* and *observe*—try to forget about yourself and concentrate exclusively on the client—watch his behavior, it will tell you about his reactions to data that he is discussing as well as his reactions to what you are saying—learn to react to minimal behavioral cues.
- (5) Learn to tolerate and feel at ease during reasonable periods of *productive silence*. Techniques of acceptance, reflection, and silences often result in further development of the problem at a more significant level, and the development of understanding and insight on the part of the client. It also helps you to get a reasonable share of the responsibility placed over on the client and gives him time to think and integrate the things that are going on within the interview.
- (6) Don't *push* to complete the paperwork. Help the client feel free to make observations or comments on his past. Too often counselors allow completion of the survey interview form to become a goal in itself. The result can be that their clients will perceive them as being a disinterested administrative agent. Thus, later attempts to form a counseling relationship are hindered by the client's initial perception of the counselor. If all the forms are not completed in the first interview, you can always do them at a later date. *The rehabilitation program was not designed to cope with emergencies; its goal is to assist disabled individuals to attain the best possible vocational adjustment, not the most expedient.*

A few examples of appropriate and inappropriate initial interview responses are presented below. Please note *what* is being said, *now how* it is worded. Readers may want to try to put the appropriate responses in their own words to see how they would convey the same thought in different situations:

- (1) Get acquainted by listening—don't probe or press for important decisions.
TRY: "I'd like to get acquainted so I can help you with your problem."
NOT: "We'll arrange for a physical examination then give you some tests to see what you can do."
- (2) Help the client improve his own planning—don't mastermind the case.
TRY: "What would you like to know about yourself, that you don't know now?"
NOT: "What courses did you take in school? What kind of grades did you get?"
- (3) Make your contacts a safe place to explore some ideas—not a cross-examination.
TRY: "What do you want to be doing in 10 years?" or "What do you think of the idea now?"
NOT: "Do you really think it was best to have quit that job. You've got to eat you know."
- (4) Avoid cliches in preliminary small talk—concentrate on the client.
TRY: "Well, Mr. Jones, what would you like to talk about today?"
NOT: "How are you today?" or "This is a nice day, isn't it?"
- (5) Develop any potentially good topic that comes up—even if it wasn't your idea.
TRY: "This (hobby) sounds mighty important to you. How did it all start?"
NOT: "OK, now getting back to your work history—."
- (6) Show enthusiasm about the client's successes—don't just acknowledge them.
TRY: "Sounds exciting! You must be pretty good at _____. Tell me about it."
NOT: "OK. What else have you been doing?"
- (7) Find out what the client expects—don't just tell "what we can do."
TRY: "What would you like to accomplish with us?"
NOT: "If you are eligible, we can provide medical treatment, training, maintenance, etc."
- (8) Respond to the client's feelings—not just to the facts being presented.
TRY: "Sounds like you didn't care much about school."
NOT: "Was this a big school? What courses did you fail?"
- (9) Let the client answer his own questions—don't put your words in his mouth.
TRY: "How do you suppose you would go about it?"
NOT: "Don't you think it would be a good idea just to tell them to leave you alone?"
- (10) Ask one question at a time—don't add questions or amendments.
TRY: "How do you suppose your friends would describe you?"
NOT: "What kind of a person are you? Are you a good worker? Do people like you?"
- (11) Allow the client time to think—don't talk just to prevent silence.
TRY: (client pause) "It's all right to think about it awhile."

- NOT:** "Maybe it doesn't matter anyway" (new question).
- (12) Have the client take tests because he wants to—not to please the counselor.
TRY: "So you'd like to verify some of your ideas with tests. Fine."
NOT: "We have some tests here that you will have to take first."
 - (13) Don't try to impress the client with your competency in medical matters—let him tell how he feels about his disability.
TRY: "This must cause you to worry quite a bit."
NOT: "I see, it sounds like you have Angina Pectoris." or "Just where does it hurt most?"

Suggestions for Test Use and Interpretation

- (1) Develop short, clear, concise methods of *describing* to the client the purpose of the test he has taken and the meanings of the results—get this out of the way before you go into the interpretation of his actual test scores—then, you can concentrate on his *reactions* to the test scores rather than to run the risk of being trapped into a technical discussion of the purpose of the test, its construction, etc., during the interpretation period.
- (2) Make test data meaningful in terms of the *client's behavior*—make the transfer from the test score to the client's behavior. Ask yourself the following questions: "What does the score mean in terms of client behavior?" and, "How can I express the scores to him in such a way that he can relate them to past, present, and anticipated behavior?"
- (3) Do not become *overidentified* with the client's test scores. The test scores are his, not yours. Present test material in such a way that he can question it, discuss it, reject it, or accept it, without having to reject or accept you by doing so.
- (4) Know how you *perform yourself* on objective tests and try to work out, as best you can, a reasonable acceptance of your own test scores. Generally this will mean you are able to work with test scores and to interpret them objectively to clients. If you think test scores are either very good or no good, you will be communicating this in many ways to the clients that you are working with. Avoid projecting too many of your own subjective feelings into the objective tests that you are using.

Listed below are several suggestions in regard to test interpretation:

- (1) Have confidence in the client's problem-solving ability—even if he has shown little.
TRY: "You are the world's No. 1 expert on yourself. How can you tackle the problem?"
NOT: "Maybe later your doctor, employer, and I can help you decide."
- (2) Remind girls of both career and homemaking plans—not just one or the other.
TRY: "Do you plan to work marriage and family into your future plans?"
NOT: "Your future seems all set then with college and a career in journalism."
- (3) Make alternate plans sound respectable—not like impending failure.
TRY: "If that doesn't happen to work out, what else could you try?"
NOT: "Everything seems to point to bookkeeping as your most likely career."
- (4) Open new educational and vocational doors—don't just close them to the client.
TRY: "There are 20,000 good jobs besides drafting, many of which you might qualify for."
NOT: "You won't be able to get into drafting with your eyes."
- (5) Relate test data to other experiences—don't discuss them as abstractions.
TRY: "How does this fit in with your interests as you know them?"
NOT: "That's the way your interests look. Any questions?"
- (6) Reflect a client's rejection of low-test scores—don't write off low performance.
TRY: "You don't think this is your real ability? What other clues do you have?"
NOT: "Tests aren't foolproof. There might have been a slip-up."
- (7) Get clients involved in test interpretation—don't just recite the results.
TRY: "What did you think of that test? How do you suppose you did?"
NOT: "On this test you are at the 45th percentile. On this one, the 23d percentile."
- (8) Explain the purpose of the test in functional terms, not in psychological jargon.
TRY: "This test allows you to compare yourself with people like yourself in numerical ability."
NOT: "This DAT test, like the ACE, measures numerical perception."
- (9) Distinguish carefully between interest and aptitude—don't use the terms loosely.
TRY: "Now, this is interest (what you like)—not aptitude (what you can do)."
NOT: "This test shows where your interests and aptitudes lie."
- (10) Use test results in content with all other data—not as goals in themselves.
TRY: "Add this test information to everything else you know about yourself."
NOT: "According to these tests you should be in mechanical work."
- (11) Use test results for client planning—not for the counselor's diagnosis.
TRY: "This allows you to compare yourself with others in ability to learn."
NOT: "This confirms my hunch that you would be able to succeed in business college."
- (12) Refresh the client's memory on each test before discussing it—don't discuss it cold.
TRY: "Remember this test on which you chose which things you liked best and least?"
NOT: "On the Kuder you were high on persuasive and mechanical, low on artistic."
- (13) Let tests add to the client's picture of himself—not be a mysterious magic formula.
TRY: "Add this test information to everything else you know about yourself."
NOT: "According to these tests you should go to college and study law or journalism."
- (14) Explain test results simply—don't use elaborate statistical devices.
TRY: "This is high, this low, this average for seniors; here is about how you stand."
NOT: "You fall within these fiducial limits. If you flip a coin 100 times, etc."
- (15) Express low-test performance or unpleasant information honestly—but with perspective.
TRY: "You are within the range of successful college students, but well below average."
NOT: "Only 20 percent of college students have less scholastic ability than you."
- (16) Remember expressed and demonstrated interests—not just interest inventory results.
TRY: "This inventory gives you another kind of picture of your interests."
NOT: "This inventory will show where your interests lie."
- (17) Have the client summarize often—don't deprive him of the chance to review and organize.
TRY: "How would you summarize your interests as you see them right now?"
NOT: "Your interests are highest in this, lowest in that area. Any questions?"
- (18) Have the client summarize the whole interview—don't do it for him.
TRY: "How would you summarize the results of our discussion today?"
NOT: "You will have to work harder to get the job you want."
- (19) End on a positive note—even though some of the interview has been unpleasant.
TRY: "You can enter many good jobs now."
NOT: "It looks like you won't be able to qualify for mechanics training."

Some General Counseling Suggestions

- (1) Do not try to "overunderstand" the client (particularly when you really don't). It is better to allow the client to develop his problem personally by verbalizing it to you. Remember that the insight you are working for should come

on the part of the client, not the counselor—and, that no matter how well you understand the problem, the thing you are working for is the client's understanding and acceptance of it.

- (2) You are trained to *recognize* and *respond* to minimal cues. Use and develop this skill. Feel free to play hunches and communicate them to clients, but in such a way that clients can modify or change them in their reaction. If you are aware of the fact that something is happening within the counseling interview, even though you are picking it up from the client's nonverbal behavior, feed this material back to the client in a nonthreatening, permissive, manner.
- (3) You are transmitting most of your own feelings and attitudes verbally and *nonverbally* in dealing with your clients. Get them out where the clients can deal with them and when it would help to clarify the relationship go ahead and express them. However, do so objectively, without strong emotional feelings, and identify them as your own. Remember, "reality is, for the individual, the world as he perceives it"—avoid projecting your own attitudes, ideals, values, etc., onto the client, without identifying them as your own.
- (4) *Keep out* of the client's way when he is moving well by himself. Do not interrupt him when he is dealing with significant material or when he is involved in discussing highly emotional material. Most of the things that you would say are inappropriate anyway. Merely indicate that you are accepting and understanding the material.
- (5) Let the needs of the client determine your course of action. Try to adjust to the client rather than having the client adjust to you. Agree on common goals, then work to reach them.
- (6) *Know yourself*—know your therapeutic ambition and attempt to develop a relationship with your clients which is a basically healthy one. Set up as your final criteria for a counseling case "a personal feeling of a professional job, well done."

Counseling and the Selection of Occupational Objectives

The rehabilitation counselor is dealing with prob-

lems of human behavior and, therefore, is essentially working with the fundamentals of psychology. Any single case may take the counselor into areas of physical condition, recent or chronic illness, family problems, community relations, etc. But, in essence, he is concerned with the intelligence, the aptitudes, the interests, and the personality of the individual with whom he works. These psychological aspects are the area of the counselor's unique contribution and he must ultimately fit them into a workable pattern and form an acceptable plan for the client if the counseling is to be successful.

Wilson (1950) wrote in his book "My Six Convicts" that "work is man's oldest therapy and one of the best." Certainly, placement of a client into meaningful activity provides an opportunity for a successful experience which could be the beginning point for the disabled person who is fearful, apprehensive, insecure, and doubtful of himself and society. Equally significant is followup which stabilizes, reassures, and strengthens an employer-employee relationship.

Arthur L. Voorhees (GTP workshop, 1954), Specialist in Rehabilitation of the Blind, Vocational Rehabilitation Administration, in discussing the importance of counseling and placement as substantial services, commented:

Sometimes when a client comes in and tells us what he wants to do, and it sounds all right to us, we merely provide what I look at as a sort of confirmatory type of counseling. We say, "Well, yes, that's fine. Yes, I think you can do that. That sounds pretty good, and we'll just refer you over to the employment service. Suppose you look in the classified advertisements of the telephone book." Or, "I know a friend down the street you might go see and talk to about a job." And, that is considered counseling! How often have you seen in the case records that we counseled the man into this kind of a job or we counseled the man into that kind of a job, meaning we directed him into it, we recommended him to it. Is that good sound counseling? On the other hand, it seems that substantial counseling should be directed toward creating within the client a high degree of self-understanding. In fact, in many instances, it may mean a complete change of his outlook toward his disability. Certainly, sound counseling is required to affect such a change. How many times do we find a person coming to the counselor's office with a preconceived job objective? He merely expects the counselor to agree with him and help him to find a job, whether or not it is suitable for him. "I want to be a radio repairman," "I want to be a watchmaker," or "I want to get a job down at the hotel as a dishwasher because I need some money right-a-way. Got to have it immediately." "I want this or that kind of job." You have all heard such expressions. Yet that person may not be fit for that particular job. He is not ready. His whole outlook towards his disability would mean failure the minute he went to work. His skills, his abilities, his aptitudes, do not add up to a potential of successful employment in that field (p. 9).

S. A. Fine (1960) in a discussion of the use of occupational information in rehabilitation counseling states that it can take the form of discovery or invention which he defines as:

By "Discovery" I mean engaging in a hunt or finding operation for a place or thing that is known to exist, using various techniques (maps, measuring instruments, etc.) in order to get there.

By "Invention" I mean defining the problem in terms of relevant parameters, hypothesizing alternative solutions, designing a particular final solution, testing it out, and getting enough feedback from the test to improve the solution and possibly throw light on the other alternative (p. 44).

Fine (1960) feels that these two approaches have different implications for the client-counselor relationship, and in regard to the counselor's attitude toward the counselee he states:

If your approach is one of discovery, then your attitude toward your client tends to be one of sympathy rather than empathy. He is less than normal and you must find out how much less in what respect, so that you can fit him to the less than normal job. You are performing an act of suzerainty and social welfare for the client—not really anything for yourself.

If your approach is one of invention, then your attitude toward the client tends to be one of empathy. The challenge is as much to you as it is to the client. Every effective placement is a mutually creative act. In fact, the approach of invention is the same toward every placement, rehabilitation, or otherwise. The less opportunity for invention there is in placement or on the job, the less vocational counseling really matters or is needed. Possibly the less suited the job is for a person at all. I have elsewhere elaborated on this point and cannot take the time to do it here (p. 46).

Also, Fine points out the following implications for the "Role of the Counselee":

Discovery places the counselee in a passive, nonparticipating role in the vocational guidance process. He is an object of analysis and study from which is to be derived a pattern or profile. The job similarly is regarded as a fixed entity accepting or rejecting the profile potential. Lost in the process is the infinite variety, drive, and possibility for change. Lost is the particular individual and his particular problem.

Invention keeps its focus on the individual and his problem, involving him every step of the way in developing a vocational plan. It uses objective information about him to help formulate opportunities in fields of work and to verify possibilities. Limiting factors in jobs are frequently merely obstacles to be overcome by redesign or reeducation both of counselee and employer. Here the counselee is an active participant in the counseling process (p. 46).

He ends his treatise on these two approaches to the use of occupational information by suggesting that rehabilitation counselors:

Learn occupational information from the dynamic functional standpoint I have described; integrate it into the counseling process just as personality theory is integrated; make in-

vention rather than a discovery your objective, and rehabilitation counselors will become scientific professionals rather than high-grade clerical technicians (p. 48).

Use of Occupational Information in the Counseling Process

Occupational information should be introduced when a client has reached a stage where he recognizes his own assets and abilities and their application to vocations.

Admittedly, some work experience, either on a part-time or summer basis, is valuable in providing a realistic understanding of jobs and self when it is coupled with occupational information. As a corollary, optimal vocational choices are made when work experience, occupational information, and expert counseling are teamed. This can lead to a more realistic occupational choice which quite frequently will lead to a lowering of aspirations.

In order to use occupational information effectively, the rehabilitation counselor should:

- (1) Have a functional knowledge of the major occupational classification systems.
- (2) Know the characteristics and contents of job descriptions and sources of job descriptions.
- (3) Understand the effect that technological and other changes have upon the worker, his work, and employment trends.
- (4) Know the sources of data in the area of vocational training.
- (5) Possess techniques for ascertaining local employment opportunities and utilization of all placement resources.

Callis, Poljanec, and Roeber (1955), coauthors of "A Casebook of Counseling," make the following observations regarding the use of occupational information in counseling:

The information per se is not as important as client reaction to various facets of the information obtained (p. 193).

Throughout the interview client and counselor examined many kinds of materials. Pertinent passages were read out loud and the client given a chance to react to them. This method of using information seems far superior to the "hand out" method whereby the client is given materials for reading with few further checks on the actual outcome of such reading. It seems to be a dangerous assumption that clients can assimilate all of the information and relate it to their own self-concepts. Furthermore, the personal interest of the counselor in such occupational and educational materials may provide the stimulus necessary to motivate the client. The counselor is striving to aid the client in an understanding of the role played by a worker in a given occupation. The

purpose of occupational information provides a splendid non-emotional stimulus for the client to examine his own drives, needs, and values (p. 197).

Throughout this interview there has been extensive use made of occupational and educational information materials. Many times the client asked a question, the counselor and client found the answer, and then the client reacted to that information * * *. This practice is the use of information in its best sense. There is no reason why occupational information, in a manner similar to test data, cannot also be made to provide the stimulus necessary for developing self-understanding (pp. 210-211).

A few sources of occupational and educational information are listed next and should provide the counselor with almost all the occupational information he will need.

A Few Sources of Published Occupational and Educational Information

(Specific information available, cost, date of latest publication, etc., should be obtained from the publisher)

I. General Information

- (1) "Census of Population," Superintendent of Documents, Washington, D.C. 20401. (Alphabetical Index of Occupations and Industries; Classified Index of Occupations and Industries.)
- (2) "Dictionary of Occupational Titles," Superintendent of Documents, Washington, D.C. 20401.
- (3) "Directory of National and International Labor Unions in the United States," Superintendent of Documents, Washington, D.C. 20401.
- (4) "Estimates of Worker Trait Requirements for 4,000 Jobs," U.S. Department of Labor, Superintendent of Documents, Washington, D.C. 20401.
- (5) FORRESTER, G., "Occupational Literature." An Annotated Bibliography, the H. W. Wilson Co., New York.
- (6) New York Life Insurance Co., 51 Madison Avenue, New York, N.Y. 10010. (Handout material and posters on a wide variety of occupations.)
- (7) "Occupational Outlook Handbook," Superintendent of Documents, Washington, D.C. 20401.
- (8) "Standard Industrial Classification Manual," Superintendent of Documents, Washington, D.C. 20401.

II. Periodicals

- (1) "Career Index," Chronical Guidance Publications, Inc., Moravia, N.Y.

- (2) "Guidance Index," Science Research Associates, Chicago, Ill.
- (3) "Occupational Index," Personnel Services, Inc., Peapack, N.J.
- (4) "Occupational Abstracts," Personnel Services, Inc., Peapack, N.J.
- (5) "Occupational Outlook Quarterly," Superintendent of Documents, Washington, D.C. 20401.
- (6) "Personnel and Guidance Journal," The American Personnel and Guidance Association (formerly Occupations). Washington, D.C.

III. Guidance services

- (1) Chronicle Guidance Service, Chronicle Guidance Publications, Inc., Moravia, N.Y. (Occupational briefs, reprints, posters, and filing plan).
- (2) "Bennett Occupations Filing Plan and Bibliography," Sterling Powers Publishing Co., Box 252, Terre Haute, Ind.
- (3) "Counselors' Information Service," published periodically by B'nai B'rith Vocational Service, Washington, D.C.
- (4) "Science Research Associates Career Information Kit," Science Research Associates, 57 West Grand Avenue, Chicago, Ill.

IV. Educational Information

- (1) "Accredited Institutions of Higher Education," Sept. 1, 1955, National Committee on Regional Accrediting Agencies of the United States, c/o C. Scott Porter, Amherst College, Amherst, Mass.
- (2) BOGUE, JESSE P. "American Junior Colleges," American Council on Education, Washington, D.C.
- (3) "Directory of Private Home Study Schools," National Home Study Council, Washington, D.C.
- (4) "Financing Your Way Through College," B'nai B'rith Vocational Service, Washington, D.C., 1952, 8 pp.
- (5) HURT, H. E., AND ABBOT, M. E. "College Blue Book," Yonkers, New York, Christian E. Burckel, 1956.
- (6) "Scholarships Available to Entering College Freshman," Chronicle Guidance Publications, Moravia, N.Y.
- (7) SHOSTECK, ROBERT. "The College Finder," Washington, D.C., B'nai B'rith Vocational Service Bureau, 1955.

Only a sample of the published occupational and educational information is represented in this appendix. The counselor will find many more sources with little effort. Information applicable to the specific geographical vicinity of the counselor is available from the State employment services, yellow pages of telephone directories, newspapers, etc.

Section 16

CASE RECORDING

IN THIS section the purposes and content of case recording will be discussed. The correct professional use of records as an aid to serving clients will also be considered. There will be no emphasis on specific methods of case recording as such, nor on the mechanics of case recording, since these recommendations are not intended to standardize case recording practices.

The section does contain material on the content of records, but does not attempt a detailed content description. Since each State has its own forms, it will be necessary to refer to the State in which a counselor is working for exact forms.

THE PURPOSE OF CASE RECORDING

The purposes and content of an agency's recording are determined in large measure by the objectives and practices of the agency itself. Therefore, the purposes of case recording in vocational rehabilitation may not be the same as those in other health, educational, or welfare agencies. According to the Vocational Rehabilitation Manual (ch. 24) the primary purpose of case recording is to:

* * * facilitate the counseling relationship by bringing into focus all the pertinent data about the client. This enables the counselor to understand his client, to counsel with him and help him plan his future adjustment, to help him secure necessary medical, educational, and other rehabilitation services and finally to help him find suitable employment (secs. 1-4).

In the professional literature, case recording is frequently categorized as meeting needs of the administrator, the supervisor, and the counselor, and many reasons are cited for keeping case records. Typical of these is that recording: Should serve as a diagnostic aid; should be a learning device for the counselor; should provide evidence of service; should be used in evalua-

tion (of the supervisor, counselor and/or the agency program); should facilitate supervision; should facilitate data collection; should aid in determination of the client's eligibility for service; should facilitate review of the legality and wisdom of administrative decisions; should provide teaching aids for beginning counselors; should facilitate research; and finally, should prevent duplication of previous interviews and make for continuity of service, etc.

Such diverse and heterogeneous purposes imply that case recording is good for everyone involved in the rehabilitation process. At least this broad spectrum of purposes makes it evident that everyone somehow has a stake in the case record. What is actually expected of the case record seemingly depends upon the agency's policies, and the position the person responsible for recordkeeping holds within the agency.

There are three general purposes of case recording applicable to almost all rehabilitation programs. They are:

1. *The Primary Purpose of Case Recordings Is to Facilitate the Client-Study Process by Bringing Into Focus all the Pertinent Data About the Client.*—This enables the counselor to understand his client; to help him plan his future adjustment; to help him secure necessary medical, educational, and other rehabilitation services; and, finally to help him find and adjust to suitable employment.

During early contact with the client the case recording should emphasize his history, his present adjustment and environmental situation, and the objective measures of, or reports on, his physical and mental capacities. This provides an informational basis for the counseling relationship and provides substantiation for planned programs of services.

Good case recording provides continuity with respect to all general information, evaluations, and services provided. For each interview or case contact the written record provides the point of departure for additional services. Also, when there is personnel turnover or

when more than one person participates in the development of the case, the case record enables each professional participant to coordinate his work with that of other professional workers.

Case recording can contribute to sound thinking by the counselor in two ways: (1) Since no case record will reproduce everything that is said or done in a case, the counselor is forced to be selective in what he records. He must sift out and select those items of information that he thinks have the greatest significance in evaluation of the client's present capacities and adjustment, and in predicting how and in what area his future adjustment can best be facilitated, (2) the writing of any diagnostic or evaluative summary calls for sound logical thinking. The counselor's writings record the meaning which he sees in the client's experience; the significance he places on the test results, examinations, or observed behavior of the client; or gives his justification of a proposed course of action.

2. *Improvement of Staff and Program.*—Case records are indispensable as a device by which the agency maintains and improves the quality of its operations, and tests the effectiveness of the services it provides. Good case records are essential for supervision; they can be an important source of teaching materials for the agency's inservice training program and they can provide information for making an evaluation of the program. They also contain data usable for research purposes.

3. *Administrative Purposes.*—Case recording is used in many ways to facilitate administration of the program. Program administrators must rely on case records to assure themselves that the acceptance of cases, the provision of counseling and planning services, and the purchase of services meet the criteria that are established by law and regulations. Case recording is often useful to correct an erroneous or unfair interpretation of the agency's performance. In general, good administration is promoted by well-kept case records.

RECOMMENDED GUIDES FOR A CASE RECORDING SYSTEM

An appropriate staff member of the State agency should be responsible for developing basic standards for case recording. The agency standards are usually issued in a case manual or other appropriate medium.

It is assumed that most agencies will use certain basic case study forms. Agencies will probably use the survey interview forms and the individual plan form in

all cases. However, no set of case study forms can adequately reflect the dynamics of the client-study process. Throughout each step in the process there must be some narrative recording to depict the sequence of the client's progress, to reveal the counselor's diagnostic interpretations and counseling goals, and to indicate the client's movement toward a suitable vocational adjustment.

The different purposes which case recording may serve have been discussed earlier in this section. Obviously, the style used in recording data about the client will be determined largely by its intended use. The Institute on Rehabilitation Services Committee on Case Recording (1963) reports *five common styles* or variations in form of recording. These common styles for recording are:

1. *Recording on Established Forms.*—E.g., face sheet; social history; work history; R-4; R-11, etc. Forms are useful when minimal amounts and types of information must be gathered uniformly in all cases. For uniform reporting and data processing, established or prescribed forms are essential.

2. *Summary Recording.*—This is usually a condensed account of transactions between client, counselor, and agency. This may be a summary of what happened in a given interview or over several interviews with particular notations as to important characteristics of the client or of the events that transpired during the interview(s). This may also be a periodic review of progress toward an objective agreed upon by the client, counselor, and agency. Summary recording works best when there is a clear-cut objective which is spelled out early in the case record. Summary accounts then described any movement or retrogression regarding the objective and any changes in the client's situation or the objective during the time interval which the summary covers.

3. *Process and/or Verbatim Recording.*—Process recording refers to a highly detailed record which covers the series of actions, motions, feelings, and events which transpire in the interview situation. Verbatim recording actually refers to the complete record or word by word transcription of the interview. This type of recording is primarily useful for purposes such as psychological evaluation, content analysis or thematic analysis or for training purposes to demonstrate methods and techniques in interviewing and counseling. The process record is familiar to all counselors who have at any time attempted to describe and analyze the feeling tones, attitudes, and behavior of himself and his client in an interview. Obviously, such recording is helpful when the focus is on the process

of counseling. Whenever the counselor has some question as to what is occurring in the counseling process or whenever he desires consultation regarding his interviewing methods and techniques, process recording can be a useful device.

4. *Recording for Research Purposes Using Research Schedule(s).*—Use of research schedule is akin to the use of forms. When the data to be gathered is known and the format in which it must be gathered is decided in advance, either a structured or semistructured recording format is appropriate. Parenthetically, it should be noted or perhaps should be emphasized that the Study Committee does not consider the case record as ordinarily recorded as serving the purposes of research. Almost all studies on closed case records or studies using case records recorded for counseling purposes and not for research purposes indicate that the records are inadequate to the purpose of research. Again, the committee reiterates its stand that the case record cannot meet all purposes for all people. The case record may be a useful device for evaluating the effectiveness of service, but can only be a useful device in this respect if it is decided beforehand what the format of the record should be, and if the case record is then uniformly recorded using such a format.

5. *Narrative Recording.*—The narrative form of recording is the standard form. Usually the narrative tells a story regarding the client, the counselor and the agency. It should therefore include factual data pertaining to the background of the problem which the client brings to the counselor and agency, what the client has done regarding his problem and what has motivated him to seek additional help at this time. The narrative also should describe the client in his total situation, giving a clear picture of the impact on him of his relationships with significant people such as those in his family, community, work associates, friends, authority figures, and his relationship with the counselor and agency. It should be clear that the narrative form may lend itself thus to brief shorthand descriptions or to more lengthy diary-style recording or even to a style approaching the novel. It should be noted further that any form of recording may be either descriptive or analytic or both. Any form of recording may be either static or dynamic or may contain aspects of both. What is needed is a dynamic picture of what has happened and is happening to the client in his important relationships as he, together with the counselor and the agency, strive for attainment of new objectives. The record therefore, must be to some degree a process account. (pp. 45-46).

While specific recommendations are difficult to

make as to the appropriate recording system, it might be advisable to use as a guideline a book review that was published in a New York newspaper several years ago. The review was short and reads as follows:

This book has 80,000 words, with enough plot for 8,000 words, and enough content and originality for 800 words.

CONTENT OF CASE RECORDS

Rehabilitation services are provided on an individualized basis to meet identified needs of clients. Some clients do not need many services, while others require detailed study-evaluation, counseling and multiple services. Peterson (1963), in a study of the services provided clients by a State agency, formulated a list of 18 possible rehabilitation services. From a sample of 213 closed cases he found that generally these clients were provided three inclusive services: (1) Intake evaluation, (2) medical evaluation, and (3) followup, plus two additional services. The *mean number of services provided to clients was five*. Therefore, there can be no specific rules regarding the amount of information that will actually be included in the case record.

Since the client is the focus of the counselor's attention, the case folder should provide enough information about his past experiences and present situation that both personal and agency objectives can be properly identified, achieved, and evaluated.

Any item of information which helps the counselor to understand the client's behavior should be explored and recorded. The reason for this is that any standardized list of questions, such as a survey-interview form, will be inadequate in most cases. For adequate recording there must be some written record of the additional information which is secured in nearly all cases.

The recorded information about a client should be both accurate and reliable. If there are any conflicting or contradictory reports, they are to be fully explained or reconciled. Reported observations or generalizations about a client are recorded in such a way that the reliability of the reports can be determined. The source of all recorded data about the client should be clearly indicated.

It is of little value to record items of information without indicating the meaning of the information to the client and to the counselor. Some data, for example, especially important in understanding a client's emotional adjustment, should be interpreted in these

terms. This might be true of such types of client experiences as the following: A series of hospitalizations; a report of juvenile delinquency, or family discord or disruption. Other data may be especially pertinent in understanding the client's occupational adjustment, and is to be interpreted in relationship to these areas. These include, for instance, such client experiences as: Past employment in specific jobs, the parents' opinions with respect to suitable work for the client, or unusual skills or aptitudes possessed by the client.

The contributions of the counselor in serving a client should be indicated by the record. The counselor should give an account of his contacts and of the arrangements he works out. It should reflect the major problems which he encounters in working with the client and in helping him to secure services from community agencies; and should indicate the nature and extent of his professional contribution to the progress of the case.

The case recording will reflect the effectiveness of the services. While a detailed evaluation is not called for, there should be enough information for a reviewer of the record to tell whether the medical treatment or surgery was successful, whether the trainee developed the vocational skills that were planned, and whether the personal counseling and social adjustments which were the counselor's contribution resulted in an improvement in the client's situation.

There are certain critical points in vocational rehabilitation case recording which can be used by the counselor as a guide in his work. The IRS Case Recording Committee (1963) lists the following 15 topics that should be included in the case record:

1. *Determining Eligibility.*—A narrative explanation is needed to describe why the client is eligible or why he is not being accepted for service. These statements should be specific.

2. *Client's Perception of His Problem(s).*—There should be descriptions of how the client perceives his needs and problems during the determination of eligibility, after acceptance, and during the life of the case.

3. *Counselor-Client Relationships.*—The counselor should describe his first counseling goal: The establishment of a counseling relationship that will permit the client to explore his problems and plans in an accepting and nonauthoritarian atmosphere. Marceline Jacques (1959) in her study "Critical Counseling Behavior in Rehabilitation Settings," found that "the creation of a therapeutic climate" (which might also be called a "positive counseling relationship") is the crucial point in vocational rehabilitation counseling. This should be adequately reflected in case recording. If the establishment of a positive counseling relationship is not ef-

fective, then it is critical to record the specific reasons why this is not possible. By a review of the narrative, the counselor may be assisted to adopt a different approach to overcome the obstacles to the establishment of such a counseling relationship. The new counseling approach should be recorded in specific terms.

4. *New Information.*—The counselor should record significant data such as medical, vocational, psychological, personal, and financial at any time during the life of the case. For example, he should record his interpretation of the psychological test results and how they relate to other case data, or describe current function periodically when a condition is progressive.

5. *Discussion of Alternate Vocational Goals.*—The counselor should relate the pro and con discussion of various vocational goals considered.

6. *Case Evaluation* (also referred to as case diagnosis, vocational diagnosis, etc.)—The counselor should define his perception of the client's rehabilitation problems and assess the likelihood of overcoming them through the vocational rehabilitation agency and other community resources. Problems such as the following should be clearly identified: Loss or impairment of physical function, inadequate personality, immaturity, dependency, poor social adjustment, limited education, special family responsibilities, inability to use English, transportation difficulties, remoteness from rehabilitation and employment resources, age, work experience, financial limitations, etc.

7. *Plan Justification.*—Case recording should indicate the vocational objective and the specific reasons for the choice of the objective. It should describe the services to be rendered and explain how they will accomplish the client's rehabilitation. It should reconcile any conflicting data which may cast doubt as to the successful completion of the plan. It should explain any proposed course of action which seems incomparable with data in the case.

8. *Changes in the Rehabilitation Plan.*—Any change of vocational objective, an addition of new services, or other plan amendment requires a written explanation of the reasons for the change in the plan.

9. *Case Supervision.*—Because the first few days or weeks of training or employment are critical to the success of a rehabilitation plan, the counselor should record his contracts with the client during this period, the identification of any problem, and the plan for solution.

10. *Case-Service Interruptions.*—The counselor should describe and evaluate the specific reasons causing the interruption. He should explain the next steps he plans to take in the case.

11. *Case Reevaluation.*—When new factors significantly affect the counseling process and/or rehabilitation plan, the counselor should describe his current interpretation of the case dynamics. New factors might include behavior or personality disturbance, child care, transportation, physical problems, difficulties with study habits, etc. The counselor will record his plan of action to overcome the problems.

12. *Loss of Contact With the Client.*—The counselor should describe specific efforts made to locate or reestablish contact with the client.

13. *Readiness for Employment.*—This is a critical point often lacking in emphasis. The counselor should record a brief review of the services provided and his evaluation of the client's prospects to obtain work on the current labor market. He should record the client's attitude toward employment and his evaluation of the client's ability to meet the requirements of the job.

14. *Job Placement Plan.*—The counselor should record a specific and organized plan for placement and indicate the responsibilities of the counselor and the client. Community resources to be used in assisting in job placement and specific places of employment to be visited should be recorded.

15. *Case Closure.*—When the case is closed as employed, the counselor should explain the basis upon which rehabilitation employment has been determined to be suitable. Such a statement will explain to what extent the work performed is consistent with the client's physical and mental abilities and to what extent the client has overcome the problems indicated in the case evaluation. He should also list the job title, salary, date started to work, employer comments, and a statement of client satisfaction.

The new "Case Service Report" form R-300 now required by the Vocational Rehabilitation Administration is designed to accumulate basic information about each individual at various stages in the rehabilitation process. In brief, the new form is a comprehensive, standardized system of statistical reporting (by the counselor to responsible supervision) on the complete rehabilitation process, for every individual coming into contact with that process, from first referral to final closure. Since the exact format prescribed by the Vocational Rehabilitation Administration is mandatory for statistical reporting purposes, it will influence the type of case records maintained in State vocational rehabilitation agencies.

The Vocational Rehabilitation Administration has also devised a series of case status codes (00 through 30) to indicate the different phases of the rehabilitation process. Use of these codes enables the counselor and his supervisors to assay the nature of his caseload, or to trace the development of an individual case. Also, the inclusion of a client's current status with each entry in the case record can clarify the remarks and add continuity to the total record. A description of the case status codes is presented in the section of this manual dealing with the administrative duties of the counselor. It seems this could be useful to trainees and readers not currently working for a State agency.

Thomason and Barrett (1959) edited a manual on "Casework Performance in Vocational Rehabilitation" from the Proceedings of the Guidance, Training, and Placement Workshops which provides a comprehensive review of the standards of casework performance and related topics. Anyone interested in further information about case recording should consult this manual; its full reference is listed at the end of Part Three.

Section 17

PLACEMENT AND FOLLOWUP

THE REGULATIONS governing the vocational rehabilitation program (1966) make specific provisions for the job placement and followup of rehabilitation clients. They state:

The State Plan shall provide that the State or local rehabilitation agency will assume responsibility for placement of individuals accepted for service. The State Plan shall set forth the standards established for determining if the client is suitably employed, and shall provide for a reasonable period of followup after placement to assure that the vocational rehabilitation of the client has been successfully achieved (sec. 401.40).

The rehabilitation counselor accepts responsibility for the placement of his clients. *The emphasis on final outcome or product is a variable that distinguishes vocational rehabilitation counseling from most other forms of counseling.* A disabled individual who has been physically restored, has accepted his disability, knows his assets and limitations, is adequately trained, but who has not achieved a reasonable level of vocational adjustment is not truly rehabilitated, and the goal of the vocational rehabilitation program has not been fulfilled.

Any plan for the employment of disabled workers is founded on the same basic principles as those involved in the effective use of able-bodied workers—namely, matching people to jobs for which they are suited by virtue of education, aptitude, skill, experience, and physical abilities. In many instances, with able-bodied workers, employers use hit-or-miss methods of selection, depending upon a casual visual survey of the applicant's physique and a random appraisal of his education and job experience. While many employees selected on the basis of such criteria do work out satisfactorily, there are misfits, poor producers, and accident-prone employees as a result of much random selection.

In some cases, finding employment for the handicapped is a relatively simple matter. For example, it requires no great skill in employee placement to put a skilled mechanic who has lost a leg to work at a

lower level job as a crossing watchman or elevator operator. The problem has been solved in one sense. However, such a simple disposition of a case can and often does completely miss the mark of true rehabilitation. The individual is not dependent upon charity and has a remunerative job, but with lower pay and work involving the use of none of the skills he still possesses; the placement is basically unsatisfactory. Although the counselor's intentions are commendable, the goal of rehabilitation is far from being reached in such a case. An excellent source of material related to beneficial job placement is a GTP bulletin edited by Thomason and Barrett (1960) entitled "The Placement Process in Vocational Rehabilitation Counseling."

LOCATING JOB OPPORTUNITIES

To be successful in his placement activities, the counselor must know where job vacancies are and the sources and leads he can utilize to locate job opportunities for his clients. Information on employment vacancies and leads can be obtained from the following sources:

1. *The Client.*—The proceedings of a workshop on guidance, training, and placement (OVR, 1957) report that in recent years, nearly 50 percent of the clients whose cases were closed as rehabilitated found their own employment, and did not need help with placement from their counselor. From their own experiences, from leads and suggestions supplied by their friends and relatives, or from their own knowledge as to where they might find employment, they were able to find suitable work. A counselor's former clients can often supply first-rate leads to job opportunities which the counselor can mention to present clients.

2. *The Counselor's Employer Contact Program.*—The counselors who are most effective in placement

know employers, and employers, in turn, know them. This circumstance does not just happen—it is usually the result of an employer contact program carefully planned and developed over a long period of time. Not every employer contact will result in a “sale” (a placement); in fact many will not. Topflight salesmen have reported that on the average they must call on a potential customer 10 times before making the first sale. But in the process, they have been learning about the customer, his business, his problems, and his needs, and at the same time the customer has been learning about the salesman and his product and seeing how that product would fit into his business. On this basis, the sale was finally made. The counselor, too, must pick his potential customer (the employer) and often call back again and again until he can sell his product (a handicapped client).

“How large should the employer contact program be and how many employer contacts should be made in a day?” An answer might be found in this story: A salesman who was producing good results was driven by a new sales manager to increase his daily calls. Later he was showing 20 to 30 calls a day which still did not satisfy the manager. When he finally was averaging 50 to 60 calls a day, the manager told him that he was doing better. The salesman replied, “I could have made more but some stupid fool stopped me and asked what I was selling.”

3. *The State Employment Services.*—The State employment services through more than 2,000 local offices are major sources for information on local job vacancies and leads to potential employers. Information is available from the employment service regarding job vacancies in other parts of the State and in other States for which recruitment is underway.

Special testing, counseling, and placement services are provided for handicapped job applicants by the State employment services. It has been emphasized that the vocational rehabilitation counselor should take advantage of these services. The Vocational Rehabilitation Act, Public Law 89-333, states that the State Plan shall “provide for entering into cooperative arrangements with the system of public employment offices in the State and the maximum utilization of the job placement and employment counseling services and other services and facilities of such offices” (1965, sec. 5(11)). The responsibility for the use of these services evolves around the counselor. (Toward the end of this section there is a more detailed discussion of the Employment Service’s responsibilities for the job placement of the handicapped.)

4. *Former Employers.*—A client’s former employer should be considered for rehiring the client. This is particularly true if the client is disabled as a result of an industrial accident sustained on the job. His former employer may properly feel some special responsibility for the welfare of the client. As one counselor put it, “I use workmen’s compensation referrals for all their worth in making the employer’s acquaintance and selling him on rehabilitation concepts.”

5. *“Help Wanted” Ads.*—Many counselors feel that this is a good source for locating employment opportunities for clients. By following up on these ads, they are in direct contact with an employer who has an immediate need for worker services and help. The employer is ready to “buy;” the counselor is ready to “sell.”

6. *Business Reports.*—Information on business and industrial relocations in his area, expansions of existing operations, industrial changes and trends which can be translated into job opportunities for his clients are available to the counselor through such sources as newspaper accounts, industrial reports, and chambers of commerce surveys.

7. *New Construction, Remodeling, etc.*—As the counselor works his territory, he can find many cues to employment leads in the construction of new plants and factories, stores, gas stations, and in the remodeling and alteration of buildings for new business tenants. If he waits until the opening of the business, he may find employment opportunities are limited by the turnover rate and/or expansion plans. The time to contact the employer or other person responsible for hiring is when he is recruiting to “staff-up” for his opening.

8. *Training Agencies.*—The training agencies—the colleges and universities, technical trade and vocational schools, high schools, etc.—have their own employer contact and placement programs and can supply leads to employment openings for client-trainees and even for other clients if they have no qualified applicants of their own to recommend.

9. *Key Worker Contacts.*—An interesting suggestion for developing leads to employment opportunities for clients was offered by a counselor who described his key worker contact program as follows: “I keep up my contact with key workers in various places rather than with the employer, personnel manager, etc. I find that I can do this much more informally, more quickly and more effectively. These key workers often know about job openings because of ‘quits’ and operational changes before the front office does. They know what is going on from top to bottom. I get better job leads—and more of them—from this source than from any other.”

10. *Civil Service and Merit System Examinations and Employment Announcements.*—Government employment at Federal, State, county, or local level is a possibility for a handicapped worker whether he is looking for work in the “white” or “blue” collar category. The Federal agencies and many State and some local governments have adopted the policy that employment may not be denied an applicant because of any disability or handicap he might have if *he is qualified* and eligible for appointment and can perform the duties of the job without danger or hazard to himself and others.

Examination and employment announcements with details on qualifications, rates of pay, and location of job are posted regularly in the post offices and other public buildings and are reported in the newspapers, given to the State employment services and are publicized through other media.

11. *Unions.*—Business managers, stewards, and other union personnel make it their business to know what is going on both locally and nationally that will affect employment of the members, and are a good source of information.

12. *Trade Associations.*—Many types of business establishments organize associations to promote developments of mutual interest. These mutual interests often include recruitment of qualified personnel. In urban centers some trade associations maintain employment offices for their members. Officials of these associations can provide occupational information that is current and local, and can assist with placement of many clients.

ARRANGING AND PLANNING FOR THE EMPLOYER INTERVIEW

The counselor, having located potential employers for his client, must then arrange and plan for the employer interviews. There is no single answer as to how this can best be done, and judgment plays a large role in this matter. The personality and capabilities of the counselor, the individual makeup of the employer or his representative, and the circumstances under which they will meet are controlling factors.

The job solicitation interview with the employer is frequently likened to a sales contact. The counselor is trying to sell the vocational rehabilitation concept that it is *good business* to hire the handicapped and/or the vocational services of a particular handicapped client.

The principles of good salesmanship require planning. A machine salesman, for example, would get information about the accounting and bookkeeping methods of his potential customer; he would study his own machine in relation to these operations; he would learn all he could about the personality, the interests, the likes and dislikes of the individual to be interviewed. With these data he would prepare his sales approach to gain interest and through this interest lead the customer to the purchase of his machine. The counselor should plan in much the same way for his employer interview.

The success or failure of the employer interview may be determined by the approach of the counselor. One purpose of planning for the interview is to save time. The counselor's time and the employer's time are valuable. In the interview, the counselor should be prepared at the outset to identify himself and to explain the purpose of his visit clearly and concisely. This does not mean that he has a “canned” presentation but rather that he knows just what he wants to say, and how, when and why to say it so as to raise questions, comments, and the interest of the employer.

If the counselor intends to secure the best job placement for his client, *a sincere belief in the client's ability is essential*. The counselor must be ready and able to convince the employer that the client can do the job, and that there are good, substantial reasons why he should hire the client rather than someone else. Experienced counselors warn against appealing to the employer's charitable or humanitarian interests or even his concern as a taxpayer with problems of the handicapped. They do recommend that the counselor approach the employer in a businesslike fashion; he should explain the merits of his proposition; i.e., that the employer should hire the handicapped client, in terms of the business interests of the employer; and he should show a willingness to accept the employer's decision based strictly on those considerations. A counselor cannot “sell” someone he would not “buy” himself.

STEPS IN PRESENTING THE CLIENT

In hiring and paying for the services of a worker, the employer has one thought in mind—he wants the best available man for the job. He may or may not use the term, but he is certainly going to apply some of the principles and techniques of “selective placement,” that is, the optimum matching of job requirements with worker qualifications. If he can be

convinced that the rehabilitation client is the best available applicant, the client will be hired. It is the counselor's job to "sell" the employer the conviction that his client is the right man for the job.

The counselor might begin by stating that he is not just looking for "a" job for his client, but for "the" job for him—the job which is right for the client and for which he is right. He can then explain the client's qualifications in terms of the:

* * * Evaluation and diagnosis of medical data; psychological testing reports; training and work experience reports; personal; socioeconomic and other history.

* * * Rehabilitation services provided—The physical restoration, training and other services furnished so that the client might become employable in his predetermined vocational objective.

* * * Client's readiness for employment—An explanation to the employer of the client's "readiness for employment" with emphasis upon his qualifications.

Caution: "How much is the employer told?" The counselor's first responsibility is to his client, and confidential information is not unnecessarily disclosed. On the other hand, the counselor must be fair with the employer. For example, psychological test data may be used, with the client's knowledge, to the extent that they will assist in the placement; medical information is interpreted in terms of the client's abilities to perform functions of the job sought. Pertinent emotional components of disability should be explained to the employer but the counselor should be certain that he is correct in his evaluation of these factors. Basic information concerning the marital and family status of the client is usually expected, as is a vocational history indicating the kinds of jobs with rates of pay the client has received as well as reasons for leaving previous jobs. The employer is entitled to know the information directly pertinent to his decision in the matter. One employer may want to know only about the client's qualifications as a worker; another may want to know these and also more about the client as a person. Pertinency is the rule, and discretion governs the practice of releasing information about the client.

"Selective placement," the matching of worker qualifications and job requirements, can be described as an employment technique applicable in hiring and assigning the able bodied. It is equally applicable in the employment of the handicapped. The counselor can explain how, through the preparatory rehabilitation services, considerations of selective placement have been observed; e.g., that the employment objective has been determined feasible in terms of the client's physical and other capacities, his interests, his skills and knowledge, and his potentials, and that

there is every reasonable assurance that in the job category of his vocational objective he will prove to be a competent and satisfactory worker. In the course of this explanation, the counselor can note other selective placement principles: Few, if any, jobs require 100 percent of the mental, physical, and other capacities and potentials of the workers employed. Theoretically, any given job can be suitably performed by a *specially selected* handicapped person. Performance duties vary widely in jobs of the same title from place to place and even within the same factory, plant, or place of business. Good placement requires more than a matching of the applicant's mechanical and physical capacities to the requirements of a job, consideration must be given to the degree of responsibility he must assume, the amount of initiative, adaptability, judgment, and mental alertness he must exercise, to environmental working conditions, to the applicant's temperament, to his social and economic background and needs.

WORKMEN'S COMPENSATION INSURANCE

One of the most difficult stumbling blocks in the placement of handicapped persons has been employer concern about increased insurance rates if you have handicapped workers. Many employers actually believe this to be true; others may cite it as an excuse in lieu of their real reason for not hiring the handicapped. In either event, the counselor should not lose the opportunity to help destroy the myth concerning the adverse effect of employment of the handicapped upon insurance rates. Workmen's compensation insurance rates for any given employer are determined by only two factors: First, the nature of the business in which the employer is engaged. A base rate is determined according to the relative hazards of a company's work. A company with a high incidence of hazards in its work will have a higher base rate than one with a lower incidence of hazards, second, the company's own accident experience record. Two companies in the same kind of work can have varying insurance rates if one has a low-accident record and the other a high one.

The formulas for determining premium rates make no consideration for the kind of personnel hired. It makes no difference whether all, some, or none of the personnel are handicapped persons. The contract says nothing, implied or direct, about the physical conditions of the workers the insured may hire.

JOB ANALYSIS

Job analysis is an indispensable tool and technique in selective placement. Only through the analysis of the job for which the handicapped client is an applicant, and only by analyzing the job right in the shop, factory or office where the client will work if hired, can the counselor determine whether or not the job is suitable. Certainly he cannot decide on the suitability of the position by job title alone. One counselor tells of the "electrician's helper" whose job assignment was changing burned-out light bulbs in a large office building, and of the outside mechanic who was really an automobile mechanic but was classified in the other category because it had a higher pay schedule. A bookkeeper in one office may be just that; in another, he may really be an office manager with many additional responsibilities and duties.

Good placement requires more than a matching of the worker's physical and mental qualifications to the performance requirements of a job. Consideration must be given to the degree of responsibility the worker must assume, to the amount of initiative, adaptability, judgment, and mental alertness he must exercise, to environmental working conditions, to his temperament, and to his social and economic needs.

The importance of completing a thorough study cannot be overstressed. An example of the difficulties and embarrassment which can result from slipshod analysis is illustrated in this story: A counselor was trying to place a blind client. He did an analysis of the job observing the flow of materials to the bench, the handling and feeding of stock into the machine, and the disposition of the machined product. He noted the working conditions, safety elements, etc., and in full confidence assured both the client and employer that this job was "right." But when he went back to the production floor to introduce the client to the job, in the presence of the employer and the supervisor, the counselor suddenly discovered that every 10th finished article had to be inspected and that codings had to be placed on the route cards for every finished lot of products.

It is not within the scope of this manual to give a detailed account of job analysis. However, it is an area of knowledge that should be a part of the counselor's repertoire of rehabilitation skills. There are numerous guides available giving this information listed in the suggested readings for this section, and local employment service offices should be able to provide references to other sources.

JOB ENGINEERING

An important selling point in the placement of vocational rehabilitation clients is that they are ready and able to compete, *without special favor*, for employment in their chosen occupational objectives. Any request for a major reengineering of the job or method for doing it refutes the counselor's basic argument. If, however, from his job analysis he sees that his client could perform better through such *minor modification* in procedures as the placing of work materials on his bench rather than on the floor, it would be proper for him to make such a recommendation.

Job engineering costs money. In asking a potential employer to make changes and to meet their costs, the counselor is lessening his chances for placing a handicapped person with that employer. Also, job engineering immediately calls attention to the fact that it was necessary to establish special working conditions, a circumstance prejudicial to the handicapped person in his relationships with coworkers and the employer.

On the other hand, the counselor is fortunate if, as a result of his job analysis, he can recommend a special device which can be used advantageously by other workers as well as by the disabled job applicant. For example, one counselor studied an operation in which employees were required in part to pick up and feed small bearings into a machine. His client had both a visual and manual handicap and although he could do the total job, he could not pick up as many bearings at one time as his coworkers and was losing time and motion. The counselor, with the supervisor, designed and developed a chute to feed the bearings directly from stock into the machine. The chute worked so well it not only saved the client's job but duplicates were installed on all machines thus speeding up production in the department.

Right controls installed in place of left controls, leg controls substituted for arm controls, etc., as an accommodation for one handicapped worker would be considered special devices. Such devices should be recommended only when absolutely necessary. Before making such recommendations, the counselor would be well advised to know his client well, the potential employer, the job, and have information at hand concerning the source of the needed device, its installation and cost.

UTILIZING THE PLACEMENT FACILITIES OF THE EMPLOYMENT SERVICE

By law, each State Plan for vocational rehabilitation must provide for the maximum utilization of the services and facilities of the public employment offices in the job placement of vocational rehabilitation clients. The responsibility for the utilization of those services is the counselor's.

Because the public employment offices and the vocational rehabilitation agency both offer placement assistance, questions have been raised concerning duplication of services. The correct legal answer to those questions is unmistakably clear: The State vocational rehabilitation agency (the counselor) is responsible, absolutely and ultimately, for the placement of each client accepted for service. That responsibility may not be delegated. Even though a placement may actually be by the client who secures his own job, by the training agency, by the former employer who rehires the client, the employment office or by another person or agency, the counselor is obligated to make certain a satisfactory placement is obtained.

In referring a client to a State employment service and in enlisting the service of that agency, the counselor is only calling upon the one community resource which under legal specification must be utilized in providing placement services to the client who needs such aid. Other resources exist in the community also which could and should be drawn upon. The placement services of the employment office are not in lieu of, but complement and supplement the counselor's own efforts to find suitable employment for his client.

Details of a plan with procedures for using the expanded facilities of the State employment service offices in the placement of rehabilitation clients were announced in OVR director's letter No. 76—Supplement 2, "Cooperative Relationships Between the State Vocational Rehabilitation Agencies, the Employment Service, and the President's Committee on the Employment of the Physically Handicapped" (Jan. 6, 1956). In summary, this plan provides that:

* * * the counselors of the rehabilitation agency and the employment service will jointly develop a placement plan for each rehabilitation client ready for and in need of an employment opportunity and that the two counselors in pursuit of their plans will work continuously, concurrently, and cooperatively until the client has been placed or other disposition which would cause withdrawal, temporarily or permanently, of the client from the competitive labor market is indicated.

Surveys have been made on the implementation of

this plan with particular attention to the nature and extent of the cooperation between the two agencies in finding suitable employment for the client. A definite relationship was noted between the effectiveness, qualitatively and quantitatively, of the employment office in placing rehabilitation clients and the following factors:

- (1) The referral methods and techniques of the rehabilitation counselor. The probabilities of the employment office's placement of a rehabilitation client were enhanced to the extent that the rehabilitation counselor personalized the referral by visit or telephone call to the employment office and provided complete case data including specification of the employment objective with appraisal of client's readiness for employment in that work.
- (2) The rehabilitation counselor's meeting with the employment office representative to plan a placement action program and his participation in effecting the plan.
- (3) The followup to the referral in the exchange between the two offices of information pertinent to the client.

The interplay of factors between the two agencies shows that, to secure full utilization of the placement facilities of the employment service, the rehabilitation counselor must nurture his relationships and must be ready to work cooperatively with his counterpart in the employment service by providing a full exchange of information and services, to their common end that the client may be placed in suitable employment.

FOLLOWUP

The counselor's responsibility to the client does not stop when that client has been employed. Before the case can be closed as rehabilitated, the counselor must follow up to determine that the employment is suitable; i.e., that the client is actually employed according to his capabilities and potentials and that the employer is satisfied.

The timing of the initial followup is controlled by the circumstances of the individual case. With some clients it might be advisable to follow up within the first few days after placement; with others the employer or the client may feel this is an unwarranted imposition. Usually followup should be initiated 15 to 30 days after placement. This allows opportunity for

the client to adjust to the job situation and decide if he likes the position as well as its suitability for him; also, by this time the employer and coworkers will have formed some opinions on the client's acceptability as a worker and as a person.

Additional followup might be scheduled at 60- and 90-day intervals after the placement. The suitability of the placement can generally be determined within these periods. Of course, there will always be exceptions and then followup must be extended.

For both the initial and subsequent followup contacts, a schedule should be prepared. It is important that the counselor stay close to the situation so that he will know how the client is adjusting, how the employer is reacting, what problems are developing which he might resolve, whether he should remove the client from the job and all of the other details essential to his giving proper service to the client and to the employer.

By way of summary, the counselor should have a thorough knowledge of job opportunities in his area, and become familiar enough with job analyses to ascertain which jobs his client can perform efficiently. The counselor assumes responsibility for job placement and in this connection should interpret the client's disabilities and abilities to employers; refer client to employment service; and inform client as to how to apply

for a job. Placement planning should be done far enough in advance so that the client can step into a job upon completion of other necessary rehabilitation services.

The client's work should be suitable and in line with the plan at the time of placement. The job duties, working conditions, wage rates, suitability for the client personally and in terms of his disability, client adjustment, employer satisfaction, and completion of all necessary services are key factors in the placement of the person in suitable employment.

Two excellent sources of information regarding placement and followup were published by VRA in the rehabilitation service series. The first one contains general information and is entitled "The Placement Process in Vocational Rehabilitation Counseling." It was edited by Bruce Thomacon and Albert Barrett (1960) of the University of Florida. The second one, "Small Business Enterprises in Vocational Rehabilitation," is concerned with specialized type of placement; i.e., establishing the disabled individual in a business of his own. This manual was edited by Wade O. Stalnaker, Keith C. Wright, and Loren T. Johnston (1963). These two publications would be worthwhile references in the rehabilitation counselor's professional library for problems related to placement and followup.

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SUGGESTED READINGS PART III

Rehabilitation Counseling: Problems and Techniques

There are several excellent books related to this topic that are listed in the references for part III. Some of them are: McGowan and Schmidt (1962); Lofquist (1959); Jacobs, et al. (1961); Hamilton (1950); Callis, et al. (1955); Rusalem (1963); Patterson (1958 and 1959); Tyler (1961); Wright (1960); Brammer and Shostrom (1960); Arbuckle (1961); Bordin (1955); Rogers (1942, 1951 and 1961); Pepinsky and Pepinsky (1954) and Williamson (1939). These will not be cited again here even though some of the better books in the area of counseling techniques and theory are included.

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PART FOUR

THE REHABILITATION COUNSELOR'S ROLE

1-6

Section 18

COUNSELOR'S ROLE AND FUNCTION IN THE VOCATIONAL REHABILITATION PROGRAM

REHABILITATION, as Mary Switzer (1963) so perceptively stated:

... is a poor word to express the multitude of talents, skills, engineering, and, most of all, human understanding of man's potential put together to make the paraplegic self-sufficient, to give the quadriplegic the maximum use of what is left of his body so that he can use his mind well, to help the old hemiplegic back to some function and sense of joy in life, to encourage the cerebral palsied boy in the mysteries of strength and courage needed to survive in today's world (p.32).

With the above in mind, it is easy to understand the difficulties encountered in attempting to establish a concrete and specific job description for the rehabilitation counselor. Generally, it is the function of the rehabilitation counselor to provide or arrange any services, within the limits of law and reason, that will enhance the opportunities of his clients in arriving at the best obtainable vocational adjustment. Yet such a definition of the rehabilitation counselor's role is too nebulous to provide a frame of reference from which the counselor can operate or from which a university can plan a training program. There are two other reasons for delimiting the counselor's function in the rehabilitation process: (1) To insure the most effective utilization of his training, time, and efforts in the vocational rehabilitation of handicapped individuals, and (2) to enable rehabilitation counselors to gain professional stature.

Wrenn and Darley (1949) list as one of the criteria of a profession that it have a definition of job titles and functions. Mueller (1959) states that "Any emerging profession must justify its claim to certain unique skills which other professions and the general public do not have access to" (p. 411).

In this part of the manual and in the sections that follow many terms will be used which have previously been identified as part of the vocabulary or technical "jargon" of these other professional groups. It may

help to clarify the situation to introduce this area with an explanatory statement to the effect that the vocational rehabilitation counselor's main job is to provide for the *vocational rehabilitation* of the clients he is seeing. It has been assumed that the main technique which he will use is counseling. However, as part of the total process of vocational rehabilitation he may, and generally does, provide services which involve case-work, placement, medical referral, and arranges for services to be provided by many related disciplines. All of these services are integrated by the rehabilitation process

The purpose of this section is to summarize the issues relevant to establishing an occupational role for the rehabilitation counselor. There are wide differences of opinions among authorities in the area regarding who the counselor is, could, or should be. And, related research has done little to clarify the situation.

The subject is introduced by presenting several definitions of rehabilitation counseling, defining rehabilitation services, presenting models of the counselor's role that are found in the literature, and finally material related to what the counselor actually does.

VOCATIONAL REHABILITATION COUNSELING DEFINED

Two definitions of vocational rehabilitation counseling previously presented in section 15 are, for the purpose of continuity, repeated here, in addition to Lofquist's (1959) operational definition.

- (1) Previous Guidance, Training and Placement Workshops, sponsored by the Vocational Rehabilitation Administration, have defined rehabilitation as:

A process in which the counselor thinks and works in a face-to-face relationship with a disabled person in order to help him understand both his problems and potentialities, and to carry through a program of adjustment and self-improvement to the end that he will make the best obtainable vocational, personal, and social adjustment (Thomason and Barrett, 1959, p. 51).

- (2) McGowan (1963) offers the following ideas on the rehabilitation counselor's unique role:

For me, personally, the vocational rehabilitation counselor's unique contribution to handicapped clients consists of intrinsic interest, special training, and supervised experience, which have prepared him to combine medical data from the physician, psychological data from the psychologist, psychosocial-vocational data based on his own special training in testing and counseling, and finally information about the world of work obtained from the employment service and other sources, and, to transmit these data through the counseling process to the client in such a way that they are able to arrive at a vocational plan which is acceptable to both the client and the counselor, and which promises the client the best possible chance of achieving job satisfaction and vocational success.

- (3) Lloyd H. Lofquist (1959) offers an operational definition of vocational counseling. He feels this is the sort of counseling that should be the concern of vocational rehabilitation counselors. His definition is:

Vocational counseling is a continuous learning process involving interaction in a nonauthoritarian fashion, between two individuals whose problem solving efforts are oriented toward vocational planning. The professional vocational counselor and the counselee with a problem are concerned not only with the solution of the immediate problem, but also with planning new techniques for meeting future problems. While the counselee has need for anxiety reduction concerning his vocational problem or set of problems, psychopathology is not involved and the counselee is capable of learning new attitudes and appraising vocational realities with reference to his unique assets and liabilities, without first requiring a major restructuring of his personality. Psychotherapy may result in some measure; but vocational planning, not psychotherapy, is the primary orientation of the process. The vocational counselor serves in this learning process as the reinforcing agency, facilitator of counselee activity, resource person, and expert on techniques for discovering additional data relevant to the vocational planning. A counselor also learns continuously in the process, but keeps his need-satisfaction demands at a level subservient to those of the counselee (p. 8).

Lofquist's definition clearly indicates that while the work of the rehabilitation counselor may involve many

different types of problems, he is *primarily* concerned with the total implications of the vocational rehabilitation problem. These, of course, may include vocational problems, health and physical problems, and personal and social problems.

Vocational Rehabilitation Services

As stated in an earlier section, vocational rehabilitation services are defined as any goods and services necessary to render a handicapped individual fit to engage in a gainful occupation, including: Diagnostic and related services required for the determination of eligibility for and the nature and scope of services to be provided; counseling; physical restoration services; training; books and training materials (including tools); maintenance; placement; tools, equipment, initial stocks, and supplies, including equipment and initial stocks and supplies for vending stands; management services and supervision provided by the State agency and acquisition of vending stands or other equipment and initial stocks and supplies, for small business enterprises, operated under the supervision of the State agency, by the severely handicapped; transportation; occupational licenses; reader services for the blind; interpreter services for the deaf; and other goods and services. Through counseling, the rehabilitation counselor assists the client in choosing an appropriate occupational objective and in relating a plan of services to the best possible vocational adjustment.

The Vocational Rehabilitation Counselor

With the above definitions of rehabilitation counseling and rehabilitation services in mind we can discuss the role of the rehabilitation counselor. Most authorities (Thomason & Barrett, 1959) agree that "the core of the rehabilitation counselor's work is counseling." However, no one will deny that the counselor is also continually involved in the process of providing additional services to his clients. Theoretically, he accomplishes this function by establishing and maintaining a counseling relationship which prevades the entire vocational rehabilitation process.

The counselor's role in the rehabilitation process is basic to the success or failure of any given program. *The agency is personified in the counselor, and through him the client gains his perception of vocational rehabilitation.* The rehabilitation counselor establishes a *professional* relationship with the client, continuing from the onset or recognition of disability to the attainment of his greatest competitive capacity. Reports from

the VRA sponsored Guidance Training and Placement Workshops (1951, 1954, 1955, 1958, and 1959) indicate that, from the location and selection of cases to the completion of services, the counselor interprets rehabilitation functions and services to community organizations, agencies, and individuals, and coordinates all of these services with the client himself. The major functions of the counselor require assuming responsibility for the evaluation of the client, planning with the individual from the initial counseling interview and diagnostic services to the establishment of eligibility, planning, and arranging for supervision of services, and being responsible for final job adjustment. Also included in his job is the responsibility for effective management of his caseload, case records, correspondence, reports, and workflow.

An essential characteristic which differentiates the work of the vocational rehabilitation counselor from that of other counseling specialists is the fact that the rehabilitation counselor's final aim is to bring about the vocational rehabilitation of the handicapped individual.

NECESSARY KNOWLEDGE AND SKILLS

With the passage of Public Law 565 in 1954, money was available for an expanded program of rehabilitation and it became evident that more rehabilitation counselors would be required. As a result there was an urgent need for a study of the rehabilitation counselor functions and training needs. The National Rehabilitation Association (NRA) recognized the dearth of authoritative material on the training needs of rehabilitation counselors, so in cooperation with the National Vocational Guidance Association (NVGA) revised and adapted a previous NVGA (1949) publication, "Counselor Preparation," to reflect current thinking with respect to the preparation of rehabilitation counselors. A workshop of authorities in areas of rehabilitation, including counseling, which was made possible by a grant from VRA, was held at the University of Virginia, Charlottesville, in 1955. This workshop produced a document entitled "Rehabilitation Counselor Preparation" (NRA-NVGA, 1956), that was edited by Hall and Warren.

A statement of the knowledge and skills needed by the rehabilitation counselor was contained in this report and is listed below:

Successful rehabilitation of the disabled requires rehabilitation counselors to have professional competence. Rehabilitation counseling has a professional scope which is concerned with all areas of the adjustment of the disabled.

The rehabilitation counselor demonstrates his competence as he applies his knowledge and skills to a great variety of operational problems. The knowledge and skills needed by the rehabilitation counselor in the performance of his functions include:

- (1) An understanding of human growth and development; the effect of childhood and adolescent experiences upon adult behavior.
- (2) An understanding of human anatomy and physiology; the effects of disease or injury on body structure, function, behavior, and personality.
- (3) An understanding of mental and emotional conditions affecting social and vocational adjustment; their nature, course, and probable cause.
- (4) The ability to detect and identify the manifestations of disability, mental or physical, and to understand their relationships to vocational and social adjustment.
- (5) Familiarity with medical information, therapies, prothesis, services, and equipment designed to remove or minimize the effects of disability.
- (6) Ability to use accepted methods and techniques of individual case study, recording, evaluation, and reporting, and to adapt procedures to the practices of employing agencies.
- (7) The ability to establish and maintain a satisfactory counseling relationship.
- (8) The ability to use methods and techniques of vocational and personal counseling to assist the client in achieving an understanding of his problems and potentialities in planning constructively for his own rehabilitation.
- (9) The ability to analyze occupations in terms of skills, physical demands, training requirements, and working conditions.
- (10) An understanding of relationships of aptitudes, skills, interests, and educational background of the handicapped person to occupational requirements.
- (11) An understanding of community organizations and of the facilities and procedures, policies, and limitations under which their services are made available to applicants.
- (12) The ability to make use of available community services and resources in meeting problems of disabled persons and to maintain effective relationships with such sources.
- (13) Ability to analyze the rehabilitation needs of a community and to organize resources to meet these needs.
- (14) An understanding of the relationship of administrative policies and procedures to the counselor's work.
- (15) The ability to organize his work to make the most economical use of his time.
- (16) The ability to analyze reports furnishing medical, psychological, or social data, and to interpret the relationship of such data to the needs of the client.
- (17) The ability to carry on basic study and research growing out of his rehabilitation practices and to interpret and apply the findings.

- (18) The ability to use consultative services both within and outside the rehabilitation agency staff.
- (19) The ability to utilize National, regional, and State reports concerning industrial, occupational, and labor market trends; and to analyze specific community job information and opportunities.
- (20) The ability to collect occupational information and use it effectively in counseling.
- (21) The ability to orient employers to the employment of disabled persons.
- (22) An understanding of Federal, State, and local laws pertaining to rehabilitation and of related social legislation.
- (23) An understanding of agency policies, practices, and standards as they apply to the counselor's work.
- (24) Ability to interpret agency policy, laws, and regulations to clients and others (pp. 20-22).

The report of the Charlottesville workshop represents the "traditional" approach to defining the rehabilitation counselor's occupational role. Since 1955 there has been a great deal of discussion and disagreement on what the counselor's exact role should be. These opposing opinions will be discussed below in terms of theoretical models.

THEORETICAL MODELS OF THE COUNSELOR'S ROLE

A review of the opinions expressed in the literature regarding the rehabilitation counselor's appropriate occupational role reveal two rather diffuse but nevertheless discernible theoretical models. The first model conceptualizes the rehabilitation counselor functioning as an interdisciplinary or sometimes multidisciplinary worker, a coordinator of services, and "captain of the rehabilitation team" (Coordinator Model). The other model depicts the counselor as being primarily a "professional counselor" whose main contribution to the rehabilitation process is his counseling function (Counselor Model).

Patterson (1957), discusses the rehabilitation counselor's role in an article entitled "Counselor or Coordinator?" He states that: "On this point there appears to be some difference of opinion, or confusion, or both" (p. 13). He further points out that the rehabilitation counselor training programs need an answer to this question in order to plan a course of study that will prepare counselors to perform their prescribed function. A discussion of the pros and cons of the Coordinator Model and the Counselor Model follows.

The "Coordinator" Model

Cottle (1953) has this to say about the rehabilitation counselor's job:

In himself and his fellow counselors he (the rehabilitation counselor) sees a combination of parent, doctor, psychologist, teacher, policeman, public relations expert, personnel manager, placement specialist, and jack of all trades. Certainly the field of vocational rehabilitation is one of the broadest in the whole catalog of professions (p. 446).

Hamilton (1950), and Johnston (1960), suggest that they do not perceive of "counseling" as being the counselor's major task. They try to show the counselor as a "coordinator" of many types of services, and therefore a person who must possess a multitude of skills based on a wide range of training. Johnston (1960), maintains that the rehabilitation counselor is not a psychologist, psychiatrist, sociologist, social worker, or physician. He is a "Maverick" of the highest caliber drawn from all the above and more. To quote him, "he is an expert coordinator of services. * * * He has many general abilities and special abilities in at least two or more disciplines" (p. 9).

Fletcher (1954), sees the rehabilitation counselor as part of the team made up of medical, social service, hospital, placement, and other specialists. He feels that the rehabilitation counselor should be the team coordinator, but does not see him as established in this role.

Hall and Warren (1956) and Smith (1960), list the following activities that are expected from rehabilitation counselors, although admitting that only an ideal counselor or person could perform *all* the suggested duties. According to them the counselor is asked to: Interview the client, evaluate his problems, help the client choose a rehabilitation plan, facilitate action on the plan, establish and maintain a counseling relationship, maintain relations with community organizations, interpret rehabilitation services to the public, encourage referrals, determine eligibility, collect and analyze educational and occupational data, administer psychological tests, assume responsibility for placement, and prepare case records and reports. In addition, the rehabilitation counselor is also expected to perform certain auxiliary services which include: Gathering material from employers and trade associations, assessing community resources, and making his own occupational and economic analysis.

Propst (1958), offers a three-part definition of the rehabilitation counselor's function:

- (1) A counselor is a member of the professional staff of an agency whose function is the rehabilitation of handicapped individuals.

- (2) He is an administrative agent to such individuals insofar as he supplies vocational information, arranges for tests, the purchase of prosthetic devices, interviews with others, workshop or training experience, and so forth, and insofar as he controls the client's utilization of, and passage through, the facilities he makes available.
- (3) He is a therapeutic agent to such individuals insofar as he provides a setting, and makes responses, of such character as to facilitate the client's working through, to some degree, that alteration in self-view of which, in part, his handicap consists (p. 6).

Propst contends that the counseling and administrative roles of the rehabilitation counselor are compatible, and that, in fact, such a combined function is both possible and desirable when working with a handicapped person.

The danger of holding to the "Coordinator" model is that the rehabilitation counselor *could* lose his perception of the client as a unique individual. That is, there seems to be a danger that the "Coordinator" would become too *product oriented* and begin to mechanically provide services without considering the personality dynamics involved in a client's problems. He then would be providing the services a client was entitled to by law without consideration of the client's individuality or needs. Also, the training of "Coordinators" presents problems. To provide an individual with formal training in each of the areas listed by the Charlottesville group would take much longer than either time or money would permit and it is very likely that a person trained this broadly would not be professionally competent in any one area. The "Coordinator" might not have a professional identity, be neither fish nor fowl, and a "jack of all trades and master of none."

The "Counselor" Model

The proponents of the rehabilitation counselor as a "Counselor" criticize the above approach as being humanly impossible in terms of the counselor's ability and time for training, as well as making no new contribution to the rehabilitation process. Patterson (1958a) states the following in opposition to the "Coordinator" point of view.

The rehabilitation counselor will become an accepted member of the team only if he can contribute as a specialist, not on the basis of having been exposed to a heterogeneous smattering of courses in these other fields * * * The rehabilitation counselor is fundamentally a vocational counselor or a psychological counselor working with handicapped clients. He is not a member of a unique or interdisciplinary profession. Rehabilitation counseling will develop and advance

as a profession to the extent that it recognizes itself as a part of the general counseling profession and identifies itself with other counseling specialties both in training and professional affiliation (p. 312).

In another publication Patterson (1958b) offers the opinion that too often rehabilitation does things to and for the client rather than helping him learn to do things for himself. He stresses that there are several ways the counselor can help his client learn independence. They are: (1) Counselor attitudes, (2) the softening of the "case-hardened" counselor to treat the client as an individual and not as just another case, (3) confidence in the client's ability to assume responsibility, (4) recognition of individual differences among clients, and (5) no counselor stereotypes of occupational choices (e.g., shoe repairmen of all amputees, etc.). Patterson (1958b) feels that the rehabilitation counselor can only gain personal independence and professional status through his identification with the area of counseling.

Garrett (1953), Miller and Garrett (1955), Lofquist (1959), and Anderson (1958), also perceive the rehabilitation counselor as a person professionally trained as a counselor. They recognize that the rehabilitation counselor's role often includes other functions which cannot be described as counseling. However, they feel that the basic identification of the rehabilitation counselor should be with counseling.

In discussing the rehabilitation counselor as a counselor, Anderson (1958) points out problems in defining the rehabilitation counselor's role. He says that the "actual" (coordination role) and "ideal" (counseling role) are widely separated, but that this state of affairs is maintained by the necessity of reality. He proposed that the quandary could be resolved by:

... the counselor's ability to create a warm, understanding relationship with his clients which does not necessarily have as its purpose "counseling." For want of a better term this can be labeled as a therapeutic climate (p. 5).

There is an inherent danger in the "Counselor Model." This danger is that in terms of actual practice the rehabilitation counselor who, through a combination of training and personal preference, perceives his job as primarily involving counseling, *may* become more therapeutically ambitious than either the local agency or the average client is willing to "buy." However, in spite of this danger the rehabilitation counselor needs to be trained as a professional counselor and to possess the knowledge related to this profession in order to provide comprehensive and adequate rehabilitation services based on a philosophy of counseling and individual needs.

Role Conflict

Evidence that there is no clear agreement on the rehabilitation counselor's occupational role may be found in Smith's (1960), unpublished doctoral dissertation completed at the University of Missouri. He designed a study to identify areas of agreement and disagreement concerning the counselor's role by sampling the opinions of three groups of rehabilitation personnel: (1) State agency counselors (N160), (2) directors and supervisors of State agencies (N44), and (3) students in graduate training in rehabilitation counseling (N61). Opinions regarding eight counselor duties were sampled. These were: (1) Counseling, (2) testing, (3) office routine, (4) placement, (5) incidental services, (6) occupational information, (7) public relations, and (8) counselor self-improvement. He found significant differences of opinion concerning the counselor's occupational role within or among the groups of rehabilitation personnel on all the duties except counselor self-improvement. The differences found were apparent among rehabilitation counselors, their supervisors, and rehabilitation counselor trainees, as well as among counselors from different States and different training institutions. Smith (1960) concluded that the differences in opinion on the counselor's role might lead to difficulties in communication and role perception between these groups. Therefore, continued attempts to reach a mutually acceptable definition of the rehabilitation counselor's occupational role would seem essential.

A dissertation by Johnson (1961), also completed at the University of Missouri, reports differences between how rehabilitation counselors and their clients perceive the counselor's role. The investigator devised four scales, each representing one major component of the rehabilitation counselor's role. These were: (1) The counselor as a "Counselor," (2) the counselor as a "Coordinator," (3) the counselor in terms of his "socio-economic and academic status," and (4) the counselor in terms of his "personality, mannerisms, cleanliness, and dress." Johnson (1961) drew the following implications from his study:

Role conflicts exist in rehabilitation counseling as indicated by significant differences in all of the scales.

Clients prefer rehabilitation counselors who "fit" the clients' established concept of a "good" personality. Perhaps fewer role conflicts would develop, in rehabilitation counseling, if rehabilitation counselors had an even greater understanding of personality development and interaction than they now have.

Better communication is needed between rehabilitation counselors and their clients. The clients do not know what

to expect from the counselor, or how to react to him. The clients have a vague idea of the services rehabilitation counselors are expected to deliver or to perform, but many services expected by the client are not the same service which the counselors are prepared to deliver.

Patterson (1957), offers four possible solutions to the conflict regarding the rehabilitation counselor's occupational role. His solutions are:

One would be to consider the counselor as primarily a coordinator, and develop a training program which includes a sampling—a smattering—of knowledges from a broad area, including legal aspects of public assistance and social welfare programs, detailed medical information, administration of social welfare benefits and programs, public relations information, and social casework procedures, as well as some limited acquaintance with counseling. This seems to be the emphasis of a few of the recently developed training programs in rehabilitation counseling.

A second approach would be to try to train an individual for both functions, for counseling and coordinating. Some training programs appear to be struggling to do this, which appears to be impossible in the time available.

A third alternative is to concentrate on the training of competent counselors in the time available. This is the approach taken by many employers of rehabilitation counselors, who seem to desire coordinators rather than counselors.

Before suggesting a fourth alternative, I should like to indicate the advantages of this third approach. In the first place, an individual who is well trained as a counselor is trained in a basic profession which extends beyond the field of rehabilitation. While there are those, some of them quite vociferous, who would make of rehabilitation counseling—or coordinating—a new and distinct profession, that is, in the opinion of the writer, a shortsighted view of the goal. Counseling is broader than rehabilitation, and its basic principles are the same whether one is counseling children, adolescents, high school students, delinquents, college freshmen, displaced persons, those with marital problems, the emotionally disturbed, or the physically handicapped. To be sure, a counselor specializing in any one of these areas needs training—or experience—in working with the particular type of client. But this, although necessary, is not sufficient, or even primary. The individual with good basic training in general counseling principles and methods can quickly learn to work with a particular type of client.

The individual with good basic training as a counselor is then versatile with respect to the type of clients with whom he can work. This may be seen as a disadvantage by some who fear that the field of rehabilitation will lose its counselors to other fields if they are so well trained as to be in demand in many fields. Here, no doubt, is a real danger. But if it is to attract and keep competent counselors, rehabilitation must compete with other fields. It is precisely this inability to compete in terms of salary and congenial working conditions, including the opportunity to do professional counseling, that is responsible in part for the present lack of staff and applicants. But the recognition of the important role of counseling in the rehabilitation process, and the developing of the counseling phase, with the opportunity for well-trained counselors to contribute at the level at which they are trained, rather than demanding that they be jacks of all

trades and master of none, will lead to the development of professional respect for rehabilitation counselors. That this is possible has been demonstrated by the Veterans Administration programs.

Another advantage of this approach is that counselors with such training can act as coordinators. Without belittling the requirements of a good coordinator, it can be stated that a well-trained counselor can function better as a coordinator than a coordinator can function as a counselor. Much of the background and training for functioning as a coordinator is better achieved through experience than through formal training. The coordinator need not necessarily be a counselor, of course. In some situations the social worker may best function as the coordinator, and in other situations other specialists may perform this function.

While a counselor may function as a coordinator, however, it would be harmful if he were to perform such a function to the extent that he was unable to do an adequate counseling job with his cases, which is a situation existing all too frequently today. If he is to function entirely as a coordinator, then other counselors should be available to perform the counseling function. It would also be unfortunate if the coordinator's position were considered to be a higher level or more valuable function than that of the counselor. If this became the case, with coordinators having higher status and salaries than counselors, the counseling function would suffer because of inability to attract competent and well-trained counselors to the field.

A fourth alternative was mentioned above. Perhaps, instead of thinking in terms of either counselors or coordinators, we should be thinking in terms of counselors and coordinators. It may be that there are two distinct functions and two positions, so that in many situations, we should have both.

McGowan (1960) has previously stated that the rehabilitation counselor's job includes, "the ability to establish and maintain a wholesome counseling relationship, including an understanding of the importance of the client's views and needs * * *" (p. 40).

While this statement emphasizes the rehabilitation counselor as a "counselor," it goes on to indicate cognizance of other aspects of the counselor's job. The rehabilitation counselor needs the professional training of a counselor in order to have a knowledge and awareness of personality dynamics and evaluative techniques. *In addition* to these skills he must also know community organization, job structures and requirements, and the legal and clerical factors associated with his job. Before the rehabilitation counselor can recognize the needs of his clients and adequately "coordinate" the indicated services he needs to have all the skills associated with a professional counselor.

In summary, it would appear that the rehabilitation counselor should have the training and qualifications of a professional counselor for two reasons: (1) To provide productive counseling as a rehabilitation service when needed, and (2) to have the psychological insights necessary for designing and implementing a

beneficial plan of services. Both of these functions are perceived to be equally important, since the counselor is obligated to assist a client with *all* of his needs, not just his personal and social problems. The counselor must be an active participant in the *total* rehabilitation process in order to fulfill his obligation to his clients. The multiplicity and variety of problems which are concomitants of disability are believed to necessitate this position in regard to the rehabilitation counselor's training and occupational role.

The Counselor's Actual Role

An important consideration of the rehabilitation counselor's occupational role is how he actually spends his time on the job. Of course, this will vary between and within agencies, depending on the nature of the counselor's caseload, the size of his territory, administrative policy, and the counselor's own interests and abilities.

Miller, et al. (1955), in formulating a job description for the rehabilitation counselor, list the following as examples of the work performed:

Obtains, analyzes, and evaluates pertinent information; arranges for medical diagnosis to determine kind and extent of disability and rehabilitation possibilities; and determines eligibility on the basis of law and established policy.

Secures information about the applicant's educational background and work experience, special interests, social and economic circumstances, personality traits and attitudes; provides for the administration and interpretation of psychological tests, when indicated for diagnosis; evaluates and interprets information and assists the individual in making a suitable rehabilitation plan.

Makes rehabilitation services available to the applicant, such as medical and health services necessary for physical restoration, prevocational and vocational training, transportation and maintenance when required; advises with the applicant throughout the rehabilitation process and assists him in meeting problems of personal, social, and vocational adjustment.

Aids the individual in securing employment consistent with his capacities and preparation, and assists him in meeting the problems of adjustment; makes followup visits as necessary for vocational adjustment of the individual.

Makes use of available community services and facilities and maintains working relationships with cooperating agencies; when gaps exist in services, makes necessary recommendations.

Gathers information on occupational requirements and keeps informed on employment possibilities. Prepares and maintains necessary vocational rehabilitation records and makes reports as required (p. 444).

A Committee on the Utilization of Counselors' Services of the Ninth Annual Workshop on Guidance, Training, and Placement (1956), conducted a study

of counselor activities. An inspection of the findings can provide an indication of how counselors utilize their time and some idea of the various types of activities that rehabilitation counseling involves.

The committee gathered information from the top one-third of the regular counselors from several States. The counselors were selected for having achieved both quantity and quality in production. Each participant was sent a questionnaire requesting an analysis of his time spent in the following 10 areas:

1. Clerical Work:
 - (a) Filling out forms not directly related to counseling clients.
 - (b) Typing.
 - (c) Filing.
 - (d) Writing letters, etc., in longh: for mailing or for recopying.
 - (e) Making appointments.
2. Counseling and Guidance:
 - (a) Interviews with clients and potential clients.
 - (b) Completing forms which are primarily counseling devices, such as the Survey Interview form, the Financial Need Sheet, etc.
 - (c) Giving and scoring tests and interpreting the results of tests.
 - (d) Review and study of case records for the purpose of counseling clients.
 - (e) Giving occupational information to clients.
 - (f) Followup of clients who have received all services necessary, except for counsel and guidance, either in securing or adjusting to employment.
 - (g) Supervision of inservice clients.
3. Overall Planning of Your Work:
 - (a) Making general allocation of time.
 - (b) Planning office work.
 - (c) Planning itineraries and clients to see in field.
 - (d) Planning caseload management.
 - (e) Planning business and industrial contacts.
 - (f) Planning job surveys, etc.
4. Professional Growth (inservice training):
 - (a) Group conferences; i.e., State or district staff meetings, etc.
 - (b) Individual conferences with supervisors, etc.
 - (c) Formal training courses.
 - (d) Reading which is related to your job.
5. Public Relations and Program Promotion:
 - (a) Securing and investigating referrals.
 - (b) Speeches to clubs, groups, etc.
 - (c) Work on community projects.
 - (d) Personal contacts, etc.
6. Recording: The dictation or writing of material, after counseling with a client, which will become a part of the case record of an individual client, other than the completion of forms that are an integral part of counseling.
7. Reporting: To the district, area, or State office; to supervisors, doctors, other agencies, or individuals.
8. Resource Development: Such activities as finding facilities and arranging for services, as—

- (a) Arranging for physical restoration services (hospitalization, doctors, etc.).
- (b) Locating training facilities.
- (c) Finding placement opportunities.
- (d) Arranging for transportation, rooming and boarding places, etc.

9. Travel: All travel on official agency business.
10. S.S. Disability Determination: This item applied only to those agencies which use the regular VR counselors for this purpose.

The 139 counselors who participated in the study reported the following distribution of their time (in hours) over a 40-hour week:

Activity	Average number of hours	Range of hours
1. Clerical.....	3.53	0 -13.3
2. Counseling and guidance.....	13.44	2.8-24.3
3. Overall planning.....	2.35	0 - 7.2
4. Professional growth.....	2.24	0 - 7.8
5. Public relations.....	3.19	0 -10.5
6. Recording.....	4.23	.3-13.5
7. Reporting.....	2.04	0 - 8.3
8. Resource development.....	2.39	0 -10.0
9. Travel.....	6.24	1.5-12.0
10. S.S. disability determination.....	.31	0 - 3.9
Total.....	40

In a second part of this study, the counselors reported that they would like to be able to spend more time in counseling and guidance and public relations. Also, they felt that too much of their time was consumed by clerical work and duties that could be delegated to nonprofessional personnel.

A part of Peterson's (1964) study of "Counseling in the Rehabilitation Process" was designed to determine how State agency counselors utilize their time in providing rehabilitation services to their clientele. From a sample of 26 counselors and 213 of their clients he reported the following analysis of how the counselors spent their time providing rehabilitation service to clients:

Activity area	Percent of clients who were recipients of the activity	Percent of counselor time spent in the activity
Administrative functions.....	99.5	26.5
Discussion with clients (counseling included).....	97.7	54.1
Arranging services.....	67.1	10.9
Obtaining information.....	7.5	.7
Consulting with others.....	13.2	4.1
Case record review.....	5.6	1.6
Testing.....	11.7	2.1

In summarizing the extent to which counseling was actually provided his sample of rehabilitation clients, Peterson (1964), states:

Counseling is provided as a service to clients by the State agency, however, the extent to which it is provided is limited in two ways: First, it is provided to less than half of the clients served by the agency; second, of those clients provided counseling, almost half of them received 50 minutes or less of actual counseling time. *Counselors spend more time with clients providing services other than counseling, than they do in providing counseling* (p. 131).

The findings of these two studies indicate that there is a wide difference between how the counselor actually utilizes his time and the *ideal* role or function of "counseling with disabled individuals." It appears that either the ideal or actual role of the counselor will need to change in order to eliminate the inconsistencies in his training and job description.

THE COUNSELOR IN SPECIAL SETTINGS

Another complicating factor in defining the rehabilitation counselor's occupational role is the trend for counselors to work in specialized settings. The rehabilitation counselors in these settings have unique problems in terms of their place and function. Two of the problems are: (1) An atypical population of clients, and (2) interprofessional conflicts. As examples of these, short discussions of the counselor working in a medical setting and of the counselor working toward the vocational rehabilitation of emotionally disabled clients are presented next.

The Rehabilitation Counselor in a Medical Setting

Aside from the problems encountered in working with a more severely disabled population of clients, the rehabilitation counselor in a medical setting is confronted with a sociological dilemma. The staff doctors, nurses, physical therapist, etc., with whom the counselor deals are primarily concerned with medical problems; yet it is the counselor's job to translate patient functioning into expected future vocational potential. While this division of professional responsibility appears logical, compatible, and desirable, the sociological structure of hospitals often can cause a conflict in establishing the role of the vocational counselor in the medical setting. In a discussion of the rehabilitation counselor in medical settings, Scott (1962) states:

* * * we would expect that all, or at least most, questions which arise regarding patients' needs in any particular

area would be decided by persons whose professional training best qualifies them to make judgments. Thus, just as a physician is best qualified to diagnose and treat the physical illnesses of a patient, the vocational counselor is best qualified to deal with the vocational problems of a patient. In effect, we would expect that the role, and hence the function, of vocational counseling would be defined primarily by those best qualified to judge—namely, the vocational counselors (p. 185).

However, Scott feels that the ideal situation described above is seldom realized. He holds that it is the physician and *not* the vocational counselor who has the major voice in defining the counselor's role. And he gives the following reasons for this circumstance:

- (1) The first factor is the referral system as it operates in hospitals. Its relevance lies in the fact that physicians, and not vocational counselors, make initial, and often times crucial, decisions, regarding patients' vocational needs. Thus the types of services which are in fact rendered by vocational counselors are partially a function of the kinds of vocational problems which filter through the physician to them (Scott, 1962, p. 186).
- (2) Vocational counselors may be called upon to tailor their programs to the physician's recommendations. * * * This "right of veto" does not stem directly from the referral system. * * * it has its roots in another aspect of traditional medicine. * * * the legal and moral responsibility which the physician assumes when he agrees to treat a patient. * * * The vocational counselor is thus at a structural disadvantage since he is not seeing his own patient but the patient of "Dr. X" (Scott, 1962, pp. 186-187).
- (3) Third * * * is the factor of status differences between the two disciplines. * * * The counselor's status is not as autonomous as it might be if he were interacting with other similar status professionals (Scott, 1962, p. 187).
- (4) Finally, there is a considerable discrepancy between the present state of knowledge in vocational counseling and the state of knowledge in medicine. Because of the relative youth of the former discipline, counselors must cautiously temper their activities to the limitations of their tools and knowledge. This tends to limit the degree of assertiveness which any particular counselor can show, since he would jeopardize his status if he were to overextend the range of his capabilities (Scott, 1962, pp. 187-188).

Even though the situation described above often exists, it is the counselor's responsibility to develop lines of communication and strategies that will permit him to deal effectively with the vocational problems of his clients within the existing structure. Role conflicts must not be allowed to divert his energies from client care. There are too many handicapped persons needing help for counselors and physicians to generate friction at the service level. In actual practice, the interprofessional rivalry is generally at the administrative and staff levels, and when the vocational counselors, physicians, social workers, nurses, etc., are confronted with a common problem of service to a handicapped individual they are generally able to devise a suitable means of dividing and sharing responsibilities.

The Counselor and the Emotionally Disabled Client

The vocational rehabilitation of mental hospital patients and individuals with an emotional disability has received increased emphasis over the past 5 years. In the period, from 1959 to 1966, the number of rehabilitation clients whose major disabling condition was psychosis or psychoneurosis has more than quadrupled—from 3,663 to 14,780.

Improved treatment methods; i.e., modern pharmacotherapy, the open hospital approach, the concept of the therapeutic community, along with other new psychiatric procedures, have made it possible for an increasing number of individuals to leave mental hospitals and to function adequately in the community. Their remaining in the community depends largely on their ability to function within the standards the community establishes for their behavior. Productive employment is one of the main requirements that is expected of an ex-mental patient. This requirement, when coupled with the therapeutic value of work, makes vocational rehabilitation services an important part of the emotionally disturbed client's total readjustment.

The vocational rehabilitation counselor is likely to be apprehensive about working with clients who have emotional disabilities. He may feel he does not have the skills necessary to cope with the problems inherent within psychiatric disorders, or perhaps his lack of understanding of emotionally disturbed individuals manifests itself as actual, although ungrounded, fear of these persons. Waldrop (1961) in answer to the question, "Is there really any difference in the vocational rehabilitation of the physically disabled and the emotionally disabled?" states that:

If we recognize the realities with which we are dealing, the answer is *no*. The basic concepts affecting each group, the basic sociological and psychological factors, and the basic methods and techniques are the same. What differences there may be lie in the application of these basic principles to the particular situation (p. 16).

Dr. Rives Chalmers (1961) outlines, as follows, the essential differences in vocational rehabilitation of the physically and mentally handicapped as seen by a psychiatrist:

Differences for the Client:

- (a) Diagnostic evaluation of the client is not as precise, and plans of service more difficult to formulate.
- (b) Prognosis is more difficult to evaluate because social variables have more crucial significance in the treatment process.
- (c) The client's motivation and cooperation are more significant in determining outcome of treatment.
- (d) The client has a major problem in interpersonal communication.
- (e) Cost and time required for adequate treatment is greater than for the usual physical handicap.
- (f) A major lack of adequate personnel and facilities for treatment.

Differences for the Counselors:

- (a) There is more personal involvement of feelings and attitudes in the counseling relationship.
- (b) Personal psychodynamics of the counselor are a more important influence on the client with an emotional disability.
- (c) Relationships with other significant persons (family, employer, etc.) are more difficult and potentially more frustrating.
- (d) Complete closure of case is more difficult.
- (e) Personal satisfaction with success is greater and more rewarding for the counselor.

Differences for the Community:

- (a) Social concepts of mental illness, psychiatric treatment, and bizarre thinking or behavior.
- (b) Family dynamics are more crucial to promoting or increasing the client's disability, and resistance of the family to the client's personal growth.
- (c) Employers caught between social and personal attitudes of their employees and their need for the client's services (p. 16).

Another difference is that counseling, guidance, and placement are the major services rather than the more traditional physical restoration and vocational training.

Waldrop (1961), points out that historically, the first function of the public mental hospital was to protect the community from disturbed individuals. The next chronological function was that of care rather than treatment, comfortable custody rather than restoration. These roles of the public mental hospital created a public image of psychiatric patients as chronically ill individuals. He further states that the effectiveness of vocational rehabilitation is reduced if it

adheres to the general public's attitude that the mental hospital should serve as a protection to society or a place to care for the mentally ill. A solution to the problems encountered in the vocational rehabilitation of emotionally handicapped individuals requires a positive and optimistic approach by individuals who can objectively deal with this type of disability.

As mentioned above, the essential differences in vocational rehabilitation between the physically disabled and the emotionally disturbed appear to lie in the application of casework procedures. There will need to be special techniques developed for work with the emotionally handicapped as was necessary for other disability groups such as the epileptic and the deaf.

COUNSELOR SALARIES

While this is not generally a professional problem, salaries will be discussed here because of the relationship between an individual's pay and the functions he can be expected to adequately perform. If a vocational rehabilitation counselor is required to have all the training and skills necessary to perform the duties previously discussed, he must receive a salary commensurate with his training and level of professional responsibility. Otherwise, professionally competent people will not be attracted to, or remain in, the field. And, considerations of an occupational role must take into account the abilities and training of the individuals who will be engaged in the activity.

A study by Porter, Crisler, and Megathlin (1967) indicates that:

Rehabilitation counselors' beginning salaries (excluding the traineeship positions) vary from \$4,773 a year in one agency to \$9,108 in another. The highest salary ranges from \$6,060 to \$16,380. The midpoint salary varies from \$5,581 to \$10,620. There seems to be no discernible relationship between salaries paid and qualifications required.

Neither does geography seem to be an important factor. The more wealthy States tend to pay higher salaries than the less wealthy, as compared by per capita income, but there are notable exceptions to this.

CONCLUSIONS REGARDING THE COUNSELOR'S ROLE

It seems the only conclusions that can be drawn regarding the rehabilitation counselors' occupational role are that they work: In many settings; at a wide

range of salaries; under differing State plans; for diverse administrations and administrators (whose training may range from Ph. D.'s in psychology to bachelor degrees in business administration). It may also be concluded that they are expected to do many different things in varying proportions within and between agencies and that opinions regarding what they should be doing are as divergent as the activities in which they are actually engaged. Generally, the counselor's role is a generic one and is determined locally, however, the training and skills of a professional counselor can best equip the rehabilitation counselor to perform optimally his prescribed occupational role.

TRENDS IN VOCATIONAL REHABILITATION COUNSELING

Evidence of the rapid expansion of the Federal-State vocational rehabilitation program has been presented in previous sections. Change is a concomitant of growth. This is proving to be especially true in the area of rehabilitation counseling; we can be sure that more clients will be served and provided services earlier in the rehabilitation process and that services will be extended to the more severely disabled and to special disability groups including the aged, the emotionally disturbed, and the mentally retarded.

Patterson (1962), discusses three distinct trends that he believes are present in the field of vocational rehabilitation counseling. These are:

- (1) *Specialization of services.*—"The specialization will be two kinds: First, there will be specialization within the rehabilitation process * * * secondly, counselors will specialize in the clients they serve, becoming experts in particular disability areas (p. 60)."
- (2) *Counselors will be working in varied settings.*—"There is growing recognition that every institution or hospital should have rehabilitation counseling services * * * This means that the counselor must adapt to new situations; new kinds of personnel. There is a need to define, or redefine, duties and functions in these situations, and for working out problems of overlap in services * * * (pp. 61-62)."
- (3) *Professionalization of rehabilitation counseling.*—This topic is discussed in detail in the section on The Rehabilitation Counselor as a Professional Person.

The exact implications that such legislation as the Manpower Development and Training Act, Youth Employment bill, Mental Illness and Mental Retardation bill, President's War on Poverty, Urban and Rural Community Action Programs, etc., will have for the Federal-State rehabilitation programs remains to be seen. However, the Federal Government's support of these programs to assist economically and otherwise oppressed citizens is indicative of a trend which could have far-reaching effects on the rehabilitation program and the counselor as we know them today.

SUPPORT PERSONNEL

Recent Federal legislation has created a greatly increased demand for rehabilitation counseling service. To make more efficient and effective use of the personnel who are now providing these services, a new group of nonprofessional positions have been developed. Under the supervision of the counselor, appropriately prepared support personnel will be able to contribute to meeting client needs.

APGA (1966) discussed guiding principles, preparation and typical activities of support personnel. A brief summary of this policy statement is given below. It should be noted that support personnel should not take the place or responsibility of the counselor. The counselor is responsible for incorporating all supporting activities into a meaningful pattern of services to the client.

- (1) Support personnel who wish to be upgraded must meet the academic and personal qualifications of counselors.
- (2) Counselors perform the counseling function while support personnel perform activities which contribute to the overall service.
- (3) Counselors synthesize and integrate services for clients.
- (4) The counselor bases his performance on the use of relevant theory, authoritative knowledge of effective procedures and evaluation of the total endeavor while the functions of the support personnel are characterized by more limited theoretical background and specialization in one or more support functions.

The preparation of support personnel varies according to the setting in which they will work and the duties they will perform. In general, preservice preparation is brief and should be supplemented with in-

service training; selection is based on suitability and potential competency; the preparation program must involve opportunities to work under the field supervision of counselors; and the staff for preparing support personnel should include experienced, highly successful support personnel, counselors, and counselor educators.

Typical activities of support personnel involve direct and indirect helping relationships but not in the sense of counseling as it is conducted by the counselor. In direct helping relationships, support personnel meet clients face to face to perform two functions; i.e., individual interviewing and small group interviewing within the limits set by counselors. In indirect helping relationships the support personnel usually do not deal face to face with clients but perform such functions as gathering and processing information and assisting with the mechanics of referral, placement, and followup.

The States of Wyoming and California have grants from VRA to study how well support personnel can be used in rural areas.

By way of summary, in any vocational rehabilitation program most authorities agree that the core of the rehabilitation counselor's work is *counseling*. He accomplishes this function by maintaining a counseling relationship which serves to unify all rehabilitation services into an organized plan resulting in the client's reaching a maximum adjustment from all aspects—social, medical, psychological, and vocational.

Among the most important functions of the counselor is to help the client acquire insight into his own capacities, attitudes, interests, and personal characteristics; to relate these to the requirements and possibilities of the occupational world, and to assist him to plan and carry through a program of services which will lead to a successful job adjustment. This level of understanding should be attained by every client to the degree that he is capable of doing so. Many clients do not have such initial insight, and the development of these insights through counseling for self-understanding and motivation is the unique contribution of the rehabilitation counselor. In some cases, the counselor by means of counseling techniques assists the client to modify basic attitudes that have resulted in social maladjustment, however, as pointed out by Lofquist (1959), this is not the essential duty of the rehabilitation counselor and he should be careful not to engage in counseling activities which are beyond his training and competencies.

The vocational rehabilitation counselor assumes

varying degrees of responsibility depending on his agency, his training, and the specialized type of service he can contribute in the different steps of vocational rehabilitation. In a State agency he functions most effectively as a professional person who integrates all services needed by the client for his rehabilitation, including those for which he arranges through purchase or referral.

The vocational rehabilitation counselor may have

to subordinate his own drives and desires in order to develop close cooperation with other members of the rehabilitation team. He should work closely with physicians; physical, occupational, and speech therapists; social workers; psychologists; nurses; teachers; and other team members; but must, at the same time, be cognizant of the fact that the focus of vocational rehabilitation should be on the client and not on the person doing the helping.

Section 19

THE REHABILITATION COUNSELOR AS A PROFESSIONAL PERSON

THE PROBLEMS related to establishing a professional role for the rehabilitation counselor were reviewed in the previous section. In this section various professional issues will be discussed; i.e., training, personal qualifications, inter-professional problems, professional growth, etc., all of which are involved in the establishment and maintenance of rehabilitation counseling as a profession.

DEVELOPING A PROFESSIONAL IMAGE

Over the past 45 years the State-Federal rehabilitation program has rehabilitated almost 2 million handicapped persons. It is significant that more than three-fourths of these have been rehabilitated since 1943, thus attesting to the recent accelerated growth of rehabilitation programs in the United States. The vast expansion of vocational rehabilitation in recent times has placed a spotlight on rehabilitation counseling as a profession. Public Law 565, passed by Congress in 1954, providing for the expansion of State-Federal programs, included funds for a training program for rehabilitation counselors. The momentum for professionalization of rehabilitation counseling was thus provided, bringing with it the difficult problems of determining the nature and extent of training, desirable personal characteristics of trainees, and the precise role of the rehabilitation counselor.

In developing the theme of the rehabilitation counselor as a professional person, an overview of historical antecedents of the present status of rehabilitation counseling will be presented. Then the opinions of authorities regarding the desirable personal and training requirements for rehabilitation counselors will be examined. Finally, problems of interprofessional relationships, ethics, and other pertinent problems facing the counselor in rehabilitation will be explored.

One means of charting the development of rehabilitation counseling as a profession is to view it in the larger context of recent expansion in the entire personnel field. Patterson (1958), comments on the large-scale professionalization of psychology as a recent development stimulated and accelerated by World War II. The dramatic change that has taken place in psychology from its early laboratory experimental and teaching focus to a profession with a large service responsibility is aptly illustrated in the data presented by Daniel (1953), which show an increase from 18 percent in 1916, to 56.7 percent in 1951 of nonteaching positions held by American Psychological Association members. Commensurate with this shift in focus was the tremendous numerical growth as revealed in figures showing an APA membership of 535 in 1926, as compared to a total in excess of 24,400 in 1966.

Hall and Warren (1956), refer to the expansion in the social services as a recent phenomenon in American life, wherein significant growth is felt to be a product of the enactment of relevant legislation at the State and Federal levels; of the leadership of industry and labor in fulfilling community responsibilities including obligation for employee welfare; and, in general, increased community understanding and acceptance of the need for such services. Rehabilitation has been in the forefront of this expansion in social services.

As previously indicated, perhaps the most prominent motivating factor in arousing public interest in restoring the handicapped individual to gainful employment was the Second World War. The pervasive impact of this event seemed to foster the development of a strong sense of public responsibility for the war injured, and the direct result of this public notice was the expansion of vocational rehabilitation programs for the disabled. Through the momentum of this movement, accelerated programs were initiated by the Veterans Administration and other governmental and voluntary agencies. This led to a significant increase in

rehabilitation facilities, a general expansion of a vocational rehabilitation program for civilians, and the need for more rehabilitation personnel.

In 1952, the task force on the handicapped listed the outstanding developments in rehabilitation for the preceding decade. A look at some of those developments provides a good overall picture of future trends. Their list of the major points included: (1) The vast increase in medical knowledge and improvement in medical care, (2) the remarkable progress made in the treatment of mental disease, (3) the rapid development of specialized rehabilitation centers, (4) the growth of the State-Federal programs of vocational rehabilitation, (5) the marked improvement in prosthetic and self-help devices, and (6) the increase in the number, size, and quality of voluntary organizations serving the handicapped.

It can be noted that the early objectives of rehabilitation which consisted in the main of protection, custodial care, and maintenance, were broadened in scope to encompass the fusion of the goals and skills of many different professions so that all might work together on the special needs of the handicapped person for the common end of his becoming a useful productive member of society. In a large sense, the movement was away from a fragmented approach to the individual and his rehabilitation needs, and towards a dynamic approach embracing an effective interchange of ideas among professional workers.

The modern concept of rehabilitation as a comprehensive service developed out of years of experience with handicapped persons and repeated demonstrations of the need for treating the whole patient (Wright, 1960). The efficacy of treatment of the client within his total life sphere by medical and nonmedical services in a comprehensive rehabilitation program has been tangibly demonstrated in the restoration of severely handicapped persons to independent and useful lives. It is this concept which is basic to the emergence of rehabilitation counseling as an accepted profession, for in it is encompassed a recognition of the principle that large expenditures of professional time and money are of little ultimate value unless implemented by a vocational plan that is in accord with the handicapped person's physical and mental condition (Lofquist, 1959). In such a process, the rehabilitation counselor is called upon to perform the crucial task of helping the individual make the best use of his positive vocational aspects in order that he might achieve a good vocational adjustment.

The concept of the rehabilitation team conveys the idea of a cooperative effort by a number of profes-

sional workers in rehabilitation working toward a common goal; i.e., maximum rehabilitation of a handicapped person. The rehabilitation counselor is now on the team as a full-fledged member. Acceptance as a member of the rehabilitation team has come, ironically, at a critical period when many people are becoming weary of the naive perception of the team concept as a "cure-all" for every rehabilitation problem. Yet, there exists a clear challenge for the rehabilitation counselor to demonstrate that he, as holds true for other team members, can offer something unique and substantial to the solution of the handicapped person's problems.

THE TRAINING OF THE REHABILITATION COUNSELOR

The realization of a need for trained rehabilitation counselors to work with the handicapped is reflected in the Vocational Rehabilitation Act of 1954 (Public Law 83-565). This act authorized the Vocational Rehabilitation Administration to encourage and support the development of counselor training programs in universities to provide for the graduate training of rehabilitation counselors. By 1957, more than 30 universities had developed graduate programs in rehabilitation counseling, and in 1966, 41 programs were in actual operation while 16 more were in various stages of curriculum planning and recruitment of students. In 1966, of the total \$24,800,000 appropriation for training rehabilitation personnel, the share accorded to the training of rehabilitation counselors was exceeded only by the share given to rehabilitation physicians.

There are wide variations in viewpoints among professional rehabilitation workers as to just what should constitute desirable knowledge and skills for the counselor. Whitten (1954), observed that when Public Law 83-565 was passed there were no generally acknowledged criteria for evaluating the qualifications for a rehabilitation counselor. This was not true of other disciplines engaged in rehabilitation; unlike the rehabilitation counselor, most other professional workers in rehabilitation had approved schools, established curriculums, and general standards by which a determination of qualifications of a person to perform the functions of the profession he represented could be made.

As pointed out in the previous sections, there are disagreements regarding whether the counselor should

be trained primarily as a "counselor" or a "coordinator." The opinions expressed in the literature regarding the proper training for rehabilitation counselors exemplify this dichotomy.

McDonald (1944), made a thorough study of the State-Federal legislative program in rehabilitation through the 1943 amendments to the Vocational Rehabilitation Act. As a part of her study, she analyzed the personnel standards and qualifications for those employed in the program. She found that the tendency had been to select personnel from the field of education rather than from areas which focus on the adjustment problems of the individual. It was McDonald's opinion that the work of vocational rehabilitation is primarily a complex application of social casework. She feels a person could not prepare in all the specialties demanded in this work, and that the basic preparation should be in casework, with consultants filling in the other specialized areas.

More recently Hahn (1954), suggests that the counselor's training should be divided into four areas: (1) Psychological training, 40 to 50 percent of the curriculum, (2) social casework, 30 to 40 percent, (3) medicine, 10 percent, and (4) contributing areas 5 to 10 percent.

Patterson (1957), feels that the training time of rehabilitation counselor trainees would be more profitably used by concentrating in the psychological area in order to make them better counselors, rather than half-trained social workers. (The review of the opinions presented in the previous section regarding the rehabilitation counselor's occupational role is also applicable to considerations of his training.)

In the years following the passage of Public Law 83-565, considerable effort has been made toward clarifying the problem of suitable criteria for evaluating the job of rehabilitation counselors; nevertheless, we still see a general lack of agreement among persons in rehabilitation regarding the precise ingredients of desirable training, and, as a consequence, the particular profession with which rehabilitation counseling is to form primary identification. However, there are data available which tend to indicate some positive movement and suggest significant long-term trends.

One indication of the course that the training of rehabilitation counselors is going to take may be found in the professional identification of the coordinators of the university rehabilitation counselor training programs. A report by the American Psychological Association's Division of Counseling Psychology (1963), entitled "The Role of Psychology in the Preparation of Rehabilitation Counselors" indicates that 85 percent of

directors of the rehabilitation counselor training programs received their graduate training in an area of psychology. Nearly 90 percent of these directors hold a doctorate degree.

The professional identification of the directors is reflected in their professional affiliations. Table 5 below shows the percentage of the directors (N=31) who are members of the National Rehabilitation Association (NRA), American Psychological Association (APA), American Personnel and Guidance Association (APGA), and of divisions within these organizations:

TABLE 5.—The professional affiliations of the directors of rehabilitation counselor training programs

Organization	Percent of directors (N=31) that are members
1. NRA.....	90
2. APA.....	74
(a) Division 17—Counseling psychology.....	55
(b) Division 22—Psychological aspects of disability.....	64.5
(c) Other APA divisions.....	25
3. APGA.....	94
(a) American Rehabilitation Counselor Association.....	90
(b) National Vocational Guidance Association.....	49
(c) Other APGA divisions.....	22

Therefore, by the training and professional identification of the directors of the counselor training programs it appears that the training programs are emphasizing a psychological and/or counselor oriented curriculums. In fact, this same report indicates that *all* of the counselor training programs have curriculums that consist of between 40- and 100-percent psychology courses.

In 1955, the Vocational Rehabilitation Administration provided funds for a 1-week workshop at the University of Virginia (the Charlottesville Workshop) to study and make recommendations regarding rehabilitation counselor preparation. The proceedings of this workshop were edited by Hall and Warren (1956, p. 25) and published jointly by the National Rehabilitation Association and the National Vocational Guidance Association. In an outline of the areas of content essential to the professional education of the rehabilitation counselor the following were listed:

- An Introduction to Rehabilitation.
- Legislative Aspects of Rehabilitation.
- Human Development and Behavior.
- Medical Aspects of Rehabilitation.
- Cultural and Psychosocial Aspects of Disability.
- Psychological Evaluation.
- Counseling Techniques.

Occupational and Educational Information.
Community Resources.
Placement and Followup.
Research and Statistics.
Supervised Experience.

The area of knowledge and skill suggested were not considered complete, nor was it intended that they indicate specific course titles or the specific disciplines from which they might be drawn. These matters, as well as sequence, length of curriculum, and other requirements were considered to be in the province of the administration responsible for the training program. This report represents the "traditional" approach to counselor training.

PROFESSIONAL ORGANIZATIONS AND TRAINING RECOMMENDATIONS

Another indication of the direction that rehabilitation counselor training will take may be found in the membership requirements and training recommendations of the professional organizations that rehabilitation counselors belong to. These materials will be presented in the following manner: First there will be a general overview of the organization; second, a review of their membership requirements; and then, an outline of their training recommendations and/or suggested job requirements.

NRA's National Rehabilitation Counseling Association

The National Rehabilitation Counseling Association (formerly called the Rehabilitation Counseling Division), is a professional division of the National Rehabilitation Association. By 1966, NRCA had grown to more than 3,630 members since its organization in October 1958. Approximately 98 percent of those eligible in NRA are now members of NRCA. On January 1, 1965, NRCA activated a basic program of professional standards and membership certification which is outlined below.

The NRCA has as its *purpose* the advancement of the role and function of counseling services in the rehabilitation of all handicapped people. In unity with comparable activities and interests of other helping professions, the division is engaged in a program to—

- (1) increase public understanding of the role of the rehabilitation counselor and all counseling services;

- (2) promote the highest ethical practices in rehabilitation counseling;
- (3) identify, develop, establish, and regulate basic standards for the rehabilitation counselor and for rehabilitation counseling services;
- (4) encourage graduate training for all members;
- (5) promote the development of graduate schools of rehabilitation counseling and of curriculums and training directly related to the needs of handicapped people;
- (6) promote research in the multiple areas of rehabilitation and rehabilitation counseling and training as they serve to contribute to the benefit of handicapped people;
- (7) maintain wholesome relationships, between all rehabilitation and related agencies;
- (8) develop forums and meetings where those engaged in rehabilitation counseling can meet to exchange ideas and discuss mutual interests and needs; and
- (9) encourage the professional self-regulation of rehabilitation counselors through the administration of a program of professional standards and certification.

Beginning with the membership year January 1, 1965, the following requirement for membership classifications apply to all applicants:

(a) *Professional Member*.—A Professional Member of NRCA shall have a minimum of a master's degree in rehabilitation counseling, with a minimum of 1 year of experience in a rehabilitation counseling setting; or a master's degree appropriate to rehabilitation counseling, administration, supervision, research, or training, with a minimum of 2 years' experience in a rehabilitation counseling setting.

(b) *Associate Member*.—An Associate Member of NRCA shall have a minimum of a baccalaureate degree from an accredited college, with employment in a rehabilitation counseling setting.

(c) *Student Member*.—A Student Member of NRCA shall be enrolled in an accredited college in a curriculum leading to a graduate degree in rehabilitation counseling or a related field.

In a discussion of "The Rehabilitation Counselor—What He Is and Does," the RCD Professional Bulletin (1963) states:

Effective rehabilitation requires individualized, comprehensive, and integrated professional services. Rendering such services for an individual requires skillful rehabilitation counseling in the evaluation of client needs, the definition of goals, and the implementation and integration of all professional and other services into a total plan for the achievement of these goals. In order to implement a total plan for rehabilitation, any rehabilitation counselor who accepts responsibility for counseling the handicapped must be the essential tie between the individual and various other professions and agencies that render services to the handicapped person.

The knowledge, abilities, and skills needed by the rehabilitation counselor in order to be of optimum service to handicapped individuals require a high level of professional training and well-supervised experience.

Rehabilitation counselors perform in any setting in which they may assist disabled clients in moving to goals of self-realization and a productive life. Specific functions and practices of the rehabilitation counselor may vary, depending upon the setting in which he works. In general, the following reflect "The Rehabilitation Counselor—What He Is and Does":

A. Who is he?

1. He is a person capable of, and continuously applying himself to, studying and gaining understanding of behaviors of individuals and society as they interact from the impact of disability.

2. He is a person capable of practicing skills that use the client-rehabilitation counselor relationship to help the client develop and realize suitable goals.

3. He is a person whose proficiency will demand his knowledge and skills in the areas of economics, business administration, labor market information, job analysis (from the view of physical, mental, and emotional requirements), labor-management relations, legal and regulatory requirements for employment, and vocational counseling—in addition to medical information and community organization.

4. He is a person whose knowledge, in addition to that of behavior dynamics, must include knowledge *in depth* of the world of work, and his skills in applying it to meet the needs of the disabled must be so effective that he can claim this sphere of function as his and that of no other professional.

B. How does he function in practice?

1. With the disabling client (rehabilitation counseling and casework), the rehabilitation counselor—

- (a) communicates with the client to assist him directly in achieving optimum self-realization;
- (b) shares knowledge of resources that can help the disabled person meet his needs in movement to self-realization;
- (c) helps the disabled person determine his assets and limitations in his path to self-realization; and
- (d) plans use of services and resources and assists in implementing such plans.

2. With others, the rehabilitation counselor—

- (a) works with other professionals in helping the client move toward maximum adjustment;
- (b) develops and sustains a community climate to support the disabled client in his movement to goals for self-realization; and
- (c) coordinates and integrates services of others in the planned process to help the client move to his maximum potential.

3. Within agency structure, the rehabilitation counselor —

- (a) carries out policy and applies standards for services to his client;
- (b) assumes responsibility for evaluating the effectiveness of policy and standards in supporting objectives for service to clients; and
- (c) stimulates and promotes changes and revisions of policy and standards for improved services through recommendations to administrative personnel.

American Personnel and Guidance Association

The purposes of the American Personnel and Guidance Association (APGA) are stated in its constitution (1961). They include: (1) To advance the scientific discipline of personnel and guidance work, (2) to conduct and foster programs of education in the field of personnel and guidance, and (3) to promote sound personnel and guidance practices in the interest of society.

The membership requirements of APGA (1961) are:

An individual member in good standing is a person whose primary responsibilities or interests are in the area of guidance, counseling, or personnel work and whose preparation or position is such as to qualify him for membership, as defined in the bylaws, in one of the Divisions of the Association (p. 318). (The membership requirements for the American Rehabilitation Counselor Association, an APGA Division, will be presented later.)

A report of the APGA Committee on Professional Preparation and Standards (1964), lists the following recommendations for counselor preparation:

1. Counselor education should be designed to achieve carefully formulated goals based on a philosophy which reflects the highest level of professional knowledge and social concepts.

2. The counselor education staff should be concerned with the task of continually evaluating the program and searching for more adequate methods of counselor preparation. The curriculum should be sufficiently flexible and dynamic to permit revisions and adjustment as required by increasing professional knowledge or by changes in the professional knowledge or by change in the professional responsibilities of counselors.

3. The curriculum of the counselor education program should assure that essential content and experiences are included in each candidate's program, should provide increasingly for integration of learning, and should avoid duplication of content. Each candidate's program of courses should constitute a planned sequence spiraling toward progressively more advanced work. Programs should recognize individual differences among counselor candidates (their ability, goals, educational background, and experience), and should challenge each person individually.

4. Counselor education should provide experiences which are planned to contribute to the counselor candidate's growth in self-understanding.

5. The counselor education program should assure that each counselor candidate has a background (undergraduate or graduate) in the humanities and in the social, behavioral, and biological sciences that helps him understand individuals, their behavior and adjustments; the nature of the environment and its impact on the individual, including the forces that affect his personal and vocational life; and the counselor's role in a changing culture.

6. There should be provisions to promote the integration of studies in related disciplines with the professional studies in counseling in such a manner that these related studies will

make meaningful contributions to the competence of the counselor.

7. The program should provide for such specialized study related to the setting in which the counselor will work as is needed to enable him to function effectively within that employment environment and to perform such duties in addition to counseling as may be an appropriate part of his professional role.

8. There should be a year-round program of counselor preparation that makes possible full-time graduate study. There also should be opportunities for additional continuing education of practicing counselors.

9. A program of counselor preparation which would meet the principles listed above as well as provide the professional studies described below would consist of a minimum of 2 years of graduate study, a substantial portion of which should be in full-time graduate study (p. 539).

The American Rehabilitation Counseling Association

The American Rehabilitation Counseling Association (ARCA) is a division of APGA. The purpose of the organization is to advance rehabilitation as a profession—

- (a) by providing close personal and professional relationships among professional rehabilitation counselors;
- (b) by encouraging and promoting research and the dissemination of the results thereof;
- (c) by establishing collaboration with other national and professional organizations engaged in rehabilitation work;
- (d) by formulating and fostering the maintenance of standards among rehabilitation counselors; and
- (e) by exercising leadership in developing the science and the profession of rehabilitation counseling.

ARCA has two classes of membership, professional and associate, which are defined as follows:

- (a) *Professional*: Professional membership in this organization shall be open to persons who present acceptable qualifications including:
 - (1) Minimum of a master's degree appropriate to rehabilitation counseling from a recognized college or university (or, for a period of 2 years from the date of the adoption of this constitution, equivalent education and experience as determined by the membership committee).
 - (2) Appropriate experience and devotion of at least one-half time to any aspect of reha-

bilitation counseling, such as teaching, administration, research, or service.

- (b) *Associate*: Associate membership in the organization shall be open to persons who present acceptable qualifications including:
 - (1) Minimum of a bachelor's degree from a recognized college or university.
 - (2) Employment of at least one-half time in any aspect of rehabilitation counseling such as teaching, administration, research, service, or training and placement; or, are enrolled in a recognized graduate program preparing them for work in rehabilitation counseling.

As mentioned earlier, APGA has left to its divisions the task of spelling out the standards for the preparation of counselors in the various *settings* particular to the counselors they represent. ARCA and the National Vocational Guidance Association (NVGA), on the assumption that there is much in common among counselors working in nonschool settings, decided to pool their efforts and develop a single set of standards. These standards are to be considered applicable to counselors in public and private agencies and institutions, such as State employment services, rehabilitation centers, sheltered workshops, etc. In a preliminary report of the ARCA-NVGA standards committee they state the following regarding counselor preparation:

Goals and Objectives.—The objective of professional education is not training for a specific job or position but for general competency which will qualify the individual for entrance in and ongoing competency in professional activities. Education should be process oriented and, as such, it never ends. Therefore, a professional curriculum is concerned with inculcating methods and habits of continuous learning, in the promoting of professional attitudes and identification, and a critical, questioning, and exploratory attitude. Knowledge and skills are requisite foundations, but not sufficient for the assumption of professional responsibilities.

An essential aspect of education for the counseling profession is the inculcation of a belief in and respect for the rights, abilities, and desires of others consistent with the democratic philosophy which pervades our society.

Level and Nature of the Curriculum.—An adequate curriculum of counselor preparation should meet the following requirements:

- 1. Counselor preparation is graduate level work. Paramount is the development of an understanding and acceptance of the philosophy, psychological principles, and theory that are the foundations of counseling. Techniques and skills are operations deduced from this broader base.
- 2. Two years of study, a substantial part of which is on a full-time basis, is necessary for adequate preparation in counseling.
- 3. While the program may be adapted to differing backgrounds and individual differences among students, there is a

well-defined and patterned sequence of courses fundamental to preparing a professional counselor.

4. The curriculum should include the following elements:
 - (a) The foundations of human behavior and methods of behavior change.
 - (b) Social-cultural-economic factors influencing individuals and groups.
 - (c) Professional studies in counseling—
 - (1) philosophy and fundamental assumptions in counseling services;
 - (2) counseling theory and practice;
 - (3) group approach to counseling; and
 - (4) supervised experience in counseling (see below).
 - (d) Vocational psychology, or the psychology of vocational development, and the social-environmental information necessary for vocational choice.
 - (e) Psychological appraisal by means of tests and other methods of evaluation and measurement, including the requisite statistics.
 - (f) Specific preparation for the setting in which the counselor will work. This will include material related to the agency or agencies and their programs, the community setting and its resources, the types of clients and their special characteristics, needs and problems. For the rehabilitation counselor this will include the physical (medical) and psychological aspects of disability as well as an understanding of the nature and organization of rehabilitation services to the individual. Counselors preparing for employment in community agencies dealing with the socially underprivileged or handicapped and the occupationally displaced adult will need special preparation for understanding and working with these clients, including social provisions for unemployment, retraining, and placement.
 - (g) While there may be no specific courses dealing with the general personal and professional development of the counselor candidate, there should be opportunity, both formal and informal for the candidate to—
 - (1) develop in self-understanding, including opportunity for personal counseling;
 - (2) understand, observe, or participate in research studies or activities;
 - (3) engage in independent or advanced study in areas of special interest; and
 - (4) integrate the various aspects of the curriculum, including theory and practice.

The American Psychological Association

The American Psychological Association (APA) states as its objective, “* * * to advance psychology as a science and as a means of promoting human welfare by the encouragement of psychology in all its branches in the broadest and most liberal manner” (Bylaws, 1960).

Most of the members of APA hold a doctoral degree in psychology or in a related area, however, the Association does have an Associate Member status for individuals with a master's degree in psychology

who are doing work that is primarily psychological in nature.

APA's Division of Counseling Psychology (1963), prepared a report entitled “The Role of Psychology in the Preparation of Rehabilitation Counselors.” Their introductory statement reads:

Rehabilitation counseling as a professional activity is a recent addition to the counseling family. Although vocational rehabilitation services have been available to veterans and civilians since World War I, there was little professional development until after 1945. The VR&E and hospital counseling programs of the Veterans Administration gave impetus to the professional growth of rehabilitation counseling. Until the initiation of the counseling psychology program in 1952 in the VA and the inception of substantial Federal support of rehabilitation counselor training by the Vocational Rehabilitation Administration (then OVR) few people entering this field could have a formal pattern of preparation to follow or any unique professional affiliation. With the advent of rehabilitation counselor training programs in more than 30 universities over the country and the development of two professional groups, the American Rehabilitation Counseling Association and the Rehabilitation Counseling Division of the National Rehabilitation Association, especially concerned with the professional problems of rehabilitation counseling, we have approached a level of formal requirements and organization in this field which reflects a new but growing profession. Since rehabilitation counselors are concerned with working with people in a professional counseling relationship, and since psychology has been generally accepted by rehabilitation counselor educators as the core science underlining this field, it is of concern to psychology and particularly the Division of Counseling Psychology of APA to make explicit its views regarding principles and psychological content in the preparation of rehabilitation counselors (p. 1).

This same report contains the following recommendations for the preparation in psychology of rehabilitation counselors:

Rehabilitation counseling, like all fields of counseling, finds its basic tenets and rationale in the discipline of psychology. As in the training for any profession, it is important that the student of vocational rehabilitation be given a thorough background in the basic scientific principles which form the base of his practice and that he not rely on practice of a restricted set of skills. Such scientific training provides the background for new insights, flexibility, and resourcefulness in practice. Thus, the training of vocational counselors should include courses in the theoretical and empirical aspects of psychology as well as courses concerned with the practice of the profession.

A. *Basic.*—Basic preparation in psychology should consist of upper level undergraduate and graduate courses, based upon the introductory course in general psychology and educational psychology. Areas of study should include:

1. *Developmental Psychology:*

- (a) The concept and principles of development.
- (b) The nature of development during the lifespan.

(c) The nature and extent of individual differences in development and at various stages of development.

2. *Personality:*

- (a) Survey of theories of personality.
- (b) Mental hygiene and abnormalities of behavior.

3. *Learning and Behavior Change:*

- (a) Processes of behavior modification.
- (b) Theories and principles of learning and motivation.

4. *Social Psychology:*

- (a) The structure and behavior of groups.
- (b) The effects of group membership on an individual's attitudes and behavior.
- (c) Social class structure, occupational mobility, and its effect on the individual's attitudes and behavior.

B. Professional.—In the teaching of this area, the content should be related to the basic scientific materials from which it derives:

1. *Vocational Psychology:*

- (a) Relationship between demands of the occupation and the characteristics of the individual.
- (b) Occupational and education information.
- (c) Vocational development, vocational choice, and vocational adjustment.

2. *Psychological Appraisal:*

- (a) Principles of measurement.
- (b) Study of techniques, including standardized tests, questionnaires, and interviews with emphasis on their validity, development, and appropriateness for—
 - (1) assessment of intellectual level, special aptitudes, and achievements;
 - (2) evaluation of vocational interests;
 - (3) assessment of personal adjustment; and
 - (4) biographical assessment.
- (c) Integration of data.

3. *Psychology of Counseling:*

- (a) Theories of counseling and their relationship to theories of personality.
- (b) Study of techniques and methods used in the counseling interview with some emphasis on relationship of techniques to counseling theory.
- (c) Relationship of counseling techniques to goals of client; educational and vocational decisionmaking, and personal and social adjustment.
- (d) Group procedures.
- (e) Evaluation of outcomes of counseling.
- (f) Professional relationships and ethics.

4. *Psychology of Disability:*

- (a) Psychological aspects of disability.
- (b) Social psychology of disabilities.
- (c) Interrelationships of physical and social aspects—somatopsychology.

5. *Supervised Practice in Counseling:*

- (a) Laboratory experiences.
- (b) Practicum experience (one semester minimum).
- (c) Field or internship experience (500 hours minimum).

C. Interdisciplinary (including psychology).—

1. *Statistics:* Application to psychological problems.
2. *Medical Information:* Essential to an understanding of the vocational rehabilitation of an individual with physical and emotional disabilities.
3. *Social agency structure and functions* (pp. 5-7).

Recommendations from both APA and ARCA suggest a 2-year graduate program which would prepare the rehabilitation counselor to be a Counselor. These recommendations are very similar to the ones these organizations made for the preparation of school counselors. Therefore it appears that these recommendations represent what APA and APGA feel are minimum requirements for a master's degree level counselor in any setting.

APA has a division entitled Psychological Aspects of Disability (Division 22) for members interested in the effects of disability on an individual's total adjustment. This Division has made no training recommendations for rehabilitation counselors. Their primary interest is in the area of basic and applied research.

The Joint Liaison Committee

The Joint Liaison Committee, which is made up of both the Council of State Directors of Vocational Rehabilitation and of the Rehabilitation Counselor Educators, was formally inaugurated in 1960. One of the priority topics the committee agreed upon was curriculum development. In their first published report, "Guidelines for Supervised Clinical Practice" (JLC, 1963), they list the following course/areas as prerequisites to supervised clinical practice.

Counseling, Principles, and Techniques;
Occupational Information;
Principles and Techniques of Assessment;
Dynamics of Human Behavior;
Community Organization;
Survey of Vocational Rehabilitation;
Statistics;
Social Psychology;
Psychosocial Aspects of Disability;
Medical Information;
Practicum in Evaluating and Counseling People
With Disabling Conditions;
Psychology of the Handicapped;
Psychology of Personality;
Research Methods.

Current Training Problems

In spite of the apparent trend toward training the rehabilitation counselor as a psychological practitioner,

in the final analysis it is the State directors and field supervisors who determine what the counselor's occupational role will be.

Rusalem (1963), states that until recently rehabilitation counseling lacked a substantial body of knowledge and skill of its own, and that it has grown up in the "balmy climate of interdisciplinary borrowing." He raises some pertinent questions in regard to this situation. Parts of his discussion appear below:

I am concerned with the attitudes of rehabilitation counseling trainees, the public image of rehabilitation counseling, and the question of whether we are really a profession. Rehabilitation counseling students who undertake a curriculum that is studded with unrelated courses, many of them borrowed from other departments, schools, and professions, have identity problems. A schoolteacher has a firm professional image, reinforced, in part, by State certification requirements and posed of sequences of experiences with a school of education. On the other hand, the rehabilitation counseling student may wander through the thickets of medicine, psychology, social work, teaching, and others. When he completes the program, is he a product of a well-organized curriculum embodying a "discipline" or a victim of a set of disparate experiences borrowed from good neighbors? (p. 33).

Have we been deluded by the ideal of interdisciplinary relationships to the point of "watering down" our own profession and our own training programs? I have watched some training institutions scramble around like mad to line up cooperation with other university departments to fulfill the pressures put upon them by fund-granting agencies. Is there inherent goodness in this procedure? Does it insure a stronger rehabilitation counseling program? Or does it impoverish the new profession and underscore its immaturity? (p. 34).

A firm answer to the question of the proper training of rehabilitation counselors remains to be found. There will have to be greater agreement on the counselor's actual function and role in the rehabilitation process, before the university counselor training programs can devise an accepted core curriculum which will meet his needs on the job.

Personal Qualifications

Desirable qualities for counselors have been enumerated in a number of recent publications in the field of counseling. If we view counseling as a single, unitary process, these desirable qualities become applicable to the question of counseling with the handicapped; i.e., to rehabilitation counseling. Generally speaking, qualifications are broad and inclusive, so much so that we might say they could better be considered indicative of a capacity to define counseling. Patterson (1958), in commenting on such lists, points

to the fact that desired attributes include ideal characteristics for counselors and as such are not phrased in a way that is operationally meaningful. Nonetheless, these lists have some merit and several are presented below.

The Vocational Rehabilitation Administration lists the following desirable qualities: Pleasing appearance and personality, flexibility and adaptability, physical stamina, capacity to recognize and deal with the problems of individuals, interest in and understanding of the problems of the disabled, imagination, resourcefulness, and initiative in meeting problem situations.

The "Charlottesville Workshop" (Hall and Warren, 1956), offers a rather imposing list of 14 personal characteristics that are considered desirable for the rehabilitation counselor. A partial listing of these would include: Sensitivity to rights and feelings of others, strong interest in fellow human beings, emotional poise, optimism, confidence in the humanitarianism of people, creativity, imagination, sound judgment, emotional maturity, flexibility, culture, capacity for organization, and intellectual capabilities.

In examining such lists of desirable personal characteristics for rehabilitation counselors, it becomes clear that rehabilitation counseling demands more of a person than many occupations. Good academic ability, emotional sensitivity, sound judgment, maturity, and stability, all are factors which, ideally, the counselor should possess and all affect the quality of the counseling relationship, whether the counseling is performed in a rehabilitation agency or in any other professional setting. Since individual counselors do vary in the extent to which these factors are present in their personality makeup, varying degrees of proficiency among rehabilitation counselors in the performance of different facets of their jobs may be expected. A counselor need only look (acceptingly) among his colleagues in rehabilitation in order to verify the existence of vast individual differences in the degree to which the various desirable personal qualifications are to be found among rehabilitation counselors.

Patterson (1962) studied psychometric information on approximately 550 students enrolled in graduate work in rehabilitation counseling in 20 colleges and universities, from fall 1956 through spring 1959. The battery of tests utilized consisted of: (1) A test of information and verbal reasoning, (2) two personality tests, (3) an inventory of vocational interests, and (4) a test to measure empathy. The conclusions of the study were:

* * * those individuals entering rehabilitation counseling through the training programs established under OVR grants

compare favorably with other counseling students and show characteristics that should lead to their development into capable counselors (p. 16).

The Status of Rehabilitation Counseling as a Profession

Rehabilitation as an established area of skills and techniques has created the need for professionalization of rehabilitation counseling, and has caused the upgrading of counselors in State rehabilitation agencies, and has coincided remarkably well with the raising of training requirements for VA vocational counselors. VRA has met the problem squarely through sponsoring graduate level training programs for rehabilitation counselors. There are strong indications that the credo "counseling is the core of the rehabilitation process" has been accepted in fact, as well as in principle, by rehabilitation leaders.

Patterson (1962) related the professionalization of rehabilitation counselors to the criteria of a profession as listed by Wrenn and Darley (1949). He stated the following criteria:

1. First is the performance of a socially needed function. There is now no question of the need for rehabilitation counseling. Society has, through its government agencies, given us a mandate to fulfill this need.

2. The definition of job titles and functions. The title rehabilitation counselor is now established and generally accepted. There is a DOT code number for the position. While there may still be lack of unanimity about all the functions of a rehabilitation counselor, it is becoming increasingly accepted that his major and most professional function is counseling * * * The one thing which the rehabilitation counselor does that other workers in rehabilitation do not do, and cannot do because of its professional nature, is counseling. The building of the rehabilitation counselor's job around the counseling function is thus fostering the professionalization of his functions.

3. A third criterion is the existence of a body of knowledge and skills. While some would feel that this body of knowledge and skills of the rehabilitation counselor consists in knowledge of disabilities and special skills in working with the disabled, and thus would claim that rehabilitation counseling differs from counseling in general, or is unique in this respect, this would seem to be a mistaken approach to professionalization. Other workers in rehabilitation share this knowledge and these skills, so that the rehabilitation counselor is not unique among them in this respect. Rather, as indicated above, the rehabilitation counselor is unique in rehabilitation in the possession of knowledge and skill in counseling. The sharing of this with other counselors, rather than weakening his professional position, strengthens it, since he can share the gains in professionalization of counseling as a whole.

4. A fourth characteristic of a profession is the application of standards of selection and training. Here also there is

evidence of progress. Selection constitutes a problem, as it does in all professions, and I have dealt with this in detail elsewhere (3). In the area of training, we now have established graduate programs. There is general agreement on the basic content of the training. The problem for the future is similar to that of other professional training programs—the incorporation into a time-limited program of as much desirable content as possible. We must recognize that it is impossible to include everything that is desirable, or everything that everyone thinks is relevant or desirable.

5. A fifth characteristic of a profession is the self-imposition of standards of admission to practice and of professional performance. In this area we are just beginning. But there are groups at work on the development of professional standards. The existence of an accepted training program provides a base for admission requirements.

6. A sixth characteristic of a profession is the development of professional consciousness and professional groups. This is something that perhaps must precede most of the other characteristics of a profession. There is no question but that there is now a strong professional consciousness among rehabilitation counselors. The establishment and rapid growth of the Rehabilitation Counseling Division of NRA and the Division of Rehabilitation Counseling of APGA are sufficient evidence of this consciousness.

7. Seventh is the development of a code of ethics. This also is an area in which, although no final product has been achieved, there is much activity. A code of ethics was adopted by the APGA in Denver in March 1961, which provides a basis for a general code for counselors, including rehabilitation counselors. The Rehabilitation Counseling Division of NRA has a committee working on a code of ethics specifically for rehabilitation counselors.

8. Finally, a profession ultimately acquires legal recognition, by certification or licensing of practitioners. It is too early to expect such progress in this area, but there has been some thought given to achieving this goal. One State (Oklahoma) already has a certification procedure (p. 63-65).

The problem of professionalization of rehabilitation counseling may be evaluated in terms of the larger issue involving the evaluation of the status of professional workers in general. Caplow (1954), describing the process of professionalization of an occupation, demonstrates that the steps in the process may be clearly identified. This is depicted in the analysis of professionalization of newspaper reporters (journalists), real estate agents (realtors), undertakers (morticians), junk dealers (salvage consultants), and laboratory technicians (medical technologists). Caplow observes that, as the new profession emerges it attempts to "take on the functions of the group just above, which it aspires to, and slough off the unwanted tasks to those below" (1954). In rehabilitation counseling we may find an analogous situation in the tendency for rehabilitation counselors to look disdainfully upon such functions as job placement, public relations activities, quota requirements, and clerical duties, while such functions as treating, testing, counseling, case writing

and research (functions of the counseling psychologists) become viewed as desirable, high-status activities.

Both Wrenn (1949), and Mueller (1959), state that personnel work as an emerging profession must justify its claim to certain duties and skills which are not already in the possession of other professions or the general public. The principle also applies to the question of professionalization in rehabilitation counseling. Realistic objectives and standards for rehabilitation counselors need to be formulated in such a manner as to promote professional efficiency, security, and prestige. In rehabilitation counseling, there is a pressing need for control of any unjustifiable pretentiousness regarding benefits to be accrued from the counseling relationship. Related to this is a need to gear the objectives of the rehabilitation process to the training and skills of the individual counselor.

Pertinent to the issue of professionalization is the evaluation by Lofquist (1959), of the prevalent tendency for counselors in rehabilitation to disassociate themselves from the term "vocational counselor" in favor of the higher status term "psychological counselor". He notes that a number of prestige terms tend to be used as a crutch for the counselor in building up his security; e.g., "self-concept," "body image," "whole person," "self-actualization," "dynamic process," "psychotherapeutic techniques." Lofquist recommends a clearer delineation of functions in rehabilitation counseling which would help the counselor to operate ethically and confidently. It is concluded that the mastery of vocational planning by the rehabilitation counselor supersedes other functions, and that the task is sufficiently complex to require the full-time attention of the counselor. Functions which involve a different orientation such as therapeutic counseling or clinical counseling are better left to the psychiatrist or counseling and clinical psychologists.

In a discussion of the development of a professional self-concept by the rehabilitation counselor, Newman (1960) makes the following observations:

What distinguishes the rehabilitation counselor from the members of other helping professions is the focus of his work, not its level, or quality, or intensity. The failure of the counselor to understand and accept for himself that the vocational focus is a proper, valuable, and professional area of concern underlies the general lack of a professional self-concept.

It is suggested that the counselor's own middle class values and attitudes toward work intrude into his professional image. His own striving to move upward in the professional hierarchy may have contributed to his desire to gain acceptance as a simon-pure "counselor" who just happens to function in a work-oriented setting (pp. 13-14).

It is true, nevertheless, that there is greater simplicity in theory than in practice in separating vocational planning or counseling from psychological counseling. However, this does not negate the principle that level of training and primary agency focus define the characteristics of the proposed counseling relationship. As a professional person in rehabilitation, the counselor needs to apply this ethical principle in fulfilling his dual responsibility to clientele and to the agency. There is an ethical obligation for the rehabilitation counselor to operate within the boundaries of his own competencies. Such would imply that the counselor has an obligation not to explore personality dynamics merely because it is fascinating work, or because it may have high status. Such questionable practices may result in serious damage to both client and agency.

PROFESSIONAL PROBLEMS

Like every other profession, rehabilitation counseling has its own unique problems. Because the rehabilitation process involves many different professions, the inter-professional activities of each must be delineated to avoid role conflicts. The rapid growth of the profession creates the problem of providing training so that counselors can keep up with the latest advances in knowledge. The development and dissemination of new learning through the rehabilitation literature is another professional problem. Recruitment of personnel and the ethical problems of rehabilitation counselors are other professional problems which are discussed below.

Interprofessional Relationships

The role of the rehabilitation counselor may be expected to vary considerably from one setting to another. It will vary with the scope and province of the particular agency's program, with the physical and social setting in which the counselor works, and with the level and adequacy of the counselor's own training. At one extreme it may be a relatively well-defined role consisting primarily of vocational counseling or placement. At the other extreme, the rehabilitation counselor may be required to perform multiple functions including eligibility determination, administration of psychological tests, counseling, placement, public relations work, and a variety of other functions. The locality in which a rehabilitation counselor works may have a

bearing upon the nature of his job. For example, should the counselor be located in a metropolitan area where there are a vast assortment of resource people to draw on, his task will be quite different from that facing the counselor working in a rural area remote from easy access to medical, social, vocational, psychological, and economic resources.

Regardless of the particular setting in which he works, the rehabilitation counselor must earn the personal respect of his professional colleagues. The degree of personal respect he is able to command will probably be a function of his ability to create a perception of himself as a professional person who knows his job and is performing it adequately (McGowan, 1957). The problem of interprofessional relationships is crucial for the rehabilitation counselor. In rehabilitation there are numerous professions represented whose general aim is also that of returning a person to a productive and personally satisfying life, and who may have some natural reservations about the comparative newcomer—the rehabilitation counselor. McGowan (1957), observes that the rehabilitation counselor may face real interprofessional difficulties unless he is in a position to offer a contribution and perform a service that others cannot offer. It is his belief that the rehabilitation counselor's unique services take the form of: Psychological counseling; a knowledge of the world of work as it relates to a handicapped individual; and the ability to integrate the individual's remaining assets, both physical and psychological, so that a workable vocational plan may be formulated.

The report of a Seminar on Curriculum Development for Rehabilitation Counselor Training Programs (1960) (consisting of representatives from the State's Council Committee on Training, the Training Program Coordinators Liaison Committee, and the Vocational Rehabilitation Administration) lists three points of agreement in regard to the interprofessional role of the rehabilitation counselor. They are:

- (1) We agreed that he may have strong professional identification, and still work well with other disciplines.
- (2) We recognized there is considerable overlap of his role with that of other disciplines. Some of this overlap is good and enriches the work of each profession; some produces rivalry and jealousy. Other disciplines too are examining their roles, as are we, and we anticipate that their deliberations may have an effect on our own.
- (3) We feel strongly that the practicing rehabilita-

tion counselor must respect his own contribution and must have respect for the contributions of others. On the basis of this dual respect, some attitude changes may be possible; or, as Dr. Hayakawa would say, some defensive tensions may be relaxed and some artificial professional barriers may be lowered (p. 6).

In the sound and fury of interprofessional rivalry, the point is too often missed that disharmony occurs for the most part at the administrative and staff levels. The problem of jurisdiction is real, but when faced with a common job of service to handicapped persons, social workers, psychologists, rehabilitation counselors, and physicians are generally capable of devising a suitable means of dividing and sharing responsibilities (Mathewson, et al., 1955). There are simply too many handicapped persons needing help to generate much friction at the service level.

Professional Growth

The privileges and responsibilities associated with the profession of rehabilitation counseling demands an ongoing program of professional growth. On both the State and Federal levels, there is a keen awareness of the need for maintaining pace with a changing and rapidly growing field. It is the counselor's personal responsibility to assess his level of competency in the various phases of his work, for no one can force him to learn. The counselor who desires to promote his professional qualifications is in an ideal position in this era of rapid growth in rehabilitation. There is an increased understanding of the training potential of day-to-day supervision. Inservice training by means of agency staff or outside resource persons is offered by virtually all rehabilitation agencies. Short-term training programs for both beginning and experienced counselors are available for counselors in State rehabilitation agencies, and VRA is able to cover a large part of the expenses of training institutes that are held periodically at colleges and universities sponsoring graduate rehabilitation training.

In pursuing additional training the counselor may wish to take advantage of the educational leave provisions of his agency (if such are offered). VRA can defray part of the cost of short-term training for counselors in a wide array of training areas. "The Journal of Rehabilitation," a bimonthly publication of the National Rehabilitation Association, prints a listing, in each issue, of current training opportunities for rehabilitation personnel. The information supplied is

sufficiently comprehensive to enable the counselor to gain some idea of its pertinence to his particular professional needs.

Professional Literature

The rehabilitation counselor can add to his professional growth by subscribing to, and reading regularly, the periodical literature related to his work. By knowing "what is going on" in his area the counselor can apply research findings and improved treatment techniques to his work with disabled individuals. Also, the reading of professional journals will improve the counselor's perception of himself as a professional person, and by being able to intelligently discuss current issues with other professions they will be more inclined to see him as a professional person. A few of the journals of special interest to the rehabilitation counseling profession are:

Journal of Rehabilitation: Official bimonthly publication of the National Rehabilitation Association, 1522 K Street NW, Washington, D.C. 20005. Price to nonmembers, \$4 per year.

Rehabilitation Record: Bimonthly publication of the Vocational Rehabilitation Administration. For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402. Subscription price: \$1.75 per year.

Rehabilitation Literature: Published monthly by National Society for Crippled Children and Adults, Inc. 2023 West Ogden Avenue, Chicago, Ill. 60612. Subscription rate: \$4.50 per year.

Rehabilitation Counseling Bulletin: Published quarterly by the American Rehabilitation Counseling Association, 1605 New Hampshire Avenue NW., Washington, D.C. 20009. Subscription price: \$2 per year.

NRCA Professional Bulletin and NRCA News: Both are published by the National Rehabilitation Counseling Association, 1522 K Street NW., Washington, D.C. 20005.

The Bulletin: Published 3 months a year by Division 22, Psychological Aspects of Disability, of the American Psychological Association. Nonmembers may subscribe by sending \$2 per year to: Dorothy Cantrell Perkins, Los Angeles State College, 5151 State College Drive, Los Angeles, Calif. 90032.

The Personnel and Guidance Journal: Published September through June by the American Personnel and Guidance Association, Inc., 1605 New Hampshire Avenue NW., Washington, D.C. 20009. Subscription price to nonmembers is \$10 per year.

Journal of Counseling Psychology: A quarterly journal for psychologists and personnel workers concerned with the counseling of clients, students, and employees. Published by the American Psychological Association, 1200 17th Street NW., Washington, D.C. 20036. Subscription price to nonmembers is \$10 per year.

Personnel Situation in the Field of Rehabilitation Counseling

The orientation report of the National Rehabilitation Association's (1964) Rehabilitation Counselor Recruitment Study states in the introduction to the problem that:

The field of rehabilitation is undergoing a rapid expansion. An ever-increasing demand for rehabilitation services from handicapped groups in our society has necessitated a rapid expansion of programs, facilities, and staff.

At the same time society has been demanding more extensive services from all of the health related fields, from the field of education, and from the field of social work. The result has been severe personnel shortages in all of these fields and the subsequent development of recruitment programs to help alleviate these shortages. Since these groups are all dedicated to serving people, and since each requires specialized training, they have all been trying to recruit substantially the same people; i.e., people who are interested in working with people and who have the necessary intellectual skills and the personality characteristics that suggest success in school and on the job. The result has been competition.

If rehabilitation is to solve its personnel shortages, it must compete with these other fields for people with the characteristics cited above. This means competition with well-organized, well-financed groups who are keenly aware of their need to attract quality people in larger numbers to their fields.

Perhaps it would be well, at this point, to discuss briefly the concern for quality as well as quantity by the other recruitment programs. First of all, the increased demand for services has been qualitative as well as quantitative. In order to meet the demands for better service more training has been required. As the training requirements increase, the proportionate number of people intellectually, emotionally, and economically capable of successfully completing the training decreases. Secondly, the organization of various groups into "professions" has also contributed to this demand for quality. As these groups have, at times, self-consciously related professionalism to status they have themselves attempted to upgrade their constituents and have demanded that new people entering the "profession" meet ever-increasing standards of excellence. Part of this drive toward professionalization has been the need to increase the salaries of the group. *This is not necessarily a negative thing.* On the contrary, professionalization and upgrading increase the quality of the service that is given to the group's clientele, and this is a commendable goal for any group. The point we are attempting to make is that because of the public's increased demand for high-quality service and because of the drive for professionalization among the groups rendering these services, we are all competing for an ever-decreasing proportion of our potential professional population.

For the recruitment study, questionnaires were sent to the various rehabilitation agencies. Seventy-two public VR agencies (80 percent) participated in the study. They reported that in 1963 they employed 2,743 re-

habilitation counselors (including S.S. disability determiners), of whom—

- (a) 85.8 percent are male;
- (b) 55.7 percent have B.A. degrees but have not completed an advanced degree;
- (c) 16 percent have received a master's degree from a VRA-sponsored graduate training program; and
- (d) 24.3 percent have received the master's degree from other programs.

The report states that a conservative estimate of the yearly demand for new rehabilitation counselors during 1965 and 1966 would be somewhere between 700 and 1,000. In terms of the supply, the recruitment study found that for the years 1965 and 1966, VRA sponsored training programs could be expected to supply from 240 to 270 (which is approximately 30 percent of the yearly graduates from these programs) of the rehabilitation counselors that are needed. This meant that approximately 450 to 750 rehabilitation counselors must be supplied from other sources.

In late 1966, the number of graduates of rehabilitation counselor training programs needed annually for replacement or to fill new positions in expanding programs was estimated at 1,200. University training programs in rehabilitation counseling were still not graduating enough people to meet the personnel needs even though by 1966, 41 programs were offering the master's degree in rehabilitation counseling. Recruitment from other sources was necessary. Traditionally, the main sources of support have been from those employed in education, social work, the employment service, and industrial personnel work. However, increased demands for service, and therefore personnel, within these areas, coupled with salary increases and added opportunities for advancement, are making it increasingly more difficult for rehabilitation to attract competent people from these areas.

It appears that the recruitment of personnel is another problem that will be with the vocational rehabilitation program for many years.

Ethical Problems

The counselor has a basic ethical responsibility to the agency which employs him. In practical terms, even if trained to do so, the rehabilitation counselor does not ordinarily concentrate on one aspect of his job to the detriment of other, less professional facets which are equally as important.

Warnath (1956), writing on ethical problems facing the counselor in a public agency setting, makes certain observations which have direct relevance to rehabilitation counseling and rehabilitation counselor training. He describes the discrepancy between most practicum experiences in supervised counseling which are, "carried out with little pressure and no limitation on the number of contacts and techniques," as compared to the typical service agency picture of backlogged cases. Thus, a counselor trained to be alert to underlying causes of vocational confusion must learn "to avoid deeper problems unless the client offers them on his own during the discussion of the presented problems."

Another ethical question facing the rehabilitation counselor is that of counselor research in a rehabilitation agency. The counselor, particularly one who has been trained in a graduate program in rehabilitation counseling, is likely to view research as an essential part of his job. In spite of such inclination, he is quite unlikely to find complete realization of this interest in a public agency. Warnath (1956) insists that even a brief look at the operation of counseling in public agencies makes it clear that research is at best tolerated and only then if it does not interfere with other duties. On a practical level, the counselor may discover that his responsibilities to his clientele mitigate against research efforts. Budgeting time for research projects may sound like the solution, but caseload responsibilities coupled with such factors as quota requirements, public relations work, and job placement tend to erode the utility of such an approach. There is, nonetheless, a definite demand for the counselor adequately trained in research methodology to do sound research on such topics as: Evaluation of services, the counseling process, normative data, etc. The counselor with such interests should attempt to gain a favorable agency attitude toward time arrangements for performing research.

In a real sense, the professional problems facing the rehabilitation counselor may be thought of as ethical considerations. As yet, there is no published set of ethical principles for rehabilitation counseling. The American Psychological Association (1963) has published an ethical standards guide for psychologists, part of which has direct applicability to the field of counseling. Guidelines are presented which touch upon ethical priorities with the client, the public, professional relationships, etc. Considering that counseling is the basic service to be offered by the rehabilitation agency and that it undergirds the entire rehabilitation process, consideration should be given to this publication. APGA has also published a code of ethics and is currently preparing a casebook to illustrate principles.

Many of the illustrations are from rehabilitation settings.

In order to illustrate some of the ethical considerations involved in the counseling relationship, the section of the APGA Ethical Standards (1961) regarding counseling is presented below:

This section refers to practices involving a counseling relationship with a counselee or client and is not intended to be applicable to practices involving administrative relationships with the persons being helped. A counseling relationship denotes that the person seeking help retain full freedom of choice and decision and that the helping person has no authority or responsibility to approve or disapprove of the choices or decisions of the counselee or client. "Counselee" or "client" is used here to indicate the person (or persons) for whom the member has assumed a professional responsibility. Typically the counselee or client is the individual with whom the member has direct and primary contact. However, at times, client may include another person(s) when the other person(s) exercise significant control and direction over the individual being helped in connection with the decisions and plans being considered in counseling.

1. The member's primary obligation is to respect the integrity and promote the welfare of the counselee or client with whom he is working.

2. The counseling relationship and information resulting therefrom must be kept confidential, consistent with the obligations of the member as a professional person.

3. Records of the counseling relationship including interview notes, test data, correspondence, tape recordings, and other documents are to be considered professional information for use in counseling, research, and teaching of counselors but always with full protection of the identity of the client and with precaution so that no harm will come to him.

4. The counselee or client should be informed of the conditions under which he may receive counseling assistance at or before the time he enters the counseling relationship. This is particularly true in the event that there exist conditions of which the counselee or client would not likely be aware.

5. The member reserves the right to consult with any other professionally competent person about his counselee client. In choosing his professional consultant the member must avoid placing the consultant in a conflict of interest situation; i.e., the consultant must be free of any other obliga-

tory relation to the member's client that would preclude the consultant being a proper party to the member's efforts to help the counselee or client.

6. The member shall decline to initiate or shall terminate a counseling relationship when he cannot be of professional assistance to the counselee or client either because of lack of competence or personal limitation. In such instances the member shall refer his counselee or client to an appropriate specialist. In the event the counselee or client declines the suggested referral, the member is not obligated to continue the counseling relationship.

7. When the member learns from counseling relationships of conditions which are likely to harm others over whom his institution or agency has responsibility, he is expected to report the condition to the appropriate responsible authority, but in such a manner as not to reveal the identity of his counselee or clients.

8. In the event that the counselee or client's condition is such as to require others to assume responsibility for him, or when there is clear and imminent danger to the counselee or client or to others, the member is expected to report this fact to an appropriate responsible authority, and/or take such other emergency measures as the situation demands.

9. Should the member be engaged in a work setting which calls for any variation from the above statements, the member is obligated to ascertain that such variations are justifiable under the conditions and that such variations are clearly specified and made known to all concerned with such counseling services.

By way of summary, during the past 12 years since the passage of Public Law 565 in 1954, great strides have been made toward the professionalization of the position of the rehabilitation counselor.

As pointed out in this entire manual and as emphasized in this section, serious issues and complex problems face this growing field. Many of them will take years to solve. Yet, realizing that the aims and purposes of the profession; namely, to help the handicapped to help themselves, are just and good, there seems little doubt that the issues and problems presented to counselors, trainees, and administrators, will be met and solved.

Section 20

ADMINISTRATIVE DUTIES OF VOCATIONAL REHABILITATION COUNSELORS

THE PRIMARY responsibility for the administration of the vocational rehabilitation program lies in the hands of the administrative and supervisory staff. Nevertheless, the counselor will, as a part of his responsibilities, be expected to perform a number of administrative duties.

The administrative duties logically divide themselves into two groups; i.e., those duties involving services to clients and those duties related to actual office management. The former is concerned with casefinding, caseload management, field trips, and public relations; while the latter pertains to office operation and preparation and utilization of reports.

ADMINISTRATIVE DUTIES INVOLVING SERVICES TO CLIENTS

The first mentioned of these duties, casefinding, has been previously dealt with in Section 5, Locating Persons in Need of Rehabilitation Services. Casefinding is the process of: Acquainting the public with the objectives and services of the rehabilitation agency; locating all disabled individuals in need of, and who might be eligible for, vocational rehabilitation services; informing them of the services available through the vocational rehabilitation agency; and finally ascertaining whether they are interested in receiving such services.

CASE STATUS CLASSIFICATION

The Vocational Rehabilitation Administration developed the following case status classifications to insure uniform reporting and to assist in evaluating a counselor's or agency's caseload management:

Status 00. Referral.—A referral is defined as any individual who has applied, by personal contact with any VR employee, by telephone, or by letter; or who has been referred to any VR employee by letter, by telephone, by direct contact, or by any other means; and for whom the following minimum information has been furnished: (1) Name and address, (2) disability, (3) age and sex, (4) date of referral, and (5) source of referral. This status represents entrance into the VR process for any individual who meets the above definition of a referral.

Status 02. Applicant.—Referrals (status 00) should be placed in this status as soon as the counselor has a document signed by the individual requesting vocational rehabilitation services. Generally, the document will be an agency application form, but a letter signed by an individual who provides the minimum basic information and requests service should also be considered as a basis for placing the individual in this status. While the individual is in this status, sufficient information is developed to make a determination of eligibility or ineligibility for vocational rehabilitation services, or a decision made to put the individual into one of the extended evaluation statuses prior to making such a determination.

Status 04. 6-Month Evaluation.—An applicant should be placed in this status when the counselor has written a certification that the severity of the individual's disability is such that an extended period of time is required to evaluate his rehabilitation potential prior to making a certification of eligibility or ineligibility for vocational rehabilitation services. Clients with one of the selected disabilities designated by the Secretary as eligible for 18-month extended evaluation should not be placed in this status. Individuals placed in this status may not remain in the status beyond 6 months, but may be moved from this status at any time prior to

the expiration of the 6-month period if it is determined that either: (a) There is a reasonable expectation that the individual can be rendered fit to engage in a gainful occupation, or (b) there is no reasonable likelihood that he can be rendered fit to engage in a gainful occupation.

Status 06. 18-Month Evaluation.—An applicant should be placed in this status when the counselor has written a certification that the individual has one of the selected disabilities designated by the Secretary as eligible for 18-month extended evaluation (see 401.21(c) of the regulations for the specified disabilities); and that the severity of the disability is such that an extended period of time is required to evaluate his rehabilitation potential prior to making a certification of eligibility or ineligibility for vocational rehabilitation services. Individuals placed in this status may not remain in the status longer than 18 months but may be moved from this status at any time prior to the expiration of the 18-month period if it is determined that, either: (a) There is a reasonable expectation that the individual can be rendered fit to engage in a gainful occupation, or (b) that there is no reasonable likelihood that he can be rendered fit to engage in a gainful occupation.

Status 08. Closed After Referral or Extended Evaluation.—This status has been provided to furnish a convenient means for identifying all persons not accepted for VR services, whether closed from referral (status 00) or applicant status (02), or from one of the extended evaluation statuses (04 or 06). All persons processed through referral and/or extended evaluation and not accepted into the active caseload for vocational rehabilitation services will be closed in this status.

Status 10. Plan Development.—While an applicant is in this status the case study and diagnosis is completed to provide a basis for the formulation of the individual's plan of vocational rehabilitation. A comprehensive case study is basic to determining the nature and scope of services to be provided in order to accomplish the vocational rehabilitation objective of the individual. The counselor and client formulate and plan the rehabilitation services necessary to the solution of the client's problems, and those services are clearly outlined to him. The individual remains in this status until his plan is written and approved by the proper personnel.

Status 12. Plan Completed.—A case is placed in this status when the plan has been written and approved. The case remains in this status until arrangements are made with servicing agencies to supply the necessary services and services actually begin.

Status 14. Counseling and Guidance Only.—This status should be used only for those cases having an approved plan which outlines counseling, guidance and placement as the only services required to prepare the client for employment. It is not to be used to reflect the counseling and guidance which takes place during the course of plan development, or for the same service provided by the counselor during the progress of training, physical restoration, or other purchased services. However, within the context of the meaning and intent above, in those instances where there has been a breakdown in the case progress after other services have been provided, and it has been determined by the counselor that substantial counseling and guidance is essential to the successful placement and rehabilitation of the individual, the client may be entered in this status: *Provided*, That a plan amendment has been written and approved, and that this is the only service required to prepare the client for employment.

Status 16. Physical Restoration.—A client is placed in this status if he is receiving medical, surgical, psychiatric, or therapeutic treatment, or is being fitted with an appliance. A case remains in this status until physical restoration services are completed, or services are terminated prior to completion, whether by the client or by VR.

Status 18. Training.—A case is placed in this status if actually receiving one or a combination of the following types of training: (1) School training in a public or private school, (2) employment training in a commercial or industrial establishment under employment conditions, (3) training at some other facility, or by an individual teacher or instructor or by correspondence, the training not being given under school or employment conditions. Cases remain in this status until they have either completed training or training is terminated, whether by the client or by VR.

Status 20. Ready for Employment.—An individual is placed in this status when he has completed preparation for employment (counseling, guidance, treatment, fitting of an appliance, training, etc.) and is ready to accept a job, but has not yet been placed, or has been placed but has not yet begun employment.

Status 22. In Employment.—An individual is placed in this status when he has been prepared for, placed in, and begun employment. He must be observed in this employment for a minimum of 30 days prior to being closed employed (status 26) to insure adequacy of employment in accordance with the needs and limitations of the individual. Homemakers and unpaid family workers should be included if they meet the observation criteria.

Status 24. Service Interrupted.—An individual is recorded in this status if rehabilitation services are interrupted while he is in one of the statuses 14, 16, 18, 20, or 22. Such cases are then held in this status until the client returns to one of the statuses 14, 16, 18, 20, or 22; or pending closure.

Status 26. Closed Rehabilitation.—Cases closed as rehabilitated must as a minimum: (1) Have been declared eligible, (2) have received appropriate diagnostic and related services, (3) have had a plan of vocational rehabilitation services formulated, (4) have completed the plan insofar as possible, (5) have been provided counseling and one or more other rehabilitation services, and (6) have been determined to be suitably employed for a minimum of 30 days.

Status 28. Closed Other Reasons AFTER Rehabilitation Plan Initiated.—Cases closed in this category must have met the criteria (1), (2), and (3) above, and at least one of the services provided for by the plan must have been initiated, but for some reason one or more of the other three criteria above were not met. Included here are cases meeting these criteria which are transferred to another State rehabilitation agency, either within the State, or in some other State. Also included here are those cases for which a rehabilitation plan for counseling and guidance only was written, approved, and initiated.

Status 30. Closed Other Reasons BEFORE Rehabilitation Plan Initiated.—Cases closed in this category are those cases which although accepted for rehabilitation services did not progress to the point that rehabilitation services were actually initiated under a rehabilitation plan. Included here are cases meeting these criteria which are transferred to another State rehabilitation agency, either within the State, or in some other State.

CASELOAD MANAGEMENT

Caseload management involves the attainment of balance in services provided to the clients; the attainment of a reasonable balance in service to the various disability classifications; and, the maintenance of an active caseload of appropriate size.

The term balance suggests that the counselor maintain some minimum and maximum number of clients in each case status. Although the counselor needs to maintain some balance in providing the various services available through vocational rehabilitation, he should not do so at the expense of any individual

client. The number of cases in any particular status will vary according to: The geographic area served by the counselor; the cultural backgrounds presented by clients; the setting in which the counselor works, that is, in an institution which has primary responsibility for providing some physical or mental restorative services versus a routine office setting; and finally the State agency policies and practices.

Not all cases can be successfully rehabilitated. The continued absence of any cases closed for other reasons or unemployed should cause the counselor to examine the selective process by which he determines which clients have a reasonable expectation of becoming vocationally rehabilitated. However, it is also essential that the counselor develop his caseload to the point that he has a sufficient number of cases in service, so that he can make a contribution towards the goals of the agency that employs him.

Some degree of balance in serving clients with serious or multiple handicaps is desirable since counselors serving a restricted caseload or a special disability group; e.g., the counselors of the deaf, the blind, the mentally retarded, are contributing to agency goals in other ways. The counselor should be called upon to explain the prolonged absence of any severely disabled individual or of any particular disability group from his active caseload. This may call for some self-analysis on his part and can lead to potential growth and development.

The counselor should be able to demonstrate that he has an active caseload, and one in which case movement is easily observed. Case movement may be described as a goal oriented progress which the counselor and others are able to see. The attainment of the goal is generally thought of as contributing to the client's adjustment to a job, but the relationship need not be a direct one. Case movement can be readily assessed by the counselor through a reference to his referral register and master list of cases. Clients who remain in any one status for what appears to be an abnormal length of time; e.g., those who have been referred but not accepted 6 to 12 months after the counselor receives the case, are worthy of some additional consideration or attention. Everyone will agree that the counselor should have an adequate supply of clients to satisfy agency goals; however, the only static case immediately accessible in satisfying production goals is the case "in employment."

Other illustrations of cases lacking case movement are: (1) Those who have been accepted for service but who, after several months and sometimes even after years, have never received services beyond

diagnosis, (2) those who are still convalescing long after the date the attending physician indicated they were ready to return to training or employment, (3) those who have been "ready for employment" in a worker's market for excessive periods of time, and (4) those who remain in "interrupted" status after repeated counselor contacts.

THE COUNSELOR'S TIME

Fieldwork activities must be carefully planned if the counselor is to carry out this element of the total job in an efficient manner. The portion of the counselor's working time these activities require will vary with the nature of the geographical territory assigned to the counselor. Counselors with large rural territories usually spend much more time in fieldwork activities than those working in metropolitan areas.

Most States are divided into districts to which individual counselors are assigned. The counselor is the sole full-time representative of the rehabilitation agency within his territory. He has the responsibility for making contact with agencies, facilities, employers, and other individuals and resources within his territory. The counselor can maintain contacts with agencies and facilities by setting up and holding to a regular itinerary including the specific dates he plans to make contacts with each major agency. This enables the agency to prepare its referrals and provide help in interviewing, diagnosing, planning, and supervising services.

Whenever possible, the counselor will conserve time by arranging for a central headquarters in each area where clients may be interviewed. The clients should be notified in advance of the time and place of the appointment. In rare instances when the counselor cannot keep his appointments, the clients should be provided with a satisfactory substitute or with a valid explanation.

Time spent on organization of the counselor's fieldwork activities promotes efficiency through conservation of travel time, economy of program operation, optimum utilization of counselor's energies, and notification of district and central offices of counselor's whereabouts.

Some of the preparations for fieldwork in which the counselor can engage are as follows: (1) Prepare a kit of standard materials for each field trip including necessary agency forms, copies of laws, regulations, State policies, list of agencies, facilities and employers

and occupational information, (2) prepare pertinent notes from client's case folder including statement of purpose of each contact, (3) provide a written method of recording decisions and other relevant matters essential to dictating upon return to the office, and (4) prepare for promotion of the program in the territory by listing specific contacts to be made and through participation in development of programs promoting community responsibility for the disabled.

PUBLIC RELATIONS

The intensity with which public relations activities will be pursued will vary from State to State. The following, however, are some of the basic objectives which the vocational rehabilitation agency will strive for in any State:

- (1) To substantially increase the number of handicapped persons informed of the availability of rehabilitation services.
- (2) To foster acceptance of the rehabilitation program and appreciation of its needs by authorities in the community.
- (3) To develop employer acceptance of the handicapped.
- (4) To stimulate promising students and established professionals in fields allied to vocational rehabilitation to enter the vocational rehabilitation field—that is, to encourage the training of counselors, social workers, doctors, nurses, therapists, etc.
- (5) To encourage the development of research and research projects designed to improve and/or originate methods and techniques for coping with the problems of the handicapped.
- (6) To help mobilize support and enthusiasm for vocational rehabilitation and its objectives at the grass roots—at the community level where the program must, of necessity, succeed or fail.
- (7) To foster the best possible relations between the State vocational rehabilitation agency and other agencies, public and private, involved in coping with the problems of the handicapped.
- (8) To respond to queries, complaints, and criticisms from whatever source as rapidly as possible consistent with available resources, and to funnel all constructive criticisms to those staff members most directly concerned for appropriate corrective action.

- (9) To maintain the best possible relations with and access to the media of communications; i.e., press, radio, TV.

Within the context of the previously cited general objectives, the efficient counselor can do much to disseminate required information and to foster community acceptance for the agency and program he represents. He should, however, understand the relationship between public relations and overall agency goals as well as understand the mechanics of the public relations process. Some public relations factors have a bearing on the achievement of both public relations and overall vocational rehabilitation objectives. No public program can grow and improve if it does not have the support of the community and, through the community, the legislative and administrative powers which control that program's purse strings.

The first requirement in achieving community support is to render sound service. Sound service is possible only if those who should be informed of its availability are so informed, and if the community at large understands the nature of the service, its scope, its quality, and its impact on the individual citizen as well as upon the Nation. A service such as vocational rehabilitation can, in practice, be no better or no worse than what important elements of the public think it to be. Legislators will appropriate, Governors and mayors will be friendly, and the press will keep its criticism to a minimum if the vocational rehabilitation agency does a good job and makes others aware of its services.

Important factors to bear in mind in the preparation of any material for a media which serves the general public are: (1) Simplicity of data, (2) local angle wherever possible, (3) conciseness, (4) inclusion of human interest material if possible, (5) direction of material to proper staff person of press, etc., and (6) respect for press and other deadlines.

Promptness and efficiency in the handling of correspondence from any segment of the public are very directly related to good public relations, because, in the eyes of the correspondent they place a value upon both the agency involved and the official making the reply. Promptness and efficiency are particularly important in the handling of queries which bear upon the personal well-being of the correspondent in either the physical, emotional, or economic sense. As a general rule, letters should be answered within 2 to 5 days of receipt if at all possible. Systematic filing, tickler and routing systems are invaluable if correspondence is to be handled properly.

A well-rounded public relations program takes into consideration the views, position in the community,

and activities of major social and civic groups. Service clubs, veterans groups, chambers of commerce, labor unions—all of these and other organizations play a key role in the molding of public opinion and in influencing legislative and executive action bearing on the objectives of the vocational and rehabilitation program. These groups can be most cooperative in fostering these objectives if properly approached and judiciously cultivated.

OFFICE MANAGEMENT

Efficient office management is an important factor contributing to the counselor's overall efficiency in discharging his total responsibility as a staff member. The counselor should leave the impression with the client that his problems are of vital concern to the agency. His requests and complaints are given courteous attention and prompt consideration.

The office operation leaves the general impression with the public that the program is operated in a professional and businesslike manner. High value is placed upon public approval and support. Requests from other professions and agencies are given courteous and prompt consideration. There is an atmosphere of respect for colleagues and members of other professional disciplines with whom the counselor communicates. The rehabilitation agency merits a position on the same level as other professional agencies.

The counselor utilizes the services of the office clerical staff effectively. The office secretary may be delegated duties for handling routine correspondence, records and files, reports to district and State office staff, and, in the counselor's absence, for responding to client's routine problems, as well as problems raised by other agencies and individuals. The Secretary's skill in resolving even the most minor incident in the counselor's absence often determines the perception of vocational rehabilitation by the referral source.

MAKING AND UTILIZING REPORTS

Today many vocational rehabilitation operations and services are stopped and/or started through the initiation of letters, memorandums, telegrams, telephone calls, interviews, and reports by the counselor. Most counselor actions will come to the attention of the State agency and the Vocational Rehabilitation

Administration via the written report. Occasionally a counselor may be asked for an oral report but more often a written report is required. In the final analysis, it is the counselor's report that determines the direction, control, and planning of the State agency and the Vocational Rehabilitation Administration. Good reports can facilitate all phases of the program and make for a more efficient operation.

Any modern operation requires quality reports based on accurate information. In vocational rehabilitation the quality of the report reflects the work of the State agency and its staff. Records and reports can become burdensome and it has been said that they are only valuable insofar as management is prudent in their use; to keep too many records and require too many reports merely to "have data on hand" results in unnecessary expense and a hindrance to management. A good record should receive a favorable answer to the following: (1) Is it really necessary? (2) Does it duplicate any present record? (3) It is a practical record for the organization? (4) How is the recording going to be used? (5) What constructive action will be possible from this record? (6) How much will it cost, and is the expenditure justifiable?

Finally, a few words about several statistical reports that are required by the Vocational Rehabilitation Administration. The information transmitted on these reports is used: To help the State agencies by furnishing data to them on a National, regional, and State, agency basis to facilitate and improve the operations of the State agencies; to help to keep VRA's central office and regional staff sufficiently informed of what is happening in the program that they can effectively carry out their responsibilities; to inform the Depart-

ment of Health, Education, and Welfare and the Bureau of the Budget about the vocational rehabilitation program; and to inform Congress about the program.

Keeping records and making reports is an activity that *all* professionally trained people seem to resist, especially in the area of psychological services. However, this is an important aspect of professional work that must be done. In fact, one of the criteria often used for assessing the professional performance of a counselor is the quality of his reporting. Maintaining good records, therefore, can be an important factor in judgments of a counselor's proficiency, as well as being essential to the operation of the total program.

Summary analyses of these reports are frequently made available through articles in the bimonthly publication, "Rehabilitation Record," through reports issued as part of the Rehabilitation Service Series, and in other ways. For further details as to the purpose and content of the required reports, please refer to chapter 13 of the Vocational Rehabilitation Manual, Vocational Rehabilitation Administration.

In summary, the counselor's administrative duties are many and varied, although the supervisory staff has primary responsibility for administration of the vocational rehabilitation program. The administrative duties of the counselor involve service to clients and office management. The counselor is responsible for casefinding, caseload management, field trips, public relations, office operation, and preparation and utilization of reports. The secretary may be delegated certain duties pertaining to office operation and routine client contact in the counselor's absence.

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APPENDICES

There are two appendices in this manual. They are:

Appendix A: Three complete case abstracts are presented. The general format for each of the abstracts is basically the same. Information about the case is presented, then followed by discussion questions related to the total client-study process.

Appendix B: There are 21 partial case abstracts in this appendix with each one designed to illustrate a teaching point.

APPENDIX A

COMPLETE CLIENT-STUDY CASE ABSTRACTS

CLIENT-STUDY CASE ABSTRACT NO. 1—THE CASE OF MRS. P.

Referral Source

Mrs. P. was a self-referral. The vocational rehabilitation counselor met her while investigating her husband who had been referred by a county welfare office. She had previously lost a job as a maid in a hotel and was in danger of losing a part-time job as a presser in a laundry. She complained of pain in her feet and legs, low-abdominal pain, pain in the pelvic region, severe nose-bleeds, and made some vague reference to female trouble.

Social Data

Mrs. Jane P. is a 19-year-old female. She comes from a very limited rural socioeconomic background. She and her husband have been married less than a year and have no children. They live in a poorly furnished one-room apartment. Mr. P. is 20 years old and suffers from chronic asthma. At present he is unemployed. They had been drawing general relief in White County before moving to this locality. They are not receiving any public or private assistance at the present time, although Mrs. P.'s wages have not been sufficient to provide adequately for them.

Mrs. P. presents a pleasant general appearance. She dresses neatly, but her choice of clothes clearly reflects her limited socioeconomic background. Although she likes her work and needs to hold her present job, she states she would prefer being a housewife if circumstances would permit. Nevertheless, she has apparently accepted the necessity of providing for herself and her husband. She seems to have good judgment and responds to questions thoughtfully and without too much defensiveness or exaggeration. She says she thinks she would be happier working with a group. From the reference given it appears that her circle of acquaintances is limited.

Discussion Questions

- (1) How important is Mrs. P.'s history with the public welfare agency? How can such data be obtained? Should the client's permission be secured and if so, how?
- (2) What is the possible relationship between the limited socioeconomic background from which she comes and her probable level of aspiration in establishing a vocational objective?
- (3) Is Mrs. P.'s role as provider for her husband a factor in the determination of eligibility?
- (4) What efforts should be made to rehabilitate Mr. P. who is only 20 years of age? Should the major rehabilitation effort be directed toward Mr. P. before completing the investigation of his wife's case?

Educational History

Mrs. P. completed 11½ years of school, said that she liked school and was considered to be a good student. She stated that the reason she failed to graduate from high school was due to the condition of her feet. She had to walk 2 miles to catch the schoolbus, and halfway through the senior year her feet became so painful she could not continue walking that distance. A transcript of her high school grades supported her report of being a good student, though not an outstanding one.

School authorities were not contacted about arranging for Mrs. P. to finish high school since it was believed that her disability would be reduced with medical care so as to obviate any need for training.

Discussion Questions

- (1) Was the counselor justified in not contacting the local high school because, "It was believed that her disability would be reduced with medical care so as to obviate any need for training?"
- (2) If the counselor had some doubt about the client's reason for quitting high school, how should he have gathered data in this area? Should the high school be contacted routinely in all cases? What permission, if any, is required?

Medical History

Mrs. P. stated that she had been in good general health except for her feet which had always been troublesome. The condition of her feet became so serious in her senior year of high school that they were the reason for her dropping out. She also said that recently she had been bothered with nosebleeds whenever she engaged in strenuous work.

Mrs. P. was sent to a local physician for her general medical examination. On the basis of this report she was also referred to specialists in the areas of orthopedics, and eye, ear, nose, and throat.

Discussion Questions

- (1) What ethical questions are involved in the selection of the physician who is to give the general medical examination?
- (2) If the client has no regular family physician, on what basis should a physician be selected?
- (3) When the general medical report indicates the need for a specialist examination, should it be secured before or after discussing or reviewing the case with the vocational rehabilitation medical consultant? How are the correct fees for the general medical and specialist examinations established?
- (4) Should the medical reports be mailed directly to the counselor or to the vocational rehabilitation medical consultant? Should the counselor contact examining physicians personally, or is it best to have the vocational rehabilitation medical consultant do so?

GENERAL MEDICAL EXAMINATION RECORD

This record is confidential.

P.	Jane	F.	Age <u>19</u> .	Sex <u>F</u> .	<u>M</u> S W D
(Last name)	(First)	(Middle)			

Section I (To be filled out by rehabilitation agency.)

Omitted

Section II *Physical Examination* (To be filled out by physician.)

Height: 5 feet, 5¾ inches. *Weight:* 139 pounds.
Eyes: *Right:* Normal, 20/20. *Left:* Normal, 20/20.
Ears: *Hearing:* *Right:* 20. Drum scarred. *Left:* Drum scarred, old infection (none now).
Nose: Nasal congestion, recent hemorrhage from septum.
Mouth: 3d molar and 2d molar lower right.
Throat: Chronic infection and hypertrophy.
Neck: Normal thyroid, no lymphadenopathy.
Lungs: *Right:* No evidence of disease. *Left:* No evidence of disease.
Circulatory system: *Heart:* Normal. *Blood pressure:* 120/72. *Pulse rate:* 76. *Dyspnea:* None.
Cyanosis: None.
Edema: None. *Evidence of arteriosclerosis:* None.
Abdomen: Normal. *Hernia:* None.
Genito-urinary and Gynecological: Tender right adnexa.
Ano-rectal: Normal.
Nervous System: Normal individual.
Skin: Clear, normal.
Feet: Pes planus bilateral. *Varicose veins:* Early varicosities, both thighs.

Orthopedic impairments:

- (1) Early varicose veins.
- (2) Pes planus bilateral.

Laboratory:

Blood serologic test—

Date: 7-1-59.

Test: VDRL.

Result: Negative.

Date: 7-1-59. **Sugar:** None.

Sp. Gr. 1022. Micro: Neg.

Reac. Ac. Albumen: None.

Disabilities:

Major: EENT complaints.

Minor: Pes planus.

Both can be removed or substantially reduced by treatment.

Recommendations: Consultation with orthopedist and E.E.N.T.

Treatment indicated: E.E.N.T.

Types of activity to be avoided: Long standing, heavy lifting.

Working conditions to be avoided: Long standing, heavy lifting.

Your personal evaluation of this patient: Good health generally, but is in need of treatment of E.E.N.T. and for flat feet and varicosities.

(S) RICHARD DOE, M.D.

7-1-59.

SPECIALIST'S REPORT—ORTHOPEDIST

August 1, 1959.

Re: P., JANE F.

Jane F. P., was examined in my office on the afternoon of August 1, 1959.

History: Mrs. P. states that she has had trouble with her feet for several years and recently has had some backache and cramping of the calf muscles. She is employed as a steam presser in a laundry which required her to stand on her feet for long periods of time.

Examination:

Back: The vertebra are in good general alinement. Motion of the spine is not restricted. There is a mild degree of tenderness in the lumbosacral area of her spine, but no definite deformity exists.

Lower extremities:

Hips: Motion is normal. No edema or tenderness.

Thighs: Well developed. No muscle atrophy. No areas of tenderness or impaired sensation. There are several superficial varicose veins, but they are not symptomatic.

Knees: Motion is normal. No edema or tenderness.

Legs: Well developed. No muscle atrophy. There is some soreness of the calf muscles on deep pressure, bilaterally.

Ankles: Motion is normal, bilaterally. No edema or tenderness.

Feet: There is marked pes planus, bilaterally with pronation, associated with considerable weakness on exercises.

Diagnosis: Weak feet, bilateral, severe, with marked pronation, symptomatic.

Comment: It is recommended that this lady be fitted with corrective shoes and combination longitudinal arch supports in order to give her feet the proper balance. I feel that her feet are responsible for the aching in her legs and the discomfort in the lower portion of her back. As soon as these are procured I would like to check her to see if adequate balance of her foot has been obtained.

(S) JOHN DOE, M.D.

SPECIALIST REPORT—E.E.N.T.

July 29, 1959.

Mrs. Jane F. P. was examined by me July 29, 1959. Her complaint at this time was frequent nosebleeds. Examination revealed a large ulcer of the nasal septum located in the left nares. Treatment was cauterization of the ulcer.

Diagnosis: Ulcer nasal septum.

Sincerely,

(S) JOHN JONES, M.D.

Discussion Questions

- (1) Is the medical information in this case adequate? If not, what additional information does the counselor need?
- (2) How can the counselor help prepare the client for the experience of wearing corrective shoes and arch supports?

- (3) What are some cues to which the counselor must be alert in evaluating the "gadget tolerance" of the client?
- (4) What distinction should be made between eligibility for vocational rehabilitation and provision of specific services; e.g., corrective shoes?

Psychological Data

Since data was not obtained in regard to Mrs. P.'s high school cumulative record, a battery of tests consisting of the Army General Classification Test, Wechsler-Bellevue Scale, Form I, Kuder Preference Record—Vocational and Minnesota Multiphasic Personality Inventory were administered by a local psychologist on a fee basis. The results are indicated below:

Ability:

Army General Classification Test—Score 96, 42 percentile (general population).
Wechsler-Bellevue Scale—Verbal IQ: 96. Performance IQ: 107. Full-scale IQ: 103.

Interest:

Kuder Preference Record: (Vocational).
High in Social Service: (81 percentile).
Low in Literary: (23 percentile). Musical: (21 percentile), and Scientific: (17 percentile).

Personality:

Minnesota Multiphasic Personality Inventory—Elevated scores on the following scales:
Hypochondriasis (Hs): 74 (T score).
Depression (D): 66 (T score).
Hysteria (Hy): 72 (T score).

Abstract from psychological report:

Mrs. P. is a person of average general ability. The fact that she was a good student in school is understandable because she is highly motivated to achieve. Her grades were better than might be expected in terms of her average general ability. She is concerned with economic problems, and her high interest in social service is likely a result of that. She seems to be accepting the necessary facts of her position, but no doubt would rather be in the role of a housewife rather than that of a provider.

Her MMPI profile would indicate that she is quite concerned with her physical condition and has a good deal of anxiety. At the same time, however, her eagerness to work causes her to overlook her handicap as much as she can. At times she seems rather nervous and upset, which would be supported by her elevation on the Hs and Hy scales, accompanied by a slight decline of the D scale of the MMPI. This particular configuration is usually interpreted as indicating neurotic tendencies with a high level of anxiety as the salient feature. Her pressure pattern is probably the result of severe environmental stress. She is trying to deal with the pressure, but the maintenance of elevated Hs, Hy, and D scales show her attempts to be unsuccessful. In the absence of this type of environmental stress, she would probably make a normal adjustment.

Discussion Questions

- (1) Was the need for this detailed psychological evaluation clearly indicated in this case?
- (2) Were the services provided by the psychologist within the area that the typical rehabilitation counselor could reasonably be expected to provide?
- (3) How should psychologists used by vocational rehabilitation counselors be selected and how should their fees be determined?
- (4) What would you include in referral information to the psychological examiner?
- (5) How would you prepare the client for referral?
- (6) What information would you expect in the report of the psychologist? How would you use such information?

Vocational History

Mrs. P.'s principal employment has been as a domestic maid. While going to school she held part-time jobs of this nature in order to buy clothes for herself. A neighbor reported that she should be commended for being "capable, cooperative, and not afraid of work."

The job Mrs. P. had just prior to her present one was as a maid in a local hotel. This employment was terminated because of her physical inability to do the work.

Her present employer at the Jones Laundry, where she is working part time, reported her to be punctual, able to get along well with other workers, and consistently producing very acceptable work. He stated that he would be willing to hire her full time if her physical condition was such that she could stand the work.

Discussion Questions

- (1) Should the counselor accept the client's past employment as the optimum level of of which she is capable of performing?
- (2) Who is responsible for determining Mrs. P.'s potential for performing full time as a steam presser after services are provided? Who is in the best position to evaluate this?
- (3) Will the provision of physical restoration services enabling this client to work full time at her present job fulfill the counselor's responsibility to this client?
- (4) In your opinion is the vocational evaluation of this client complete?

Eligibility

Mrs. P.'s disability has been diagnosed as weak feet, bilateral, severe, with marked pronation, symptomatic. She also has a large ulcer of the nasal septum and several superficial varicose veins which are asymptomatic. The orthopedic specialist feels that the condition of her feet is responsible for the aching in her legs and the discomfort in the lower portion of her back. These conditions cause a material inability to carry out the duties of her regular work as a steam presser, and were reported to be the reason for the termination of her previous work as a domestic maid.

Discussion Questions

- (1) What is the major disability in this case and who makes this determination?
- (2) Has the counselor fully explained how the client's physical disability results in a substantial vocational handicap? If you feel that the explanation is unsatisfactory, how would you change or add to it?
- (3) What are Mrs. P.'s functional limitations? If Mrs. P.'s functional limitations following physical restoration interfere with satisfactory job performance, what are the counselor's responsibilities?

Summary: Mrs. P. verbalizes an acceptance of her physical condition and its effect upon her availability for work. She has repeatedly stated that she likes her present job and is eager to continue work if she is physically capable of doing so. She is willing to cooperate with all required physical restoration services.

Discussion Questions

- (1) Should the counselor have explored more thoroughly the possibility of training for Mrs. P. in order to prepare her for a higher level and better paying position?
- (2) What is your general evaluation of the way this case was handled?

CLIENT-STUDY CASE ABSTRACT NO. 2—THE CASE OF SUE S.

Referral Source

Miss S. was referred to the vocational rehabilitation counselor by her high school principal following her graduation from high school. She was referred because of a speech impairment. Mr. B. the principal, stated that she was a good student and that she participated in school activities on a limited basis. She was referred for counseling and possible college training.

Social Data

Sue is an attractive 18-year-old girl who dresses in the mode of the teenager. She wears her blond hair in a pony-tail. She is 5 feet 2 inches, weighs 105 pounds, and has brown eyes.

She lives with her mother, father, and 14-year-old brother in a modern brick home at the edge of a small midwest town. The home is furnished very attractively in good taste. The relationship between Sue and her brother appears to be wholesome. Mrs. S. reportedly overprotects her, according to school records. Mr. S., the purchasing agent of the local branch of a large mining company, appears to let his wife run the household. Both parents are high school graduates.

Discussion Questions

- (1) How would the parents' expectations and concept of Sue's ability and vocational goal influence rehabilitation planning?
- (2) How important is the parents' attitude toward Sue's disability? What are some of the possible dynamics underlying the mother's reported "overprotection" of Sue?

Educational History

Sue graduated from the local high school last month. Her performance in high school was very good. She had a grade average only slightly less than an "A" for all of her high school work. She ranked first in a graduating class of 40, but ranked in only the 55 percentile on the Ohio State Psychological Examination based on high school senior norms.

Discussion Questions

- (1) Is Sue's performance in high school consistent with her results on the Ohio State Psychological Exam? If not, how would you account for any discrepancies?
- (2) Of what significance is Sue's membership in high school clubs and the hobbies engaged in while in adolescence?
- (3) How important is the length of time Sue has pursued particular activities in evaluating her high school interests?

Medical History

A medical abstract received from State Crippled Children's Service reported that Sue had a speech impairment resulting from a congenital malformation of the oral cavity. Services had been provided by State Crippled Children's Service in the form of surgery, and the report stated that no further physical restoration was indicated. No mention was made of any recommendations for, or history of, speech therapy.

The high school speech teacher reported that she felt Sue's basic speech defect was only moderate, but that there was an additional decrease in performance when she had to talk with strangers. This cleared up as she became acquainted with a person, and after some familiarity with her speech patterns was gained she could be understood without difficulty.

Discussion Questions

- (1) Would the counselor be justified in accepting a written medical summary from Crippled Children's Service in lieu of the general medical examination?
- (2) What time limits should be set on the acceptance of a medical report—how recent must it be?
- (3) From what profession or professions, would you obtain an evaluation of Sue's speech impairment? How much would you expect to pay for a speech evaluation?
- (4) What are your criteria for determining when a speech impairment constitutes a vocational handicap?
- (5) If the specialist's report indicates that Sue's speech impairment can be substantially reduced within a reasonable period of time, what is the responsibility of the vocational rehabilitation counselor with respect to vocational training in the event that she rejects speech therapy?

Psychological Data

The psychological data in this case were obtained from two sources: Sue's records in the counselor's office at the local high school; and the testing provided by the vocational rehabilitation counselor.

Tests Results:

Ability: Ohio State psychological examination—55 percentile when compared with high school seniors.

Interests: Kuder Preference Record (vocational)—

High: Social service, literary and clerical.

Low: Mechanical and persuasive.

Aptitude: Minnesota clerical—90 percentile when compared with employed clerical workers.

The vocational rehabilitation counselor reported that Sue seemed to be relatively well adjusted; but sensitive about her disability. There was some evidence of maternal overprotection.

Discussion Questions

- (1) On the basis of the apparent discrepancy between Sue's ranking first in her class in terms of grade-point average and her measured scholastic ability, what are her chances of completing college successfully?
- (2) On the basis of the test data what tentative vocational objectives would the vocational rehabilitation counselor explore with the client?
- (3) Would you recommend training away from home if it necessitated payment of maintenance, but was available locally without this expenditure?
- (4) What use would the vocational rehabilitation counselor make of the test material in helping Sue arrive at a vocational choice?

Vocational Data

Sue's first-stated vocational interest was in social work. She later said that she felt talking would be required to such an extent that she would give up this ambition, although she maintained an interest in the field. Her second choice was to enter clerical work where she thought she would not deal directly with so many people, and where she felt she would be at no dis-

advantage. She said she believed that she could obtain a clerical job locally with some additional training.

Discussion Questions

- (1) How would you help Sue make a more complete vocational analysis?
- (2) What methods would you employ in encouraging her to use occupational and educational information?
- (3) Do you believe she would be satisfied doing routine clerical work? Why, Why not?
- (4) Suggest some suitable occupations for Sue on the basis of the data you have. What are the bases of your choices?
- (5) What is your general evaluation of this case?

CLIENT-STUDY CASE ABSTRACT NO. 3—THE CASE OF JOE B.

Referral Source

Mr. B. was referred to vocational rehabilitation by the personnel manager of a large automobile company following a heart attack which he suffered while working as a millwright. The referral was made for purposes of counseling and job placement.

Social Data

Joe B., a 41-year-old male, is married and has three children, ages 3, 7, and 9. He is 5 feet 10 inches and weighs 190 pounds. He is of rather stocky build, has a ruddy complexion, blue eyes, and dresses appropriately. He lives in a neat, three-bedroom, cedar-shake, ranch-style home in the suburbs. He reports going on hunting and fishing trips with his neighbors and occasionally taking in the ball game. His drinking is limited to an occasional beer.

The family seems to be a cohesive one. Joe speaks highly of his wife and is obviously proud of the children. The two oldest are doing very well in school. Joe had hoped to save enough money that the children could attend college if they so desired. He has taken out insurance policies on the two older children for this purpose. Mrs. B. has not worked out of the home since their marriage 12 years ago.

Discussion Questions

- (1) What additional social data would be helpful in working with Mr. B.?
- (2) What information can you get from the records of the personnel manager which would help in evaluating Mr. B.?
- (3) Should the family's overall financial situation be investigated? What possible ethical questions are involved in this area?

Educational History

Joe has completed the 11th grade in high school with grades slightly above average. He quit high school to go to work.

Discussion Questions

- (1) Of what value is a high school transcript for a man in this age bracket?
- (2) Should company records be evaluated to see if he has taken any on-the-job training during the years he has been employed as a millwright?

Medical History

A detailed abstract of Joe's medical history was obtained from the company physician. The company has a progressive health program providing for mandatory periodic medical examinations. The abstract from the director of the company's medical program states that Joe's present physical condition is that of class II-C according to diagnostic criteria distributed by the American Heart Association. A functional classification of II refers to individuals with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. More than ordinary activity results in fatigue, palpitation, dyspnea, or anginal pain. Those with a therapeutic classification of "C" are patients with heart disease whose ordinary physical activity should be moderately restricted, and whose more strenuous efforts should be discontinued.

Joe denies any serious health problems prior to becoming ill while at work 3 months ago. He has always been in good health and missed hardly a day of work in 20 years at the Eighth Street plant.

Discussion Questions

- (1) How adequate is a medical abstract? What additional medical evaluation would you desire?
- (2) If you decided to send Mr. B. to a specialist in internal medicine, what information would you provide him?

- (3) What is the counselor's role in the event that the medical opinion of the company physician and that of the examining specialist are in conflict?
- (4) What is the counselor's responsibility if the client enters and persists in employment which is contraindicated by medical opinion?
- (5) If a cardiac work evaluation unit is available, what would you expect to receive in a report from it?

Psychological Data

The client feels his present inability to support his wife and three children keenly, and would like to resume work as soon as possible. Although his former employer has agreed to rehire him and place him on light assembly work, he has rejected such a plan. He thinks that this could not utilize his knowledge and skill, would result in loss of pay, and would be a reduction in status to that of a semiskilled worker. He feels he might be able to qualify for a foreman's job, but there are no openings at the present time in the plant where he worked and it does not seem likely that any openings will develop there in the near future. He also feels that there is not much possibility of finding a job with a new employer because, "No one will hire a man in my condition."

Test Results

The following battery of tests was administered by the vocational rehabilitation counselor:
 Ability: Wechsler-Bellevue, Form I—Verbal Scale IQ: 120. Performance Scale IQ: 109, and Full-Scale IQ: 115.

Interests: Kuder Preference Record (vocational)—

High: Mechanical and scientific.

Low: Persuasive, artistic and clerical.

Aptitude: Bennett Mechanical, Form AA—93 percentile compared with apprentice trainee norms.

Discussion Questions

- (1) Is Mr. B.'s general ability in line with the type of work he has been doing for the past 20 years? Does he have the ability to work as a supervisor?
- (2) What additional psychological tests would you like to have administered to Mr. B.? Why?
- (3) Would psychological tests give some clues as to why he rejected the company's offer to return to work at what he perceived to be a lower level job?

Vocational History

Joe worked 2 years in a food processing plant before starting his apprenticeship at age 19 to become a millwright. He has worked steadily since that time as a millwright for the same company. He has a good work record, has earned good wages, has been satisfied with his work, and taken pride in his skill.

He is reported to have been a very good millwright, but to have had no other significant experience and little idea of his abilities or vocational potential outside of this work.

Discussion Questions

- (1) Where can the counselor find a job analysis on a millwright?
- (2) Where can he find information about related jobs which will permit maximal transfer of skills?
- (3) What resources might be utilized by the client and counselor in assessing the labor market of related jobs?
- (4) In the event that it does not appear that Mr. B. can ever return to employment as a millwright, should the counselor seek to provide counseling services aimed at bringing about a change in the client's basic self-concept? Should the counselor attempt to provide such services himself, or should a referral be made to a qualified psychologist?
- (5) How would you deal with Mr. B.'s statement, "No one will have a man in my condition?"
- (6) Of what vocational psychological significance is the client's age at onset of disability?
- (7) What type of training, if any, do you think might be explored with this client?
- (8) What is your general evaluation of this case?

APPENDIX B

PARTIAL CASE ABSTRACTS WITH TEACHING POINTS

SUGGESTED TEACHING POINTS FOR WHICH THE CASE ABSTRACTS MAY BE UTILIZED

<i>Case Abstract No.</i>	<i>Teaching points</i>
1-----	Criteria of "substantial employment handicap". Determining financial need in individual cases. Eligibility for vocational rehabilitation versus eligibility for a "specific service."
2-----	Outside of vocational rehabilitation dictation in acceptance of cases and provision of services. Acceptance of a case for "specific service or services."
3-----	Diagnosis based on adequate case study. Motivation
4-----	Vocational rehabilitation services must be related to job objective. Disability versus handicap.
5-----	Exercise in selecting areas of case study (following initial interview). Standards for considering dental disorders as an employment handicap.
6-----	Elements involved in a statement of eligibility (or ineligibility) where no previous work experience is presented in the case.
7-----	Circumstances under which personal adjustment counseling is indicated (developing selfunderstanding).
8-----	Personal adjustment to blindness. Transitional employment as a means of preparation for final job adjustment.
9-----	Utilization of consultation. Recognition of motivation. Reasonable expectation of satisfactory outcome in cases of drug and alcohol addiction.
10-----	Case recording techniques.
11-----	Techniques of counseling with respect to unrealistic objective. Development of rehabilitation diagnosis and prognosis.
12-----	Evidence of employment handicapped.
13-----	Reason for medical evaluation—employment limitations. Employment handicap.
14-----	Psychological, psychiatric development.
15-----	Counselor recognition of the need for consultation. Need for medical stabilization.
16-----	Directive versus nondirective counseling.
17-----	Personal adjustment service. Incomplete diagnosis. Psychiatry as a resource.
18-----	More suitably employable considerations in determination of eligibility. Family need versus client need.
19-----	Equal opportunity as a goal of rehabilitation. More suitably employable—eligibility.

<i>Case Abstract No.</i>	<i>Teaching points</i>
20-----	More suitably employable—eligibility. Equal opportunity as a goal of rehabilitation.
21-----	Job analysis. Furnishing of occupational equipment—relative responsibilities of employer, client, and rehabilitation agency.

REHABILITATION CLIENT No. 1

Partial Case Abstract

This 27-year-old woman, no dependents, was married to a serviceman and was receiving a service allotment. She was trained by the rehabilitation division as a bookkeeper. She was eligible for training because her legs were paralyzed following an accident. She used long-leg braces and crutches. She was employed in the office of a large chain store where she had received on-the-job training. She was later classed as being successfully employed in a suitable objective.

About 1 year after she was rehabilitated at a salary of \$130 per month, she returned to rehabilitation stating that she had been told by her doctor that he could operate on her legs and that she would be able to walk without using crutches. She requested that the rehabilitation service provide surgery and hospitalization.

The employer did not want to release client stating her work was satisfactory, that she had no trouble carrying out her duties, and that if she would stay on he would give her a raise.

Discussion Questions and Exercises

- (1) In this case what factors should be considered in making the determination of an employment handicap?
- (2) If she is determined eligible and in need of physical restoration services, what factors should the rehabilitation counselor consider in his determination of financial need?
- (3) What distinction should be made between eligibility for vocational rehabilitation and eligibility for a specific service?

(Case Study; Evaluation and Diagnosis; Provision of Services; Determination of Financial Need)

REHABILITATION CLIENT No. 2

Partial Case Abstract

A 34-year-old, single man with a high school education, arrested tuberculosis, is 6 feet 4 inches tall and weighs 140 pounds, was trained as a linotype operator by the rehabilitation service in 1944 at which trade he has worked successfully in various places until his lungs became reinfected with tuberculosis. He had to quit his job as a linotype operator and stayed in the sanatorium for 5 to 6 months. At the present time he is under supervision of the county health officer, who has known the boy since original infection in 1939.

The county health officer contacted the rehabilitation counselor, requesting assistance for this man to go through a period of recuperation which is from 18 months to 2 years. In addition to being a linotype operator, the client has also worked as a barber with satisfactory proficiency. His type of physical condition and this occupation are not in conflict.

The county health officer recommends that the client continue barbering and has asked the rehabilitation service to provide him with barber supplies and tools and buy him a chair in order to speed up recuperation so that the client will have something to live on during this period. He lives with his parents whose sole income is from the welfare department. The county health officer states that if he can get results from new drugs and antibiotics, he feels that the client's tuberculous condition can be permanently cured.

Discussion Questions and Exercises

- (1) What are the considerations for or against disregarding the former occupation of linotype operator?
- (2) What are some of the considerations involved in dealing with a case on the basis of an outside request for a specific service? What methods would you employ in meeting this situation?
- (3) What do you feel are the client's immediate problem(s)? What are the agency's responsibilities in providing services to meet these problems?

(Case Study; Public Information)

REHABILITATION CLIENT NO. 3

Partial Case Abstract

A 46-year-old married man with four children ages 7 to 16 to support. They are receiving assistance from public welfare. He is 5 feet 7 inches tall and weighs 140 pounds. His work record is in the coal mining industry. He has not worked for the 6 years since he sustained an injury to his right hand. He had received maximum treatment and cash benefits under the United Mine Workers Welfare and Retirement Fund but during the convalescent period complained of a back disability and a rheumatic condition affecting the shoulders and arms. He was referred to rehabilitation by public welfare. He owns a small amount of personal but no real property. He has resided in the same community all of his life.

The rehabilitation process was explained to the client in detail. He has a sixth grade education and apparently has fair intelligence. His interests outside of employment are hunting and fishing. The counselor has attempted to motivate the client through a discussion of employment or training. The client usually replied that he was willing to do any kind of work. The counselor encouraged him to suggest some occupations in which he might be interested. He indicated an interest in a poultry project. One of his neighbors is a rehabilitation client who is engaged in a similar occupation. Because the client lived on rented property, which lacked proper buildings and water supply, he was advised against this program.

The rheumatism in his arms and hands seems to have bothered him recently. The use of his right hand is limited by some stiffening in the wrist but he has good use of his fingers. He makes no attempt to contact possible trainers or employers between visits with the counselor.

Discussion Questions and Exercises

- (1) What additional factors might have been considered in the case study?
- (2) What problems of motivation are involved in this counseling situation?

(Case Study; Counseling and Planning)

REHABILITATION CLIENT NO. 4

Partial Case Abstract

A 44-year-old married man, with two dependents—his wife and one brother—has been employed as a tool room attendant with the same firm for 21 years. This man has a physical disability consisting of a cleft palate and harelip. Surgery was performed at age of 12 for correction of harelip, no surgery has been attempted on the hard palate. Medical evaluation does not recommend surgery for the palate and a prosthesis is recommended. Speech evaluation recommends a prosthesis with speech training as his speech is usually nasal with nasal emission and a rather serious articulatory defect. Graduate of high school. This man has an income of \$250 per month and must contribute \$15 monthly toward brother's keep at a county home.

Discussion Question and Exercise

- (1) How does this case relate to the general field of rehabilitation as compared with the objectives of vocational rehabilitation?

(Basic Concepts of Vocational Rehabilitation)

REHABILITATION CLIENT NO. 5

Partial Case Abstract

A 53-year-old married man, father of six children, one married and one in the Army, other four range in age from 12 to 18. At present the client is drawing unemployment compensation of \$65 each 2 weeks from a railroad. He has worked as a section hand on railroad repair crew for past 7 years. Client states he is in poor health because of his teeth which are infected and draining into his right ear. Claims he "can't hardly eat and my stomach is affected."

Discussion Questions and Exercises

- (1) Assuming, as indicated from the information, that this case has gone no further than the initial interview, what areas of case study would you select in order to identify this individual's rehabilitation problems?

- (2) What factors should be considered in dealing with cases where dental disorders are the basis for the disabling condition?

(Preliminary Investigation; Evaluation and Diagnosis)

REHABILITATION CLIENT No. 6

Partial Case Abstract

A single 19-year-old girl with less than 20/200 vision in left eye. Vision not correctable and does not alter girl's appearance. At present, she is in her first year of nursing school. School course lasts 3 years, first year is spent in college, last 2 years are spent in hospital work. The girl does not consider herself handicapped but she is eligible for vocational rehabilitation services and wants help in the payment of tuition. She has no previous work experience.

Discussion Questions and Exercises

- (1) What effect would the fact that "the girl does not consider herself handicapped * * *" have on the counselor's decision as to whether or not further study should be made?
- (2) If the individual is entering an occupation which does not require binocular vision, how could you demonstrate whether or not an employment handicap exists?

(Preliminary Investigation)

REHABILITATION CLIENT No. 7

Partial Case Abstract

A single 35-year-old man, no dependents, has been working at the same firm as an accountant for the last 17 years. He is 5 feet 9 inches and weighs 170 pounds. He developed stomach ulcers and decided he should quit his job on account of it. His employer doesn't want him to quit and his doctor tells him the ulcers can be cured more readily by proper diet and medication if he continues at work than if he stays at home with nothing to do but worry.

In spite of this, he decides to quit his job since he feels that the worries caused by it are causing his ulcers. He is now unemployed and is unwilling to take another job as an accountant for the reasons stated above. He applies to vocational rehabilitation for training to become a lawyer.

Discussion Questions and Exercises

- (1) What additional information would be needed to make a decision as to eligibility?
- (2) What other types of agencies or specialists might you consult to aid you in arriving at a more complete evaluation as a basis for counseling?
- (3) What possible factors would you consider as being possible basis for this man's complaints and how would you relate them to your possible counseling program?

(Case Study; Evaluation and Diagnosis; Provision of Services)

REHABILITATION CLIENT No. 8

Partial Case Abstract

A 32-year-old married man, with two dependents, worked as a logger all of his employable life, to the time when he had to discontinue this type of work due to retinal detachment, right eye. Two years later, a retinal detachment occurred, followed by retinitis proliferous, left eye. He was considered by the examining ophthalmologist to be permanently and totally blind, both eyes, and no treatment was recommended. He was poorly adjusted to his disability, insisting that he was unable to do any work whatsoever, in spite of the counselor's efforts to convince him that there are still many fields of endeavor in which he might engage. It was thought that he might begin on a small scale by learning to make and sell belts and coin purses, and that after regaining self-confidence, he could be placed in some more remunerative work, but he was not willing to try.

The following year, another ophthalmologist operated on the client's right eye for removal of cataract, but no vision was restored and he said he had developed severe pain in his eyes and head. His case was closed as unemployable.

After 3 years he returned to the counselor, stating that he was ready to cooperate. A new eye examination revealed the right eye pupil to be eccentric and an immature cataract. After-cataract membrane, left eye. Surgery on the right eye was recommended. This was done and glasses provided. He still contends that he cannot see and insists that he has stomach ulcers; however, the general medical examination revealed "normal abdomen." After discussing numerous jobs, he finally agreed that he might wash dishes at a cafe, but we have been unable to place him, to date, and he makes no effort to help.

Discussion Questions and Exercises

- (1) Enumerate the facts which might lead to the counselor's statement "he was poorly adjusted to his disability. * * *"
- (2) What are the things to be considered in analyzing an individual's adjustment to his disabilities? (What about the stomach complaint?)
- (3) Of what value is manual work in developing self-confidence and ultimate opportunity of employment for blind persons?
- (4) What are the indications that client did not cooperate?
- (5) What consideration was given to his preparation for work?

(Counseling and Planning)

REHABILITATION CLIENT No. 9

Partial Case Abstract

Client is 59 years old, in excellent health from an organic standpoint, but with a severe psychoneurosis and a wry neck resulting from alcoholism and barbiturate habituation.

He worked as a foreman for the past 20 years for a local wax manufacturer, enjoying the confidence and respect of all who knew him. For no apparent reason he suddenly developed into a drinker. He would leave the job during the working hours and "lift six or eight quick ones." He also began playing the horses, losing hundreds of dollars at a clip. Then came the barbiturates to supplement the liquor.

The head of his firm became interested and spent \$3,000 trying to straighten him out, but to no avail. He was discharged after 1 year's hospitalization. At the time he was interviewed, he had been off both drugs and alcohol for about 5 months. He owes about \$3,000, part of it on personal, unsecured loans. He is now going through bankruptcy. He wants to be rehabilitated. He wants to earn money, but because of his wry neck and age, it is almost impossible to place him. In the meantime, his wife has divorced him. He has two sons, 16 and 17 years of age. He has a severe sense of guilt.

Discussion Questions and Exercises

- (1) Since it is said that this man is cured of his alcoholism and drug addiction, what is his disability? What limitations are imposed by his disability, if he has one? How are the limitations, if any, an employment handicap?
- (2) What specialists might be consulted in an attempt to discover his basic problem or problems? How would team evaluation help if it would help?

(Evaluation and Diagnosis; Consultation)

REHABILITATION CLIENT No. 10

Partial Case Abstract

This 41-year-old man's source of income at the time of referral was Aid to the Permanently and Totally Disabled. The maximum grant was necessary to provide his care in a nursing home. The client had been run over by a car, leaving him with multiple fractures of the right leg and a fracture of the left femur. There was malunion of the fracture of the left knee. The client needed physical therapy.

He had a second grade education. He impressed the counselor as having been through a lot of trouble but who was going to be difficult to wean away from APTD. He was receiving a grant which would probably aid him in arranging necessary physical restoration services and there was no urgency that vocational rehabilitation enter the case. However, the medical reports indicated that the client would be able to take part in light work such as sweeping, grading tobacco, and

other farmwork. It appeared reasonable to believe that the medical information meant that the client would be able to return to a reasonable amount of work. Due to lack of education and motivation, training seemed to be very questionable in this case but direct placement in a menial job seemed possible. The case was accepted and the client is now undergoing physical restoration services through vocational rehabilitation.

The client is separated from his wife. The client has been in a nursing home since we first met him, but expects no help from his estranged wife. He also has a daughter.

A report from the client's doctors states that he probably never would be able to do work which required much standing or walking and recommends that he be trained for some sedentary occupation. Since we entered this case the medical evaluation of his work prognosis has changed for the worse. Training appears to be unpracticable. It is likely that the client has not progressed as expected and cannot be expected to walk and stand as much as previously thought possible. However, he was so severely handicapped, we had a pretty good idea that we might have a nonfeasible case on our hands. He has no family resources to which he can look and will likely cling to APTD as his only source.

Discussion Question and Exercise

- (1) Using this case as presented, rewrite the diagnostic summary in accordance with previous discussions of the techniques of good case recording and summarization.

(Case Recording)

REHABILITATION CLIENT NO. 11

Partial Case Abstract

A 19-year-old girl, confined to wheelchair, very little use of legs and hands as a result of polio and spinal meningitis.

High school graduate 1 year ago. Her academic work was all done by correspondence through University Extension Division, high school average B+; wishes to be a social worker; psychological testing done, showed she is not college material—IQ 99. Subsequent testing showed average intelligence on Weschler-Bellevue; on Ohio State Psychological examination no subtest scores fell below the 97th percentile and a total test percentile rank of 99 was achieved. Psychologist suggested prior acquaintance with the test as possible explanation for this high score.

An orthopedist and a neurologist agreed that social work was beyond client's possibility due to her handicaps; counselor informed client and her parents that test results indicated that college work was beyond the ability of the girl and suggested a commercial course, which was recommended by the psychologist. This was refuted by both parents and client, who insisted on going to a university. Rehabilitation counselor suggested that she visit the school to see what special provisions were made for paraplegics and that if the university would accept her, he would be willing to submit a plan.

Client has been taking correspondence courses through this university in history and has received a grade of B; rehabilitation supervisor of the college informed vocational rehabilitation that they would accept her for the September term.

Discussion Questions and Exercises

- (1) List all the facts from the information contained in this case, which would provide a valid basis for counseling and planning.
- (2) Evaluate the consistency of the conclusion that the objective of social work is beyond the client's ability.
- (3) Assuming that a university course is beyond the mental capacity of this client, how would you counsel with this client? (How would you counsel with a client who has unrealistic goals?)

(Evaluation and Diagnosis; Counseling and Planning)

REHABILITATION CLIENT NO. 12

Partial Case Abstract

A 33-year-old man sustained a 10-percent permanent total disability while on job as a welder in construction work. He was injured by a heavy object falling on his shoulder and a third degree burn on the right upper arm and chest.

During his hospital stay, plastic surgery was performed on the chest and physical therapy was given for the shoulder and arm. The latter was continued on an outpatient basis after he left the hospital. After the healing period, medical specialists suggested that he return to employment. He was told that the residual weakness to the right shoulder and arm might partially handicap him for life but that there was a possibility that normal activity would gradually but substantially reduce the disablement.

Eight months after the accident, the man returned to his former job. He has been steadily employed as a welder for the past 16 months. His employer speaks highly of him and of his ability to do a good job.

However, the 35-year-old worker requests vocational rehabilitation services on the basis that he is handicapped in doing overhead welding and that the hoped for return of strength to the affected shoulder and arm has been negligible. He does not believe that he will be able to continue welding for an indefinite period because of his condition. He has requested a vocational diagnosis and appropriate vocational training.

Discussion Questions and Exercises

- (1) What information other than medical reports would be necessary to determine eligibility for vocational rehabilitation purposes? Where could information of this type be obtained?
- (2) How might a counselor go about resolving conflicting evidence of work competence as between the employer and the employee?
- (3) To what extent is the counselor in this case responsible for trying to direct this individual into types of welding he can do without tiring?

(Case Study; Evaluation and Diagnosis)

REHABILITATION CLIENT NO. 13

Partial Case Abstract

Client was referred by the city welfare department. He is 34 years of age. According to the general medical examination, the diagnosis of client's disability is as follows: Duodenal ulcer with symptoms thereof, nervousness. Survey information indicates that client was hospitalized 15 days for ulcer surgery. Client has an eighth grade education, part of which was obtained by attending a school for the mentally retarded.

At the date of contact client was on public welfare and was divorced. Client has a stepfather, age 59, who is unemployed, and a mother, age 52. Previous employment consisted of coal passer on lake boat 10 years, laborer scrap iron yard 1 day, and bread wrapper 2 weeks. General medical indicates limitation in stooping, straining, and work in high places.

On the basis of survey information and the general medical, a plan was developed for vocational training in welding. The plan was disapproved by the district supervisor who stated that he wanted more evidence concerning substantial employment handicap. Psychological testing was then given which indicated intelligence score of 67 on the Wechsler-Bellevue scale. Psychological report also indicated that client is unstable, is an extreme hypochondriac, is a high-grade mental defective, is resentful toward his stepfather and probably needs a suitable substitute father.

Discussion Questions and Exercises

- (1) What are the inadequacies involved in the diagnosis as shown by the counselor's submission of the plan which was disapproved?
- (2) What did the psychological testing report add to a more complete understanding of the problems of the client? What other areas of investigation are indicated?

(Case Study)

REHABILITATION CLIENT NO. 14

Partial Case Abstract

A single girl, age 17, with no dependents or immediate relatives has lived the major portion of her life in a boarding home sponsored by the Children's Aid Society. She had polio at the age of 4, has completely flail lower extremities. She walks with double braces and crutches. She has completed the ninth grade of formal education. No further medical service was recommended by the Crippled Children's Service. She has a history of syphilis in early life.

She did very good work in elementary school, fair work in junior high school, and failed most of her subjects in the 10th grade of high school. Due to her age, the Children's Aid Society were having to close their service to her. Since she was not permanently and totally disabled, there was question as to whether the Department of Public Welfare would serve her. She did not confide in anyone and appeared to have very few close friends. She was a problem to the boarding home mother as well as outright rebellious with the school authorities. She has a history of minor thievery.

On the intelligence test she functioned on the dull-normal level. Her only expressed interest was to become a secretary. Psychological tests revealed some interest in secretarial work. Our service was requested to assist her with a secretary's course at the State Vocational Trade School whereby she might become gainfully and self-supporting.

Discussion Questions and Exercises

- (1) What types of information would be needed in order to reach a decision on this case?
- (2) What consultation would be appropriate to the gaining of a more complete understanding of the client's potentials?

(Case Study; Evaluation and Diagnosis; Consultation)

REHABILITATION CLIENT No. 15

Partial Case Abstract

A single girl, aged 21, family dependent, graduated from high school at age 18 with an average of 72 and attended a Teachers' College for 2 months. She states that she left because of her health.

When about 14 years old this girl developed epileptic seizures which occurred about once a month. At the time of referral she was under medical care and taking medication but never achieved complete control. Psychometric tests indicated an IQ of 84 (California Test of Mental Maturity). She had very poor coordination of mind and hands. Her chief interests appeared to be teaching and nursing. A plan was made to train her as an attendant nurse at a large hospital. After tentative acceptance, client was later rejected because of epileptic history.

After this rejection client expressed desire to resume teacher training at another college. She was admitted to another teachers' college on a trial basis. After a month she left because she "got nervous and confused," but president of college stated that she was unable to adjust to social and academic program, attending classes irregularly and giving little evidence of ability to do college work.

After nearly a year, client was enrolled in a correspondence course in typewriting, English, and bookkeeping in conjunction with tutorial instruction. She did fairly well in typing, but the teacher said that she would never make an "all round officeworker." Client gave up training because of health, claiming she heard voices and attempted suicide. Psychiatric examination revealed "psychosis with convulsive disorder, epilepsy, epileptic deterioration." Client was placed in a State hospital.

Discussion Questions and Exercises

- (1) What are the methods for determining the appropriateness of a training situation?
- (2) How can a counselor be certain that medical information is adequate? When and to what extent is medical specialty consultation employed in rehabilitation casework?
- (3) Of what importance is motivation in the rehabilitation process?

(Case Study; Evaluation and Diagnosis; Provision of Services; Consultation)

REHABILITATION CLIENT No. 16

Partial Case Abstract

A 19-year-old boy, single, was referred by his high school principal just prior to graduation. During the first interview, the client stated he wished assistance in the selection of a proper vocation. As a result of a congenital midline deformity of fusion which involves the central nervous system and face, the client has multiple disabilities. With best correction, his vision

is 20/70 and 20/200 for distance and J-8 and J-18 for reading. He has marked nystagmus and congenital divergence. Coordination and finer movements of upper extremities are markedly impaired but the client has only slight difficulty in walking. It was recommended that the client not drive an automobile or work with tools around moving machinery or objects dependent upon sight.

The client had a "C" average in high school and psychological tests revealed in IQ to be above average. Clerical interest was high average; all other areas average with exception of the mechanical field which was low average. Mechanical aptitude tests indicated inferior mechanical aptitude. He worked slowly but his manual dexterity was rated as fair. On the clerical speed and accuracy test, he made no errors but his vision permitted him to complete only a small portion of the test. The client stated frankly that he was not too interested in attending college but would go if it seemed best or if his parents insisted. He consistently expressed an interest in some day operating a business for himself. He wished independence, financial and otherwise, from his family.

A plan was completed for the client to attend college to study business administration. He attended four quarters and during the last quarter failed in every subject. He earned a total of 35 hours with only 32 quality points. Training was terminated. He is opposed to attending business school, but still has in mind entering a business of his own even though he does not have the financial backing nor the necessary knowledge. His home situation has become unpleasant and the client has moved to the YMCA.

Discussion Questions and Exercises

- (1) What circumstances justify the plan for college training in this case?
- (2) What evidence is there that the client shared in the development of a vocational plan?
- (3) What justification exists for the exploration of a small business opportunity?

(Counseling and Planning; Evaluation and Diagnosis)

REHABILITATION CLIENT No. 17

Partial Case Abstract

A 21-year-old male, permanently blinded individual—¹one eye enucleated and other shrunken. Client has slight hearing loss. Tried to fit into schools for blind in two States for elementary education, but was withdrawn from both schools because of nervousness. He seemed overly dependent on others for daily needs. Client was tutored at home and accepted as special student in regular high school from which he graduated. He has never been employed. Test results on verbal form of Wechsler-Bellevue indicate better than average verbal ability.

Rehabilitation center for the blind reports on vocational diagnostic services: Has good ability to localize sounds; excellent obstacle perception. Potential for doing heavy work; good attitude: intelligent; poor personal appearance; poor physical orientation (lost in space); often becomes "turned around"; shapes and sizes are not meaningful to him tactually; things that he touches have less meaning for him than for anyone instructor has ever tested; very poor observer; does not make use of his available senses to explore the world around him; lacks initiative and thoroughness in observing; lazy, quits exercising when he begins to become a little tired; seems to have acrophobia; also has a childish tolerance for physical pain; emotionally disturbed; nervous manifestations, such as wringing hands, stuttering and eczema on hands; dependent; has not learned to take responsibility; has not learned to think and act for himself; immature. Has a tendency to live in a make-believe world; complacent; tries to "wish" things done. Coordination is poor between hands and feet; also between the two hands; no skills developed in working with things. Client cannot function under pressure of any kind; Center recommends a home study course in preparation for a college course. Client has expressed interest in ministry and in teaching.

Discussion Questions and Exercises

- (1) What services (adjustment or others) are suggested by the vocational diagnostic study? How does one utilize the results of a client analysis by a cooperating facility?
- (2) What further diagnostic evaluation would you as a counselor desire?
- (3) What areas of case study (social, educational, emotional, etc.) would lend themselves to further development?

(Case Study; Evaluation and Diagnosis; Provision of Services)

REHABILITATION CLIENT No. 18

Partial Case Abstract

A girl is referred to vocational rehabilitation with a left congenital club foot corrected by a series of operations. There is some atrophy of the limb and a prominent limp.

At the time of first contact, this single girl lacked three-fourths of a credit of finishing high school. Her ambition to be a nurse or a medical secretary was considered. Without training, she secured a low-paid job as receptionist for a doctor. She was married and the case closed without service.

Four years later, a divorce and two minor children brought home to her the need for training. In the meantime, she had worked as a telephone operator and considered objectives of X-ray technician, medical secretary, and stenographer. Client had a definite interest in the medical and technical field. She had the required mentality, good personality, and ambition to succeed.

Training was arranged with an X-ray specialist, including all phases of the laboratory worker's job, without cost to the bureau. Some maintenance was provided, as her laboratory earnings were insufficient for the family expenses. A high school certificate of equivalency was secured to allow for later certification. Training progressed satisfactorily and client's wages were usually advanced ahead of schedule. Towards the end of the training program, she complained about being on her feet all day. This was easily adjusted in this large X-ray laboratory by assignment of a variety of duties during the afternoon, including the typing of records.

Discussion Questions and Exercises

- (1) What justification exists for provision of service to a client with experience in a physically suitable occupation?
- (2) Discuss vocational rehabilitation's responsibility for maintaining family of client during preparation for employment.

(Determination of Financial Need; Evaluation and Diagnosis; Provision of Services)

REHABILITATION CLIENT No. 19

Partial Case Abstract

Client is a 28-year-old, unmarried male. After high school graduation he worked in an exterminating company for about 1 year before going into the Army in which he served 2 years, doing mainly clerical work. After service he worked 5 years as a laborer for a cork company. He took a laboratory technician course for 15 months, under the GI bill and at the same time, worked part time as a switchboard operator. Later he was employed full time as a laboratory technician, at a salary of \$250 per month, and after a year, he broke down with pulmonary tuberculosis. During hospitalization at the VA hospital he had a resection of his right upper lobe, and when well on his way to recovery, was permitted to work in the hospital research laboratory. Upon discharge from the hospital, the doctor advised client could safely return to his previous occupation as laboratory technician. Client has been reemployed now for a year as a laboratory technician.

Client's parents, brothers and sister have had many health and family problems which have kept client from attaining his goals—medicine (more specifically, surgeon) or bacteriology.

Extensive psychological testing shows client to be of superior intelligence; his perceptual and motor skills are of an extremely high order; and "in terms of interest, personality, and ability, he seems a natural for his chosen field." Client's parents are now deceased, his brothers and sisters are all grown and independent. He is now applying to vocational rehabilitation for financial assistance for training to become a doctor or bacteriologist.

Discussion Questions and Exercises

- (1) What are the agency's responsibilities with respect to the client's hopes and aspirations?
- (2) Is client, without further service, at the point where he can compete with the nondisabled without disadvantage?

(Case Study; Preliminary Investigation)

REHABILITATION CLIENT No. 20

Partial Case Abstract

Client is now a reopened case. Disability was polio, both legs severely affected. Client wears two full leg braces. Client is a high school graduate with a B+ average. He did artwork in

high school on the yearbook. Definite natural ability but no training in art. While driving a truck, he killed a woman. The son of the woman was riding in the cab at the time. Possible psychic trauma as result. Client is intelligent, enthusiastic and very ambitious. Should be given opportunity to go to college. Interested in doing something while convalescing. Kuder Preference Record showed very high social interest, high art interests, and interest in music.

Took two correspondence courses in the Elements of Drafting. He got a 95 grade in both courses. It seems the objective should be drafting. The original objective in school was drafting or art. In the meantime, client got interested in photo retouching and forgot about plans to go to college. He got a photo retouching machine and was then closed out by vocational rehabilitation. He now concludes retouching is too nerveracking. He says it is hard on his eyesight and he can't work at it steadily enough. Also, it is seasonal. Client realizes he should have followed the original plan.

Psychological testing indicates the following: Wechsler-Bellevue Verbal IQ 117; Performance IQ 126; Full-Scale IQ 124. Superior general intelligence. Unusual amount of ability in art and drawing. Fortunate personality, sincere, poise. Client realistic about handicap. Three careers possible—Engineering (architecture, etc.), photography, and teaching.

Discussion Questions and Exercises

- (1) Under what conditions may a client be given services to become more suitably employable?
- (2) What steps should be taken to verify a client's complaints or dissatisfaction?
- (3) Is client without need of further service, at the point where he can compete with the nondisabled without disadvantage?

(Case Study; Evaluation and Diagnosis)

REHABILITATION CLIENT NO. 21

Partial Case Abstract

Client referred by private agency. Eye report received. OD 8/200, retinal detachment. OS no vision, complicated cataract. Should avoid lifting, stretching, pushing, pulling, stooping. Travels alone with cane, can read Braille, grade II, can detect color faintly, can read headlines with magnifying glass. There are no limitations other than blindness, ventricle slightly enlarged to the left resulting from a heart attack in 1953. Doctor states he has apparently made a complete recovery. Client's blindness constitutes a vocational handicap which requires change in equipment so that he will be able to perform.

Client has degrees in English literature from three universities. Client's main employment has been in writing, copywriting, and allied research. His job, which is being held open for him, is with an advertising firm. This job paid \$7,700 per annum. Client is a 53-year-old married male, living with his wife, who is a housewife. He is an attractive looking, tall, stately gentleman with a very polished pedagogic air. Client is extremely polite, unassuming and direct. He states he has made adequate adjustment to blindness and heart condition, which is corroborated by his doctor.

Client states his old position is being held open if he can demonstrate that he is capable of doing the work. He was research director at a financial advertising and public relations agency. His work involved copywriting for advertisements. Client states that he will need some type of recording machine in order to make adjustment to his former work. A machine with a disc record is preferable to a wire or tape recorder. Client is now trying out a recording machine on a 90-day trial basis. Client feels he will need two recording machines, one for home and one for office use. Statement to be secured to determine economic need. Details of job to be discussed with client in order to make usable suggestions for working out vocational problems.

Discussion Questions and Exercises

- (1) What further medical study, if any, is indicated?
- (2) What facts show presence or absence of any employment handicap?
- (3) How does this case illustrate the importance of the principle of need for careful matching of capacities and limitations with job conditions?
- (4) What arguments can be advanced for and against having the client or the employer meet the cost of the recording devices?

(Case Study; Evaluation and Diagnosis; Provision of Services)