The Professional Practice of Rehabilitation Counseling
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The Professional Practice of Rehabilitation Counseling

Second Edition

Editors
Vilia M. Tarvydas, PhD, CRC
Michael T. Hartley, PhD, CRC
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Serve—serve proudly, ethically, professionally, and with an emphasis on empowerment—that is your mission after reading, reflecting on, and embracing the foundational and contemporary information eloquently presented in this textbook.

As a former recipient of rehabilitation counseling services, a former practicing rehabilitation counselor, and now a rehabilitation counselor educator and the president of the National Council on Rehabilitation Education (NCRE), I believe that the future for rehabilitation counseling is a positive one that will be highlighted by new opportunities, contributions, and advancements in the essential knowledge, attitudes, and skills for effective and ethical practice. The counseling profession recently reached yet another major milestone with the merger between the Council on Rehabilitation Education (CORE) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP). As the president of NCRE, I have had the opportunity to discuss the CORE and CACREP merger with faculty and students, listening to concerns about the potential loss and abandonment of rehabilitation counseling concepts, values, and traditions. Like the many scholars who have written chapters in this textbook, my message has been to note the advantages of the merger. The possibilities are endless because rehabilitation counseling concepts of consumer empowerment, psychosocial rehabilitation, and the effect of disability in all aspects of life are vital to the future practice of all counselors, regardless of specialization. The merger has also reinforced the notion that rehabilitation counselors are indeed counselors.

With this in mind, I am honored to provide my reflection and commentary on the great work included in the present edition of The Professional Practice of Rehabilitation Counseling. Readers will find that the main pillars of the new edition of this text are the unification of the counseling profession and the full inclusion of individuals in less restrictive environments regardless of gender, race, socioeconomic status, religion, physical or mental abilities, or any other individual characteristic. The position adopted in this text does not call for the abandonment of the traditional practice of rehabilitation counseling and its emphasis on vocational, medical and psychosocial aspects of disability, case management, independent living, and assistive technology. Rather, the position adopted in this text integrates these traditional concepts within the framework of advocacy, empowerment, recovery, and the clinical counseling practices embraced by psychiatric rehabilitation and mental health professionals. The editors and their contributors have

“There best way to find yourself is to lose yourself in the service of others.”

—Mahatma Gandhi
highlighted the need for rehabilitation educators, students, and rehabilitation counselors to embrace the concept of a qualified rehabilitation counselor. A qualified rehabilitation counselor is a professional who can effectively attend to the vocational and mental/emotional needs of individuals who historically have been challenged by the stigma and oppression that are caused by the disability experience. The end result is an integrated professional identity that honors the foundational concepts of our noble profession.

The present edition of *The Professional Practice of Rehabilitation Counseling* arrives at a critical moment in time with the CORE and CACREP merger. Our agenda as rehabilitation counselors must be to reexplore the contributions of the rehabilitation counseling scope of practice, research body, and knowledge domains of clinical rehabilitation counseling practice and the counseling profession more generally. This is an agenda that is consistent with the vision of many of our professional organizations, such as NCRE. It also requires the expansion of the rehabilitation counselor education curriculum to reflect contemporary professional requirements, competencies, and knowledge domains; the formulation of research agendas that focus on emerging issues and trends; and the development of professionals, leaders, and advocates who will advance the profession while meeting the needs of people with disabilities. To be sure, the chapters in this text have been conceptualized and written by forward-thinking individuals who represent the core values, knowledge base, and traditions of rehabilitation counseling as a specialty and with counseling as our profession. Many of these scholars and leaders have contributed significantly through their service to many counseling professional organizations (e.g., American Counseling Association [ACA], American Rehabilitation Counseling Association [ARCA], National Rehabilitation Association [NRA], National Rehabilitation Counseling Association [NRCA], and NCRE), credentialing bodies (e.g., CORE and CACREP), credentialing associations (Commission on Rehabilitation Counselor Certification [CRCC] and National Board for Certified Counselors [NBCC]), and licensure boards (e.g., American Association of State Counselor Licensure Boards [AASCB]), while at the same time making important scholarly contributions to the specialized knowledge base of rehabilitation counseling.

It is my firm belief that the present edition of *The Professional Practice of Rehabilitation Counseling* will crystallize the intersection of the traditional practice of rehabilitation counseling with emerging practice settings, such as behavioral and mental health. In doing so, this textbook will highlight the application of rehabilitation counseling concepts and techniques to the practice of mental health counseling, an increasingly common job function of rehabilitation counselors. Chapters included in this edition of the text present contemporary and seminal literature on the foundations of the rehabilitation counseling practice, including: an overview of private sector practice; information on the disability experience, with particular attention to family relations, disability rights, and disability issues from a global perspective; and a detailed account of perennial and emerging professional roles and competencies. Special attention is given to key aspects of practice, including advocacy and social justice, psychiatric rehabilitation, counseling and mental health issues, assessment, vocational and career development, case management, and ethics.

On a personal note, I knew Vilia Tarvydas as well as Dennis Maki, the previous editor of this textbook, while earning my doctoral degree at the University of Iowa. Their teachings, advice, mentorship, and collegiality are second only to my appreciation for their friendship. I also have had the pleasure of knowing Michael Hartley since we were fellow doctoral students at the University of Iowa. He is a strong researcher and colleague, and I look forward to his many contributions as a future leader in the field.
work of this magnitude requires the knowledge and expertise of many scholars, and I want to thank all the chapter contributors. It has been an honor to have read and followed their scholarly work, hoping one day to contribute and serve as significantly as they all have. Last but not least, in the spirit of Gandhi’s life and reflection on service to others, I encourage all of the readers of this text to read, reflect, and consider the many ways to be of service to others. There is a continued need to promote a more welcoming and inclusive society by increasing opportunities and services for people with disabilities, thereby diminishing the isms that affect their everyday life.

Noel Estrada-Hernández, PhD, CRC
We welcome you to the second edition of *The Professional Practice of Rehabilitation Counseling*, or more accurately, the fourth edition of this foundational text on rehabilitation counseling, titled in previous editions as the *Handbook of Rehabilitation Counseling* and *Rehabilitation Counseling: Profession and Practice*. The current title is the same as the third edition edited by Dennis Maki and Vilis Tarvydas, maintaining the structure and format of that edition, yet with new and most timely content to address more broadly psychiatric rehabilitation and the practice of mental health counseling as practiced by rehabilitation counselors. The opening chapter describes in detail the organization of the text and the content that has been included throughout subsequent chapters.

The information in this text has been developed by some of the strongest scholars in the field. The contributing authors are experts on their respective topics, and we are fortunate to have put together such a remarkable group of scholars. In each chapter, the authors have provided clear lines of inductive and deductive reasoning to provide clear takeaway points allowing us both to understand our past as well as look to the future. In doing so, our intent is to memorialize the history and philosophy of rehabilitation counseling, while simultaneously assimilating new research and knowledge from breakthroughs in neuroscience and pharmacology, innovations in digital communication and technology, and shifts in the economy and social milieu. In other words, without throwing out the baby with the bathwater, we fundamentally believe that the knowledge and tools used by rehabilitation counselors today should not be the same as 10 years ago.

It became apparent when we surveyed rehabilitation counselor educators and their students that there was a need for an updated introductory textbook in rehabilitation counseling. The professional practice of rehabilitation counseling is in a state of change, yet no versions of introductory texts have emerged that directly address the significant changes in the nature of practice since the last edition of this text in 2012. It is a daunting task to predict what will happen in the field moving forward, because of unprecedented changes. Although we do not claim to know the future, we believe a clear understanding of our history and philosophy will allow current and future students, educators, and practitioners to have a fairly good sense of a future for themselves as well as their clients.

Editing this text has been a remarkable journey, reassuring us that rehabilitation counselors will continue to have a wide range of professional opportunities because of their unique training, expertise, and emphasis on disability as a civil rights issue. With this in mind, we hope that readers will respond with excitement to imagining the futures that excellence in professional practice in rehabilitation counseling may bring them. We also hope that they will take to heart the knowledge and wisdom that our
authors have sought to impart to them to guide them on this journey. We have been careful to make the content as accessible as possible for readers new to the field. For qualified instructors who adopt this text, we alert you to the very fine ancillaries to this book, including PowerPoint slides, learning activities, Internet resources, and a test item bank. Requests for these ancillaries can be made by e-mail (textbook@springerpub.com).

Vilia M. Tarvydas
Michael T. Hartley
A work such as this requires the support and hard work of many individuals. First and foremost, we are grateful to the chapter authors who found time to write these chapters amid their many other responsibilities and commitments. All of these authors have generously shared their wisdom and inspired us through their contributions to this text. Many of them have shared the struggles, work, and hopes for improving rehabilitation counseling with us over the years—and for that, all of us in rehabilitation counseling will be forever grateful. We also wish to thank Sheri W. Sussman, our editor at Springer Publishing Company, who was supportive in the face of looming deadlines, and the adroit editorial team helping us produce the highest-quality text possible.

It will become apparent when reading this text that the professionalization efforts of rehabilitation counseling are greater than any single individual. With this in mind, we would like to acknowledge the presidents of the National Council on Rehabilitation Education (NCRE), the National Rehabilitation Counseling Association (NRCA), and the American Rehabilitation Counseling Association (ARCA) for their leadership and outstanding contributions to the profession over the years. In addition to honoring these remarkable individuals, we hope to inspire our fellow professionals to follow in their footsteps and continue to guide the profession and practice of rehabilitation counseling through service and leadership.

As educators, we want to express our heartfelt gratitude to the countless students whose questions and interests have caused us to remain thoughtful and passionate about the improvement of the practice and professional evolution of rehabilitation counseling. Teaching is one of the most rewarding occupations imaginable when there is genuine care and respect between teachers and students. We hope we have been gracious enough to personally express our thanks to the many students we have worked with and learned from. It is one of the most rewarding aspects of being an educator.

A final acknowledgment is to our friends and family, who have motivated and sustained us to be thoughtful scholars, the book would not have been possible without your love and support.
PART I: INTRODUCTION

ONE

Rehabilitation Counseling: A Specialty Practice of the Counseling Profession

VILIA M. TARVYDAS, DENNIS R. MAKI, AND MICHAEL T. HARTLEY

The authors are honored to present the fourth edition of this introductory text on the professional practice of rehabilitation counseling. The timing of the current edition of this text could not be better. We are gratified to see that rehabilitation counseling has become an official specialization of the counseling profession with the merger between the two major accrediting bodies, the Council on Rehabilitation Education (CORE) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP), completed on July 1, 2017. The merger was preceded by the formal acknowledgment of CORE as an affiliate of CACREP by the American Counseling Association (ACA) to support graduates of rehabilitation counseling education programs having access to state licensure as professional counselors through the CACREP accreditation in Clinical Rehabilitation Counseling. The merger represents an important step in the progression and professionalization of rehabilitation counseling. In other words, rehabilitation counselors are counselors. By this we mean that rehabilitation counseling does not meet the historical or sociological definition of a separate and distinct profession with its own unique accreditation and certification standards (Rothman, 1987). We, therefore, place rehabilitation counseling firmly within the profession of counseling and include information about the profession of counseling and rehabilitation counseling’s relationship to it in this text, making a choice in the timeworn debate about whether rehabilitation counseling at its core is essentially counseling or case management (Patterson, 1957).

Rehabilitation counseling has evolved from its inception in federal legislation in the early 1900s to its current recognition as a specialization of the counseling profession (see Chapter 4). An initial focus on case management served a constructive purpose during the early years, given the historic link of rehabilitation counseling to the state-federal vocational rehabilitation (VR) system. At the same time, an overemphasis on rehabilitation counselors (RCs) as vocational RCs prioritized case management in its identity and credentials, and diverted attention from a natural link to the counseling profession (Emener & Cottone, 1989). Specializations are common when a profession is too broad for every practitioner to be sufficiently trained to provide high-quality services in all areas, yet the profession of counseling is unique because the specializations of rehabilitation counseling, school counseling, and community mental health counseling emerged separately until changes in our society and health care system required a more unified counseling profession in the 1990s (Myers, 1995). Today, the legal ability to practice counseling and to be reimbursed for the provision of counseling services has become increasingly
contingent on the designation of counseling as a profession, including parallel mechanisms of accreditation, certification, and licensure across the counseling specialty areas.

Reflecting the evolution of rehabilitation counseling, the guiding framework for this text has been developed by the first two authors, as illustrated in the construction of the curriculum in the rehabilitation counseling program at the University of Iowa. The first two authors’ scholarship and leadership of professional organizations has been instrumental in growing and operationalizing the scope of practice for rehabilitation counseling throughout the course of their careers. The third author has benefited greatly, both personally and professionally, from his relationship with the first two authors, including his formal studies as a doctoral student at the University of Iowa. The “Iowa Point of View” was introduced in the previous edition of this text to provide a clear context for readers to understand the viewpoint that rehabilitation counseling is a specialty practice of the counseling profession. The “Iowa Point of View” is the “conviction that counseling is the core profession with which rehabilitation counseling is linked” (Maki & Tarvydas, 2012, p. 5). This is a dialectical, not dichotomous, focus. It does not diminish the traditional practice of rehabilitation counseling that is heavily linked with vocational, case management, independent living, and psychosocial adjustment to disability; rather, it incorporates these traditions and strengthens our focus on advocacy, recovery, and clinical rehabilitation that have been more characteristic of psychiatric rehabilitation (see Chapter 20). As of this edition of this introductory text, it is no longer necessary to call this perspective the “Iowa Point of View” because it has become the national point of view with the merger between the accreditation bodies of CORE and CACREP.

**REHABILITATION COUNSELING IS A SPECIALTY PRACTICE OF THE COUNSELING PROFESSION**

On the face of it, the preceding statement about the national point of view would appear to be a simple, declarative sentence, and recent changes in the field have now made it so. Rehabilitation counseling has finally arrived as an official specialty practice of the counseling profession, and now additional questions have emerged, such as how the knowledge, skills, and attitudes of rehabilitation counseling complement those of mental health counseling, one of the fastest growing aspects of counseling and an expertise necessary for new graduates who will need to gain licensure and often employment opportunities in behavioral health contexts. With this in mind, we view psychiatric rehabilitation as a bridge to understand the intersection of traditional rehabilitation counseling with mental health and clinical rehabilitation in this introductory text.

Psychiatric rehabilitation emerged in the 1960s as a result of the deinstitutionalization movement whereby hundreds of thousands of individuals with significant psychiatric disabilities were “discharged from long-stay psychiatric hospitals into the community, and others were never institutionalized” (Mueser, 2016, p. vii). Highly pioneering, respected, and effective psychiatric rehabilitation programs and models such as that developed at Boston University by Dr. Bill Anthony and his colleagues evolved within the rehabilitation and recovery traditions (Anthony, Cohen, & Farkas, 1990). Anthony is clear that this psychiatric rehabilitation model was based on traditional rehabilitation counseling philosophies and practices. Indeed, RCs have served individuals with psychiatric disabilities within the VR system since the 1940s and contributed their advanced expertise to provide innovative treatment models to assist people with psychiatric disabilities to manage mental health symptoms as well as polysubstance abuse (Corrigan,
Additionally, RCs have always found it in their mission to work with those people who experience the greatest stigma and biggest barriers to living their lives with a disability. At this point in our history, people with psychiatric disorders would certainly be the group most in need of professionals who carry this perspective and have the requisite skills to assist them (Corrigan & Lam, 2007). Therefore, RCs should be practitioners of mental health counseling, clinical rehabilitation, or psychiatric rehabilitation.

RCs work with “persons with physical, mental, developmental, cognitive, and emotional disabilities to achieve their personal, career, and independent living goals in the most integrated setting possible,” according to the Commission on Rehabilitation Counselor Certification (CRCC, 2016, p. 1). Today, mental illness is a leading cause of disability in the United States and across the world (Murray & Lopez, 1996; McAlpine & Warner, 2002). In a special issue on psychiatric rehabilitation, Koch, Donnell Carey, and Lusk (2016) summarize the prevalence of mental illness in the United States as one in five (18.5%) adults, with approximately 10 million (4.2%) individuals in 2013 meeting the criteria for a serious mental illness (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). A psychiatric disability is when an individual with a serious mental illness is unable to perform major life activities in particular life contexts, such as work, community participation, and independent living (Sánchez, Rosenthal, Chan, Brooks, & Bezyak, 2016). With unemployment rates as high as 80% to 90% (Goldberg et al., 2001), it is not surprising that individuals with serious mental illness are the largest disability group served by state-federal VR, constituting 32.2% of the cases in a study by Rosenthal, Dalton, and Gervey (2007). At the same time, individuals with psychiatric disabilities have the lowest success rates in VR, with fewer than 15% obtaining competitive employment (Anthony, 1993). It is our firm belief that rehabilitation counseling practice must evolve and become better at addressing the vocational, independent living, and psychosocial needs of people with psychiatric disabilities, not only in the state-federal VR system (Lusk, Koch, & Paul, 2016) but also in our health care system, including the delivery of behavioral and mental health services (Sheehan & Lewicki, 2016).

As a unifying paradigm to consolidate VR, clinical rehabilitation, and mental health counseling, psychiatric rehabilitation is consistent with the overall philosophy and practice of rehabilitation counseling (Olney & Gill, 2016), especially the recovery-based focus on health and wellness (Swarbrick & Nemec, 2016). All counselors, regardless of specialization, emphasize a wellness model of mental health focused on client strengths and “a holistic view of wellness across many areas of life, including physical, emotional, mental, spiritual, relational, vocational, financial, and sexual realms” (Young & Cashwell, 2017, p. 8). At the same time, RCs have developed unique expertise to promote employment, independent living, and overall quality of life (QOL) related to living well with a disability (see Chapter 5). Therefore, RCs can play a significant role in the creation of a recovery-orientated behavioral health system as called for by the U.S. Surgeon General and SAMHSA (U.S. Department of Health and Human Services [DHHS], 1999, 2005).

Recovery is defined by Anthony (1993) as a “deeply personal process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. . . . Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness” (p. 15). Rather than focusing on a “cure” for mental health symptoms, a recovery-orientated perspective emphasizes “self-determination and such normal life pursuits as education, employment, sexuality, friendship, spirituality, and voluntary membership in faith and other kinds of communities beyond the limits of the disorder and of the mental health system” (Davidson, Tondora, Staeheli Lawless,
O’Connell, & Rowe, 2009, p. 11). Similar to how RCs work with individuals with spinal cord injury, recovery does not refer to the restoration of spinal cord function or ability to walk, but rather to the rights of individuals to “access and join in with those elements of community life the person chooses, and to be in control of his or her life and destiny, even and especially while remaining disabled” (Davidson et al., 2009, p. 15). Even when individuals continue to experience mental health symptoms, Davidson et al. denote “being in recovery” as containing and minimizing the disruptive impact of mental illness on an individual's personal, vocational, and independent living goals (2009, p. 11). Aligned with the core values of rehabilitation counseling, Deegan (1988) describes a recovery-orientated behavioral health system whereby individuals' mental illness does not “get rehabilitated” in the way that cars “get tuned up” or appliances “get repaired,” but instead the focus is on “recovering a new sense of self and of purpose within and beyond the limits of the disability” (1988, p. 11). Ultimately concerned with empowerment and self-determination, the involvement of RCs in the delivery of behavioral and mental health services is an opportunity for people with psychiatric disabilities to be assisted by professionals who bring advanced knowledge, skills, and attitudes related to disability and a commitment to advocacy.

As noted by Jane Myers (2012), a leader of the counseling profession, rehabilitation counseling as a specialization of the profession of counseling “stands at the forefront in creating sustained positive change in the holistic wellbeing of persons with disabilities . . . to be effective advocates and change agents for themselves, their families, their communities and society” (p. xvi). RCs have a long history of partnering with the advocacy efforts of people with disabilities, and have specialized knowledge of disabilities, the lived disability experience, and the sociopolitical-environmental factors that impact people with disabilities (Jenkins, Patterson, & Szymanski, 1992; Leahy & Szymanski, 1995). However, in order to ethically assert our continued place in the practice of behavioral and mental health, RCs must have education and professional preparation standards that embrace and integrate all the necessary elements to practice responsibly and with skill and respect. For example, stronger attention to such areas as evidence-based practices and diagnosis and treatment of psychiatric disorders are necessary. The recent knowledge domain study (Leahy, Munzen, Saunders, & Strauser, 2009) in rehabilitation counseling indicated an increased need for preservice and continuing education in counseling, mental health, and substance abuse. It is our view that these topics have not been sufficiently addressed in rehabilitation counseling texts. Embracing the broadest scope of practice possible, the ideas and information contained in this text provide a necessary structuring of rehabilitation counseling around a clear point of view on its identity and credentials as a specialty practice of counseling.

With our counseling skills as well as disability and rehabilitation expertise, RCs also perform functions such as case management, advocacy, and consultation when working with our clients in achieving their individualized goals. Furthermore, some RCs provide assessment and forensic services and do not have clients, but rather evaluees (see Chapter 16). Yet, the fact that RCs do more than counsel does not compromise our primary affiliation with the counseling profession, nor does it diminish our other essential functions. In fact, to embrace our core identity as counselors is not incompatible with, or disrespectful to, the RCs who choose to work in areas of practice that are not titled counselor or are not primarily counseling in function. Therefore, we are proud to highlight the necessary knowledge, skills, and attitudes in this text whereby RCs may proudly announce: “I am a counselor who works with people who have disabilities”—whether the disability is mental illness, some other type of disability, or coexisting disabilities.
PROFESSIONAL CREDENTIALS

Credentialing has defined and regulated the professional practice of rehabilitation counseling in recent years (see Chapter 16). This text is predicated on creating the most robust practitioner: a licensed mental health or professional counselor with a certification in rehabilitation counseling. Thus, we advocate for the licensure of the counseling generalist and for certification of the rehabilitation specialist. It is our belief that RCs must have robust careers available to them, with access to all positions and work for which they are qualified; and the ability to experience new opportunities, mobility, and advancement throughout a long-term career. To maximize employment opportunities, RCs must understand accreditation, certification, and licensure as distinct forms of credentialing:

- **Accreditation** is a mechanism that educational institutions and programs voluntarily undergo to demonstrate quality assurance to students, professionals, and the general public that the education and training of professional counselors is consistent across the country. Accreditation guarantees that only graduates of accredited programs or those who can demonstrate completion/attainment of all accreditation standards are eligible for licensure and certification as professional counselors, and accreditation is regulated by professionals within the field. The recent merger between CORE and CACREP is important because graduation from an accredited educational program is increasingly associated with eligibility for certification and licensure.

- **Certification** is a process to ensure that an individual counselor has obtained the knowledge, attitudes, and skills to specialize and work in unique employment settings, with particular client populations, and/or implement specialized techniques. Certification is thus associated with employment in particular work settings. Certification standards are developed by senior members of the profession who wish to define and promote the necessary knowledge and skills for specialty practice, much like medical professions where medical doctors are licensed by their state to practice general medicine, yet apply for board certifications to demonstrate their expertise in a specialty field (e.g., allergist, cardiologist, endocrinologist). The certified rehabilitation counselor (CRC) certification is a critical credential to establish expertise in forensic rehabilitation counseling practice.

- **Licensure** is a governmentally sanctioned credential intended to protect the public safety by assuring that citizens are served by qualified providers of counseling services. Licensure is regulated by individual states; thus, individuals who are not licensed in a state may be prohibited from engaging in professional activities that include counseling if both the title of counseling and its practice are written into the licensure law. Licensure is important because it defines the legal ability to practice counseling, as well as to receive reimbursement from third-party insurance companies and private payers for the provision of counseling services. Although licensure laws may vary with respect to the title and practice of counseling, there is increasing parity as the licensed professional counselor (LPC) has become the most common title and practice legislation across the 50 states.

Highly regulated and supervised work environments have historically been exempt from state licensure and national certification requirements, including the state-federal VR system. However, it has become increasingly difficult to convince the public and other professionals that RCs employed in exempt settings are sufficiently trained to provide professional counseling services without state licensure and national certification requirements. As a comparison, consider that physicians who worked in hospitals were initially exempt...
from medical licensure, yet over time licensure became a requirement for all physicians regardless of setting (Remley, 2012). Similarly, licensure is likely to become a legal requirement to provide counseling services, and individual counselors will likely need to obtain licensure in order to document sufficient training and expertise to perform counseling-related job functions, such as diagnosis and treatment planning (Tarvydas, Hartley, & Gerald, 2015). It is therefore critical that RCs graduate from properly accredited educational programs, obtain certification, and continue to become licensed, especially if engaged in the provision of mental health and substance abuse counseling.

PROFESSIONAL IDENTITY

The underlying premise of this text is one of professional identity. The professional identity of an RC as a counselor has had wide formal endorsement by the major professional organizations and leaders in the field. As George Wright (1980) pointed out, “counseling is inherent in rehabilitation counseling: this is a nontransferable obligation of the rehabilitation counselor . . . the ultimate professional responsibility for the function of counseling cannot be delegated” (p. 55). More recently, the identity of RCs as counselors was formally endorsed in 2005 by professional organizations within the Rehabilitation Counseling Consortium (RCC), including (a) CORE, (b) CRCC, (c) American Rehabilitation Counselor Association (ARCA), (d) National Rehabilitation Counseling Association (NRCA), (e) National Council on Rehabilitation Education (NCRE), (f) Canadian Association of Rehabilitation Professionals (CARP), (g) International Association of Rehabilitation Professionals (IARP), and (h) American Deafness and Rehabilitation Association (ADARA). The following definition of rehabilitation counseling was established and adopted by these organizations:

A rehabilitation counselor is a counselor who possesses the specialized knowledge, skills, and attitudes needed to collaborate in a professional relationship with persons with disabilities to achieve their personal, social, psychological, and vocational goals. (RCC, 2005)

Clearly supporting the identity of RCs as counselors, accreditation and certification standards in rehabilitation counseling have mirrored the standards of other counseling specializations over the last decade.

Since the early 2000s, the accreditation and certification standards of rehabilitation counseling have been recognized as having parity with their equivalents in general counseling by the ACA (Tarvydas, Leahy, & Zanskas, 2009). CORE was the first accreditation body in counseling, accrediting master’s programs in rehabilitation counseling. With specialty standards covering rehabilitation and disability, the CORE accreditation standards were consistent with the general accreditation standards of CACREP leading up to the recent merger of the two organizations. Similarly, the CRCC was the first certification body in counseling, governing the CRC credential and the Certified Rehabilitation Counselor Examination (CRCE). As an entry-level exam for licensure in some states, the CRCE is viewed as equivalent to the National Counselor Examination (NCE), governed by the National Board for Certified Counselors (NBCC) and associated with the National Certified Counselor (NCC) credential. One part of the CRCE tests knowledge about general counseling, whereas the other part tests knowledge related to rehabilitation and disability. All candidates must pass both sections of the CRCE exam, requiring that
master’s programs in rehabilitation counseling prepare students in both counseling and rehabilitation competencies.

The driving force behind equivalent accreditation and certification has been the need for graduates of rehabilitation counseling education programs to be eligible for state licensure as professional counselors. Although rehabilitation counseling has contributed to the professionalization efforts of the counseling profession, the initial counselor licensure law in 1976 was advocated for by community mental health counselors. The Community Mental Health Act of 1963 legislated the creation of community mental health centers, shifting the focus of mental health services from institutions and into the community (Young & Cashwell, 2017). By the 1970s, “it was clear that counselors were providing services that we would now call mental health counseling” as a form of community-based care (Sheperis & Sheperis, 2015, p. 7). Counselor licensure laws emerged because of regulations by Medicare and Medicaid, as well as private health insurance, that required licensure for the reimbursement of mental health services. Advocating for counselor licensure, the American Mental Health Counselors Association (AMHCA) formed in 1976 with early ties to the American Rehabilitation Counseling Association (ARCA). Although licensure laws were slowly being passed by individual states, the Academy of Mental Health Certification approached the CRCC in the 1980s to consider the creation of a specialty certification in mental health counseling, which was not pursued at the time. Today, there appears to be more and more overlap between RCs and community mental health counselors in terms of clients served, employment settings, knowledge requirements, and counseling techniques. Additionally, if we consider it imperative for the field of rehabilitation counseling to address the needs of people with disabilities, rehabilitation counseling must be firm in continuing to pursue the education, credentials, and access to settings in which those with psychiatric disabilities are served. It could be argued that in our contemporary society people with psychiatric disabilities have great need for expert application of rehabilitation and recovery approaches (see Chapter 20). Due to attitudinal and policy barriers to services, jobs, housing, and other aspects of our society, it could be argued that people with psychiatric disabilities and those who have other disabilities that co-occur with them constitute a group most in need of assistance in achieving their goals for full inclusion in our society. Thus, the field should embrace new opportunities to provide expert assistance to this group.

With the merger between CORE and CACREP, a growing number of rehabilitation counseling programs have sought coaccreditation under Clinical Rehabilitation as well as Clinical Mental Health, a specialty CACREP accreditation created in 2009 (Newsome & Gladding, 2014). Furthermore, a joint CORE and CACREP task force led by RC was appointed in October 2016 to infuse rehabilitation and disability-related concepts into the training of all counselors regardless of specialization, in order to establish common knowledge requirements and improve services to individuals with disabilities.

In an effort to unify the various counseling specializations, the ARCA and other professional rehabilitation counseling organizations, including NRCA, CORE, and CACREP, were involved in the decade-long 20/20 Initiative ending in 2013 (Kaplan, Tarvydas, & Gladding, 2014). The 20/20 Initiative was organized by the ACA and the American Association of State Counseling Boards (AASCB) to facilitate the unification of the counseling profession and foster collaborative dialogue among the counseling constituency. The 20/20 Initiative required that all participating organizations endorse the following seven core principles of counseling:

1. Sharing a common professional identity is critical for counselors.
2. Presenting ourselves as a unified profession has multiple benefits.
3. Working together to improve the public perception of counseling and to advocate for professional issues will strengthen the profession.
4. Creating a portability system for licensure will benefit counselors and strengthen the counseling profession.
5. Expanding and promoting our research base is essential to the efficacy of professional counselors and to the public perception of the profession.
6. Focusing on students and prospective students is necessary to ensure the ongoing health of the counseling profession.
7. Promoting client welfare and advocating for the populations we serve is the primary focus of the counseling profession.

Efforts such as the 20/20 Initiative have been critical to the ability of RCs to be reimbursed by third-party health insurance for the provision of counseling services. Indeed, a driving force behind the 20/20 Initiative was a stronger collective voice on Capitol Hill to compete with the lobbying efforts of social work and psychology. The lobbying efforts of the counseling profession have resulted in legislation to assure Medicare reimbursement for counselors, the hiring of counselors into the Veterans Administration (VA), and increasing mental health counseling within elementary and secondary schools (ACA, 2016). Furthermore, the counseling profession has successfully lobbied to have counselors reimbursed for the provision of counseling services by the U.S. Department of Defense (DoD) under TRICARE health insurance services (Federal Register, 2014). The significance of TRICARE is that RCs can work with mental health centers, agencies, and organizations as well as the VA and veteran organizations as long as they obtain and maintain the necessary credentials. RCs can play a critical role in improving the delivery of counseling and rehabilitation services to all individuals with disabilities, especially those served in our behavioral and mental health care systems.

EMERGING TRENDS

It is an exciting time to be an RC. Rehabilitation counseling was recently rated as the 10th most meaningful job in America (Smith, 2015), as well as the highest-paid counseling specialization in a survey by ACA (2014), with an average annual salary of $53,561. Part of the reason for the higher salaries is the wide range of employment opportunities for RCs, including for-profit insurance and forensic settings. The types of people served by RCs, their residual assets and limitations that impact their QOL, and their successful integration into their responsibilities and communities has continued to expand in recent years (see chapters in Part III). As such, the parameters of the scope of practice of rehabilitation counseling are evolving to meet the changing needs of society and the individuals whom it serves, as reflected in the growth and diversity in employment opportunities and professional functions (see chapters in Part IV). Finally, a growing awareness and appreciation of individuals within the context of their culture, as well as the advances of technology and a broadening research base for best practices, require an increasingly broad set of professional competencies reflected in more intense preservice preparation and commitment to ongoing continuing education (see chapters in Part V). With this in mind, this text seeks to highlight the following emerging areas of importance while still providing the most up-to-date information about more traditional aspects of rehabilitation counseling practice.

Counselors were previously restricted from employment in behavioral and mental health settings because the prevention and intervention of mental illness such as anxiety or
depression, as well as substance abuse and other addictions, were protected by the traditions and credentials of psychiatry and psychology. Yet, the scope of practice for counselors licensed as independent practitioners by counselor licensure laws now includes the legal ability to diagnose and treat mental health and substance abuse disorders. As a result, trends in counseling employment indicate job growth in behavioral and mental health settings, particularly with the expansion of services available to individuals following the signing of the Affordable Care Act. In fact, the U.S. Bureau of Labor Statistics (BLS, 2015a, 2015b) estimates that the field of rehabilitation counseling will grow by 9% between 2014 and 2024, and that the field of mental health counseling will add more than 31,400 jobs and grow more than 19% between 2014 and 2024. RCs also are being called upon to work with wounded veterans as they return from Iraq and Afghanistan toward their medical and vocational reintegration (Frain, Bishop, Tansey, Sanchez, & Wijngaarde, 2013). Today’s veterans “signature injuries” are cognitive and emotional injuries, calling upon those who serve them to add strong mental health counseling skills to serve those recovering from primarily traumatic brain injuries and psychiatric disorders (Isham et al., 2010). With this in mind, we have included a chapter on psychiatric rehabilitation in this introductory text to highlight the substantial evidence-based research supporting the effectiveness of psychosocial interventions provided by psychiatric rehabilitation practitioners.

The professional landscape of rehabilitation counseling has changed globally as well. More and more international students are studying rehabilitation counseling in the United States and returning to their home countries to educate and practice rehabilitation counseling. With an increased focus on international rehabilitation, the International Classification of Functioning, Disability and Health (ICF) model has become an essential complement to the Diagnostic and Statistical Manual of Mental Disorders (DSM). This edition of the textbook more robustly addresses the expansion of international rehabilitation, including an emphasis on the ICF model in the chapter on assessment. Further, a global perspective is infused throughout the chapters, especially in the chapter on disability in a global context.

Finally, new ethical standards have emerged to address roles and relationships with clients, professional responsibility and competence, and confidentiality and privacy because of economic and cultural shifts with respect to social media, health care legislation, and insurance practices. The CRCC recently released a new Code of Professional Ethics for Rehabilitation Counselors, effective January 1, 2017 (CRCC, 2017). The textbook overviews changes to the new CRCC Code related to social justice and cultural competence, technology and social media, mental health and trauma, and assessment and forensics, as well as comparing and contrasting these new changes to the CRCC Code with the new changes to the 2014 ACA Code of Ethics.

OVERVIEW OF BOOK

Intended Audience

This text is intended to be useful to a wide range of readers and can readily serve as a core textbook or resource to explain the history, development, and current practice of RCs within the context of the contemporary practice of counseling. Although most clearly useful to counselors-in-training in an introductory course, we think that those RCs at the doctoral level or already in practice interested in the field and its broader positioning and potential will find this text appealing.
Framework for the Text

With the evolution of society in our current environment and technology, there is a place for RCs in the delivery of behavioral health services. If they are not included, their absence is a loss of practice opportunities for its professionals and the clients they serve. The following are the underlying principles of this textbook:

- Rehabilitation counselor education (RCE) and practice should include a “hybridization” of the content in rehabilitation and mental health counseling to best serve the entire range of disabilities and co-occurring conditions common in practice and to reflect a truly holistic and inclusive point of view.
- RCE and practice should involve a developmental perspective relative to the client’s needs throughout the life span.
- RCE and practice are best conducted from the framework of an ecological, transformative rehabilitation perspective that addresses the person–environment context of disability. Our practices seek to assist individuals with disabilities to adapt to the physical and attitudinal environments in which they live, work, learn, and recreate. Simultaneously, it assists these environments to accommodate these individuals.
- RCE and practice are best conducted from a culturally competent perspective that respects the individual differences, as well as the commonalities, of both the client and the counselor. This view includes both social justice and advocacy perspectives. Rehabilitation counseling must seek a better infusion of the sensibilities and “ways of knowing” about the disability experience within the discipline of disability studies. This field and the study of the various fine arts, social science, and humanities representations of disability and the sensibilities they portray must be taken as serious source material to expand the professional viewpoint that represents the traditional teachings of the field.
- The rehabilitation counseling philosophy views clients as decision makers in their own lives. This perspective is predicated on clients making meaning of their lives in their current circumstances. Making meaning requires informed consent; that is, being given accurate and complete information about the choices in a manner that is useful and tailored to the needs of the client. This is essential to the quality of the client’s ability to make informed choices.

Features of the Text

New features have been added to assist both instructors and students in gaining full benefit from this volume. Learning objectives begin each chapter, and discussion questions are provided at the conclusion of each chapter to expand the understanding and relevance of the material covered in the text. Additionally, learning activities conclude each chapter, and the appendices have been updated and expanded to provide key reference materials. Of particular note is the inclusion of the newly revised CRCC 2017 Code of Professional Ethics for Rehabilitation Counselors.

Parts and Chapters

The Professional Practice of Rehabilitation Counseling consists of 22 chapters, which are divided into parts that emphasize different themes important to understanding both the people and the types of situations with which RCs work and the specific roles and skill sets that describe professional practice.
Part II: Foundations consists of basic information about the structure and professional practice of rehabilitation counseling. It is here that the evolution and vision of rehabilitation counseling as a specialty practice of the profession of counseling is emphasized and interpreted within the context of the merger of CORE and CACREP. This perspective is integrated within the important traditional aspects of the field’s history, credentialing structures, and disability policy and laws, as well as a conceptual paradigm to undergird its practice. A new chapter has been added that explicitly sets forth these core frameworks. We have also added a focus on understanding how social justice and human development within the broader field of counseling relate to the important history and tradition of rehabilitation counseling.

Part III: People With Disability serves the important role of introducing the readers to the RC’s most important partner in the counseling process: the person with a disability. The chapters are presented to situate the lives of people with disabilities by focusing on hierarchically arranged contexts in their lives—moving from individual, to family and intimate relationships, to the disability community, and finally to disability in global contexts. Care was taken to emphasize the experience, not only the facts, of disability, and to give particular attention to the voices of people with disabilities themselves through discussion of the disability community/disability rights perspective that is too often superficially treated.

In Part IV: Professional Functions, we return to a focus on the professional practice of rehabilitation counseling and introduce the new work in the field that sharpens the emphasis on evidence-based practices and research utilization in the field in the introduction to this part. Further chapters describe in more detail the specific functions that constitute the work of rehabilitation counseling: assessment, counseling, forensic and indirect services, clinical case management and case coordination, psychiatric rehabilitation, advocacy, and career development, vocational behavior, and work adjustment of individuals with disabilities. These core functions are masterfully presented by authorities who describe the core elements of each area. Taken together, the chapters in this part sketch out the broad parameters of the professional scope of practice in the robust field of rehabilitation counseling.

Part V: Professional Competencies introduces the competencies that provide the types of skills, knowledge, and attitudes that must infuse the practice of rehabilitation counseling because of their pervasive and overarching importance in all aspects of practice. The areas of ethics, ethical decision making, and cultural competency are widely acknowledged as major forces for professionalism and are considered at the outset of the part. The increased prominence of technology used in rehabilitation is a force for innovation and critical to maintaining current practice. Fittingly, in the last chapter of this part, clinical supervision is discussed, as it performs a critical translational and evaluative role in both the initial education and continual improvement of our professional colleagues.

REFERENCES


LEARNING OBJECTIVES

After reading this chapter, you should be able to:

• List and describe fundamental philosophical values that characterize rehabilitation counselors (RCs) and how they approach their work.
• Name and explain different models of disability that analyze how disability has been perceived and interpreted in society.
• Express basic understanding of how the various concepts and perspectives presented affect the practice of rehabilitation counseling.

Rehabilitation counseling concepts and models have evolved progressively over the last century. Actually, one could say that the tasks and motivations that describe rehabilitation counseling are as old as when human nature developed to the point where people responded with a compassionate heart and helpful resources to a stranger who was injured or otherwise in need of assistance or accommodation to get back in action. Just about a century ago was the start of what has grown into our current system of service programs, followed by the formation of the profession we know as rehabilitation counseling. We have a rich legacy of groundbreaking accomplishments that have enabled the exciting activities with which we are currently engaged and blossoming opportunities for the future. Readers will notice that some of the references in this chapter are not recent, and a few are not the latest edition of that publication. This choice was purposeful, in order to recognize both cutting-edge applications and classic insights on perennial issues. The older citations offer a longer vantage point and highlight the historical context of the concepts and models presented. These ideas are still shaping the field as new knowledge develops. The majority of the observations and recommendations in this chapter apply to all counselors because the specialty of rehabilitation counseling is an integral part of the counseling profession.

This chapter is designed in three main sections. The first one describes fundamental philosophical values that characterize RCs and how they approach their work. The next section delineates four traditional models or conceptual frameworks of disability. They explain different ways that disability as a stimulus or personal characteristic—and people who have a disability—have been perceived and treated in society, from early civilizations to today. The third section presents four unconventional models of disability.
These are much less known, discussed, and represented in the implicit expectations and dedicated programs that society has developed in its response to disability. Indeed, the unconventional models were created largely as part of a consciousness and movement to change the ways disability is dealt with by society. All of the chapter’s contents are woven together to describe the complex and evolving context within which the practice of rehabilitation counseling operates. Please take the “clay” of the accumulated knowledge that is presented in this chapter and shape it for your best understanding and eventual application as a rehabilitation counseling practitioner and advocate.

THE VALUES AND PERSPECTIVES UNDERGIRDING REHABILITATION COUNSELING

Values are crucial to informing our identity and guiding our behavior as individuals, groups, and organizations. Making values explicit to the public and real in our efforts to live by them should be an ongoing process that reinforces the meaningfulness of the values. Reflecting and acting on our values also serve as methods of professional self-monitoring and continued improvement. Beatrice Wright is a groundbreaking scholar whose insights and writings have been among the most prominent influences on the profession of rehabilitation counseling, especially with respect to its value base. Over the course of several years, starting with B. A. Wright (1959), she articulated several guidelines for rehabilitation practitioners that have endured as part of our profession’s guiding conscience and ethical compass. The final list of 20 “value-laden beliefs and principles” explained in B. A. Wright’s (1983) book have been reprinted in several sources. One of them is McCarthy (2011), which included an interview with Wright wherein she emphasized the ongoing need for professionals to review, critique, adapt, and embrace values in rehabilitation counseling practice, as illustrated in the following quote:

Professionals preparing for certification should be given a list of values that have special significance for rehabilitation. . . . At the oral certification examination, candidates could be asked if there are any values that could be added or omitted and to explain their view, as a way of ensuring serious consideration of values. Each Board could revise the value-laden beliefs and principles based on suggestions made by candidates. (p. 77)

Contemporary rehabilitation counseling has benefited greatly from the progressive thinking and teaching of not only Wright, but also Jaques (1970), Rubin and Roessler (1978), Bowe (1978, 1980), G. Wright (1980), DeLoach and Greer (1981), and Chubon (1994). Many of their contributions are still incisive and germane today. The following section explains five core values of rehabilitation counseling and their underlying concepts and strategies.

Person–Environment Interaction

Beatrice Wright and other theorists and researchers who contributed to the early development of rehabilitation counseling were influenced by the field theory of Kurt Lewin (1936), a social psychologist who postulated the functional formula, $B = f (P \times E)$. That is, Lewin argued that in order to understand human behavior ($B$), we need to realize that it is a function ($f$) of the interaction ($\times$) between aspects of the person ($P$) and forces in the surrounding context or environment ($E$). This interactionist proposition seems like common sense today, but it was avant-garde at that time when behavior was
believed to be determined predominantly by the abilities, emotions, genes, motives, and vulnerabilities that existed within the person. For detailed explanations of how the early rehabilitation scholars (e.g., R. Barker, T. Dembo, G. Leviton, B. Wright) applied field theory’s interest in environmental factors to conceptualizing the experience of disability, see Dunn (2015), Livneh, Bishop, and Anctil (2014), and McCarthy (2011, 2014).

The environment has been important in other theories about the consequences of having a disability. Vash and Crewe (2004) discussed how the disability experience is likely to be affected by various aspects of the environment that they classified into two spheres: the cultural context (including societal attitudes, technological developments, and political philosophies such as free enterprise versus socialist economies); and the immediate environment (including family characteristics, regional differences, and residence in home versus institutional settings). There are also notable examples of applied research in career development, work adjustment, and mental health that have focused on the fit between person and environment (e.g., Lofquist & Dawis, 1969, 1991; Moos, 1974). Thus, RCs are more likely than many of their counterparts in other human service disciplines to be more attentive to the influences of the environment—both its resources and its barriers. Nonetheless, the attention given to the environment is still not equal to the focus on the person. There continues to be a strong bias toward assessing and trying to change the person, to the comparative neglect of investigating and manipulating the environment, as explained by Gromes and Olsheski (2002), B. A. Wright and Lopez (2005), and McCarthy (2014).

**Strengths-Based Practice**

An asset-oriented approach (e.g., Atkins, 1988) or strengths-based orientation (e.g., Galassi & Akos, 2007) of uncovering and exploiting the positive aspects in both the person and the situation is the widely endorsed current expectation for RCs. Today, taking a purposefully positive approach is fairly common in social science, as reflected in the overwhelming popularity of the positive psychology movement (Chou et al., 2013) and wellness programs. However, there continues to be a tension between positive psychology and modern medicine. A prominent characteristic of the medical professions is focusing primarily or exclusively on the pathology or the problem, in order to prevent or cure disease with military aggressiveness. This is revealed in Western medicine’s goals, such as “conquering cancer” or “wiping out polio.” These are important, laudable goals. However, the zeal that drives the problem-oriented approach in medicine to treat disability tends to direct insufficient attention to the positive elements in the person and context. Rehabilitation counseling has for many decades espoused: (a) an optimistic perspective on the achievable potential of people with disabilities to lead satisfying and successful lives; (b) a focus on building up the skills and potential that remain after the changes that were brought on by a chronic illness, injury, or other significant loss; and (c) an emphasis on utilizing the client’s situation and broader environment for supportive resources. Early explanations of the coping attitude and behavior demonstrated by people with disabilities were described by Dembo, Leviton, and Wright (1956/1975). Today, coping is often referred to by the term resilience: “the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances” (Masten, Best, & Garmezy, 1990, p. 426). Although it is widely accepted intellectually, taking such an approach requires persistent attention because of what has been called the fundamental negative bias by B. A. Wright (1988). She explained with many eye-opening examples how this tendency in the way humans process information leads to giving more attention and weight to salient negative stimuli, such as the stigma and misfortune often associated
with a disability. With similar arguments about unconscious reactions to disability, Hahn (1993) cogently hypothesized that two major contributors to strained interaction (and eventual negative attitudes) are stimulated when able-bodied people encounter a person with a visible disability. These apprehensions are aesthetic anxiety (discomfort at being close to disfigured appearance) and existential anxiety (unconscious threat felt to one's own safety or existence by seeing disability and associating it with accidents and trauma). RCs may easily and inadvertently underestimate the ability of people with disabilities, unless they consciously apply a strengths-based approach.

Holistic Perspective

Because of its dedication to clients' long-term integration into community life, rehabilitation counseling has adopted a multidimensional holistic approach to assessing clients and addressing their concerns. Depending on the client's preferred focus and possible limitations set by the service agency, an appropriate rehabilitation counseling assessment could explore many aspects of the person's life, including the following domains (each exemplified with a few representative dimensions):

- Vocational (career aspirations, work history, volunteer experience)
- Social (family roles, support networks, community participation)
- Psychological (attitudes, perceptions, affect)
- Disability-related (capacities affected, accommodations used, personal coping strategies)
- Cognitive (communication skills, academic performance, problem-solving style)
- Health-related (insurance coverage, medications, wellness practices)
- Sexual (level of technical information, current satisfaction, safety-related concerns)
- Recreational (exercise routines, hobbies, access to community venues)
- Cultural/spiritual (important values, cultural identity, sense of hope)

Not all domains will generate issues the individual client wishes to address or resources that can be marshaled to fulfill desired goals. At times, the needs of the client may be beyond the scope of a single agency and a referral is necessary. Nonetheless, the larger point is that the RC demonstrates a broad interest in the client’s comprehensive quality of life (QOL) and the factors that might complicate or facilitate the client's goals and the counseling process (e.g., Bishop, 2005; Fabian, 1991; Livneh, 2016). In many ways, RCs work to enhance resilience to cope with crises and daily stressors that emerge, and promote subjective QOL of their clients. QOL is a multidimensional wellness goal that is certainly well advanced by the wide variety of direct services, applied research, and social advocacy provided by contemporary rehabilitation counseling (e.g., Bishop, Chapin, & Miller, 2008; Hartley, 2011). It is also well served by the profession's evolved approach and commitment to its improvement and impact through theory development, meaningfully rigorous research, and evidence-based practice (e.g., Chan, Tarvydas, Blalock, Strauser, & Atkins, 2009; Tarvydas, Addy, & Fleming, 2010).

A holistic approach in rehabilitation counseling is similar to the conceptual developments referred to in counseling as the wellness model. A popular version is the wheel of wellness model developed by Witmer and Sweeney (1992) and Myers and Sweeney (2008). It defined wellness as “a way of life oriented toward optimal health and well-being in which body, mind, and spirit are integrated by the individual to live more fully within the human and natural community” (Myers, Sweeney, & Witmer, 2000, p. 252). Nested concentric circles compose the model's graphic representation of five proposed “life tasks"
(Spirituality, Self-Direction, Work and Leisure, Friendship, Love). The spokes of the wheel identify 12 “subtasks” that include various patterns of behavior and methods of adjustment, such as problem solving and creativity, sense of humor, nutrition, self-care, and cultural identity. The wellness model is quite widely embraced among the current frameworks for counseling. Its content and process are clearly holistic, affirmative, and interactive.

**Collaborative and Interdisciplinary Partnerships**

As early as the original edition of her classic book, B. A. Wright (1960, pp. 345–363) proposed and explained the necessity of counselors’ collaborating with clients as comanagers of their rehabilitation plan. At the time, that was a revolutionary recommendation to advance. Currently, that philosophy of actively involving stakeholders in activities that affect their health and welfare is infused in most human services. Some well-established procedures formalize and ensure the solicitation of clients’ input and continuing contributions to their process of habilitation (acquiring knowledge and life skills as a developmental process) or rehabilitation (relearning lost skills or developing compensatory strategies after the onset of disability). One such process is the **Individualized Educational Plan (IEP)**. This document is created annually for students with a disability in primary and secondary schools, if they are eligible for accommodations and support services. The team that discusses, determines, and implements the needed services includes the student, parent or advocate, and the school staff directly involved such as teacher(s) and the counselor. The counterpart document developed collaboratively by each new client in many vocational rehabilitation (VR) programs and her or his counselor is the **Individualized Plan for Employment (IPE)**. Clients not only discuss and sign the plan, but are also expected to write down their input in their own words. Hershenson (2015) has proposed and delineated the essential contents of an analogous instrument for the senior stage of life, the **Individualized Plan for Retirement (IPR)**.

The interdisciplinary team has been a primary model for the delivery of comprehensive rehabilitation services, especially in large clinical settings. RCs employed in hospitals and clinics coordinate with physiatrists (medical doctors specializing in physical medicine and rehabilitation), psychiatrists, neurologists, orthopedists, nurses, psychologists, occupational therapists, physical therapists, and speech-language therapists. The expectation of effective interprofessional collaboration has recently been reinforced in employment settings and preservice training programs by institutional and educational accreditation standards. RCs who work in vocational programs have an essential partner in employers, sometimes called the “second client.” By providing training, paid jobs and work experience, local businesses and industries fulfill the occupational goals of the clients. In addition, employers have their own needs which many RCs are qualified to satisfy. The needs of employers as rehabilitation’s corporate clients include assistance and consultation on topics such as (a) determining appropriate physical and procedural accommodations for their employees who require them (new hires as well as long-term employees with recently acquired functional limitations); (b) developing policies and procedures to ensure compliance with applicable laws governing nondiscrimination in employment; and (c) staff training on disability diversity, stress management, and strategies for optimizing safety and wellness in the workplace. Similarly, RCs employed in the private sector and workers’ compensation system provide direct vocational services to a variety of clientele: (a) case management of workers with acquired disabilities; (b) expert testimony for court systems; and (c) detailed life care plans for attorneys representing catastrophically injured clients. All these professionals who advise, consult, or collaborate
Promotion of Dignity and Human Rights

Two significant indicators of the social disparities experienced by the disability community are persistently higher unemployment rates and lower rates of graduation from high school and beyond. Higher rates of poverty and social isolation are additional indices of the second-class citizenship experienced by many people with disabilities. To redress these problems of inequity of opportunity in our society, it is important that counselors contribute to facilitating improvements in these social indicators reflective of discrimination against and unfulfilled potential of people with disabilities. To reinforce recollection of the main empowerment strategies recommended, this author captured a variety of practical interventions in the following five strategic A's (awareness, accessibility, accommodation, advocacy, asking before acting).

Awareness

It is often said that recognizing a problem is halfway to creating the solution; certainly, it is an essential first step in the process. Therefore, a fundamental approach that RCs must take is to develop their own awareness of important issues in the disability community and educating others to achieve that awareness. Essential to developing a thorough awareness of more subtle forms of inequity against people with disabilities is an understanding of the concept of ableism. Like institutional racism and sexism, ableism refers to a form of systemic discrimination against people with functional and aesthetic differences due to disability. It is called ableism because it establishes performance requirements not on individual needs but on a single standard based on able-bodied capabilities. It is systemic because it has become pervasive throughout our social system. Because it is so ingrained and taken for granted in society's norms, the evidence of ableism can only be revealed by questioning and deconstructing the assumed validity of relevant practices and performance standards set by the dominant, able-bodied majority. This involves (a) becoming informed, observant, and sensitive to what is going on in your organization and community that prevents fair and equal treatment of people with disabilities; (b) honestly examining existing policies, attitudes, assumptions, expectations, or requirements that everything should be done the “normal” or usual way; and (c) remembering that not all barriers are concrete and visible, so it is necessary to look broadly and reflect deeply on possible problems with the status quo and to think creatively for solutions.

Accessibility

The term accessibility is used in regular conversation to refer to how easy it is to enter and move about a location or to obtain, use, and experience something. It has acquired heightened applicability to rehabilitation counseling since we have become more aware and concerned that many settings or experiences are not easily (or not at all) approachable or available to people with disabilities. When raised awareness reveals situations of disparity in need of change, it is important to investigate what the possible contributing factors are. Careful analysis of the aspects of the situation and listening to the complaints of those who have been marginalized or excluded should help identify whether there are physical, procedural, or attitudinal barriers that prevent or complicate access and full
participation. Are there features of the natural or built environment that constitute physical barriers? Are there requirements in the process of participation that create procedural barriers? Are there assumptions or beliefs held by gatekeepers or peers in the situation that communicate attitudinal barriers that make some people feel unwelcome, mistreated, or denied equal opportunity? Reducing these barriers requires honesty about oneself and listening to the marginalized group, as well as commitment and creativity, in order to assess and then increase accessibility as appropriate. Most architectural or environmental features that promote access and convenience for people with disabilities actually improve those functional criteria for the general public as well. Ramps and automatic doors, for example, help all of us when we are transporting heavy loads or pushing a baby carriage. Technology that allows us to give information by voice or by touching a screen is generally easier and faster than writing or typing. The term universal design refers to intentionally creating such characteristics and choices that will maximize all people's access to and interface with environments, equipment, or experiences (e.g., Iwarsson & Ståhl, 2003; Null, 2014).

**Accommodation**

There is considerable overlap both in concept and in practical examples between accessibility and accommodation. Both are used to increase inclusion of people with disabilities. Accommodation has a few different definitions in its singular and plural forms. Its major meaning for rehabilitation counseling purposes was determined when it was written into the regulations for the nondiscrimination sections of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) (1990). It was recommended as a principal strategy for reducing the discrimination by exclusion that people with disabilities experienced, particularly in employment and education. It consists of a variety of strategies that substitute or compensate for the different or limited abilities of people with disabilities. Examples include (a) modifying the setting, procedures, or schedule for performing work, academic, or leisure tasks, such as individualized work breaks or telecommuting options; (b) providing adaptive equipment or resources, such as screen-reading software or sign language interpreters; and (c) substituting alternatives for accomplishing requirements, such as allowing a job coach to train a new employee on site or offering a low-distraction testing environment. Although the rationale for both of these laws is to redress the inequities of opportunity experienced by people with disabilities, the lawmakers also recognized that in many situations, there is a mix of legitimate and possibly noncompatible needs (at the personal, group, and organizational level) that must be considered. Therefore, the regulations to these laws use the qualified phrase reasonable accommodation. Thus, a limit was set on the extensiveness of adjustments and modifications that a responsible organization such as a business or school should be expected to provide to a qualified individual with a disability. The term reasonable was purposefully not delineated by any list of specific examples or by a formula. Rather, the laws and regulations provide some guidance and criteria to be considered when accommodation requests are individually negotiated and determined. Two main criteria for assessing the reasonableness of requested or projected accommodations are (a) business necessity, which examines the extent to which the desired accommodation comports with or does not detract from the purpose of the organization; and (b) the projected cost–benefit consequences of various ways of achieving the requested accommodation, to ensure that implementing it would not impose undue hardship on the responsible organization.
Advocacy

One ongoing strategy that should be used by all RCs, other counselors, and, indeed, any person wanting to make meaningful change is doing advocacy and promoting self-advocacy by those directly affected. This in itself is a multimodal way of approaching change where it is needed. Three types of advocacy are (a) individual advocacy to empower a particular person; (b) self-advocacy when one is fighting a cause on behalf of oneself or one’s community; and (c) systems advocacy to generate improvement on an institutional or societal level (such as effecting a policy change that benefits a class of people). Advocacy comes from Latin words meaning to speak up or use your voice to advance a cause. Accordingly, many modes of advocacy have to do with verbal communication: giving talks to educate stakeholders about an injustice; writing letters to controlling authorities; lobbying legislators; creating public service announcements; and participating in a boycott or protest march. Other ways of promoting a message or cause are to conduct research; solicit resources and supporters; monitor enforcement of equal-opportunity laws; and sponsor demonstration projects. These actions can serve to validate the need or instigate the change. Many other means of effecting advocacy can also be chosen to fit with the agenda and the preferred style of the advocate or self-advocate. Kiselica and Robinson (2001) discussed several qualities and skills that characterize people who are well suited to be advocates. These include ability to maintain a multisystems perspective; ability to use individual, group, and organizational change strategies; willingness to compromise; awareness of the impact of your personality on others; and ability to adjust your style in order to be an effective change agent. Internationally, both the declaration and protection of human rights are major sociopolitical goals pushed by advocates for women, children, and other marginalized sectors of society. This includes people with disabilities, as articulated in the 2006 United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD). Umeasiegbu, Bishop, and Mpofu (2013) provided informative analyses of this policy document and its relationship with counterpart laws in the United States and several other countries.

Within American academia, social justice has become the contemporary term to refer to the domain of issues and corresponding counseling and advocacy strategies focused on human rights. The goal is to reduce the impact of deprivation, discrimination, and oppression in the lives of clients and in the communities where they reside by eliminating the root causes and manifestations of the injustices. This agenda is relatively new for our profession and ought to be more fully infused into our curricula and ethical codes. That effort will require searching self-reflection and serious analysis and critique of our professional practices. Harley, Alston, and Middleton (2007, p. 44) cogently recommended that we:

provide students with opportunities to critically examine the power dynamics of the rehabilitation counseling approach to service and to identify new ways of entering into a reciprocal relationship in the community (Rice & Pollack, 2000). Both teaching and learning about social justice are not destinations . . . they are processes of continuous growth and understanding.

Asking Before Acting

To be truly effective and ethical in pursuing social justice or any of the other missions of rehabilitation counseling, it is essential to approach the process with humility and to do the work collaboratively. This recommendation to check on the acceptability and
validity of the perceptions and motivations that drive our helping behavior is an ongoing responsibility. Most directly, this can be done by getting input and feedback from the least powerful stakeholders who are most affected. The following examples refer back to the other “A-strategies” described in this section:

- Often a new awareness about an issue emerges from a powerful personal experience or an influential reading. When this happens, ask affected stakeholders what they think about the issue and why.
- Before constructing or retrofitting structures to achieve accessibility, invite a few people with different types of limitations to experience the site as is or to review the plan as designed, to give recommendations and priorities about features that would ensure access for them, before the job is started.
- When initiating a service relationship with consumers, make sure to invite them, preferably in a written document that is distributed or displayed, to make suggestions at any point in the process about accommodations to a disability that would enhance their participation in the program.
- Consult with concerned stakeholders about your ideas for engaging in an advocacy effort. Listen to their experiences and desires. Ask how you might partner with them on the journey to expand their personal sense of empowerment or to improve a cause for social justice in the community. The work of creating equal opportunity and full participation with dignity for all is not easy, but it can be effective and meaningful if it is carried out collaboratively with persistence and hopefulness.

TRADITIONAL MODELS OF HOW DISABILITY HAS BEEN PERCEIVED AND INTERPRETED IN SOCIETY

This section explains four different models that describe how people from ancient times to the present day have perceived disability. The models in this section are presented in the order in which they emerged historically; the later ones are more multifaceted; and they vary in their acceptability as useful conceptual frameworks. However, they all have some contemporary relevance to the experience of disability and the provision of rehabilitation services. Overall, these models represent the perspectives of the outsider or professional or scholar—looking out at disability and observing its interactions with the world. Although they are consistently called the models of disability, all of them discussed in this and the next section are descriptive and do not propose testable hypotheses that translate into verifiable outcomes, as the more predictive models in the physical sciences do (McLaren, 1998). Rather, the main value of these models is to examine critically how diverse perspectives on the origin and meaning of disability shape personal, professional, organizational, and societal responses to people who have, or are perceived to have, a disability. The reader should also understand that the presentations of the various conceptual models are not meant as an evaluation of specific programs, such as services that have the same label as the model (e.g., life-saving medical procedures or career-enhancing vocational services).

The Moral Model

The moral interpretation of disability is represented by a diverse accumulation of beliefs (whether explicitly expressed or unconsciously internalized), most of which are rooted
in traditional thinking in some cultures and religions. The moral model views disability as a symbolic attribute of the person that demands an explanation. If the disability is perceived positively, then the individual is revered as blessed with special powers. For example, this was the case with certain people who were blind in ancient Greek and Roman civilizations, where it was deduced that because they could not see in the physical world, they were believed to have keen powers to “see” in the metaphysical realm. Therefore, they were brought into the inner sanctum of the emperor to serve as advisers and predictors of the future. Even today, it is not uncommon for people to believe that people who are blind inherently have alternate sensory powers, rather than understanding that greater reliance on and increased practice using nonvisual cues can strengthen other sensory modalities. Much more frequently, disabilities were reacted to with fear, stigmatization, ostracism, or death by infanticide. Typically, it was assumed that the disability was an outward sign that evil had befallen the family or sin had been committed. In different cultures or circumstances, the person blamed was either the person bearing the disability, the mother or both parents, or some ancestor.

The moral model is no longer a mainstream interpretation of disability as it was in past centuries. Indeed, such beliefs may seem so superstitious in today’s scientific knowledge environment that they are considered nonexistent. But “primitive” beliefs can remain subliminally implanted in the depths of cultural consciousness and can result in imposition of stigma and shame, which are often internalized by people on whom such are imposed, however subtly. Some recent examples of these misconceptions include that HIV, the virus that causes AIDS, emerged as punishment for “choosing the gay lifestyle” over heterosexuality; and that people with biochemically based psychiatric disorders are “possessed by evil spirits.” Psychiatric and behavioral conditions are more often stigmatized and considered the person’s fault, compared to orthopedic and sensory disabilities. Perhaps the best descriptions of the contemporary intellectual (and more secular) version of this moral model are given in books by Susan Sontag (1978, 1989). She criticized some current perspectives on disease and the metaphorical language used in discussing its origins (especially cancer and the AIDS “plague”). Her discussions demonstrate how this metaphorical language is rooted in and reinforces the phenomenon of blaming the victim by shaming the character of those who acquire the disease.

The Medical Model

The conceptual framework known as the medical model is arguably the most dominant and culturally infused of those we will discuss. The medical model views disability as contained within the person as a result of an organic impairment in the body that is probed and prodded for diagnostic and treatment purposes. The role of the medical professional is to cure the disabling condition or reduce it to the closest approximation of “within normal limits.” The person with a disability is expected to be compliant and unquestioning. On the macro level, the miracles of modern medicine have resulted in tremendous strides in saving lives, extending the life span, and increasing the level of residual function after the onset of a host of diseases, injuries, and congenital abnormalities. Medically, individuals with a significantly disabling condition are likely to agree that they are better off due to medical science. Psychosocially, however, the process of having a person single-mindedly focus on “fixing” something that is a permanent part of your identity and adapted lifestyle can have negative and lasting side effects. This can be true regardless of how good the professional’s intention is and beneficial (functionally or cosmetically) the outcome is. Many people born with a disability that required
extensive treatments feel that the medical improvement came to them at a high psychological price in terms of depleted sense of self-worth, loss of dignity, and being treated by others as abnormal. For this reason, the medical model has also been called the “individual pathology” or “personal defect” model because it disparages disability, in both indirect and explicit ways, rather than seeing disability as part of the spectrum of human variation. Additional concerns about the negative impact of the dominance of the medical model on psychotherapeutic practices are cogently and succinctly summarized by Vash (2004).

Another particularly problematic assumption of the medical model is that the credentialed expertise of the professional is more valid and important than the preferences, direct experience, and learned lessons of the person with a disability. This creates a tension between the perspectives of the outsider versus the insider (who personally experiences both the challenges and the growth opportunities from disability). Marshak and Seligman (1993, especially pp. 1–19) and B. A. Wright (1983, 1988; B. A. Wright & Lopez, 2005) provide many explanations of undesirable effects of the discrepancies between the experiential worlds of consumers and providers. Despite better sensitivity training of health care professionals and more assertiveness among clients than in the past, their inherent differences in power that get reinforced by the medical model can distance professionals from understanding what is going on inside the client, cognitively and emotionally. Discrepancies in perceptions and priorities can negatively affect the therapeutic process and outcome, thus demanding that professionals engage in honest reflection and self-monitoring to address the often-covert conflicts (B. A. Wright, 1987). For further critique and examples of the paradoxical negative impact of the helping professions, interested readers are referred to Schriner and Scotch (2001), Scotch (1988), and Szymanski and Trueba (1994).

The Labor-Market Economic Model

The basic tenet of the labor-market economic model is that inability to work defines one as disabled. This tenet presents a conundrum, because many people who have a disability are either successfully employed or know that they are capable of working. Thus, there is no simple, direct relationship between disability and employability. This model’s main strategy is to rely on primarily medical assessments to determine the existence, extent, and projected time span of a disability and its limiting impact on a person’s functional capacity to perform work tasks. Thus, some scholars call it the functional limitations model or vocational model. Based on the data from the medical/vocational evaluation or functional capacity assessment, a person is determined to be fully or partially capable of working, or defined as disabled and provided disability income to replace the lost or unrealized income from a job. Usually, if disability income is approved, so is government-subsidized health insurance (Medicare or Medicaid), because in the United States most people obtain health insurance as a benefit of their job, although this has recently begun to change.

Despite the value of their intended purpose, some regulatory features of disability benefits programs have created problems. First, the system has developed too rigid a diagnostic dichotomy: one can versus cannot work. In reality, most human characteristics are more differentiated along a continuum of capacities. It would have been wiser practice for disability determinations to be made by assessing actual work performance more adequately and creatively—including samples of behavior when assistive devices, accommodating strategies, or worksite modifications were used that could eliminate or reduce the impact of the specific functional limitation(s) associated with a particular disability.
Second, for people with disabilities who have ongoing needs for medical treatments and/or personal attendant services that are provided by a single package of government-subsidized disability benefits, the system creates a difficult motivational dilemma called a financial disincentive to work. Many such beneficiaries are eager to work for a salary and give up the income portion of their benefit, but they cannot afford to lose certain medical benefits and long-term attendant services that are not covered by any employer’s health insurance plan.

The Ecological Model

Comprised of domains of interdependent components, the ecological model is a multidimensional and more humanistic expansion of the medical model. Engel (1977, 1980) and others called it the bio-psycho-social (BPS) model because they saw illness as a function of more than an impaired body (the biological component). They recognized the integral importance of additional factors that contributed to disease or dysfunction—and to its remediation. These included an array of individual psychological characteristics (e.g., feelings, preferences, beliefs, compliance behaviors), as well as various social factors. The latter can encompass variables ranging from the closely surrounding context to broad societal forces. An inherent characteristic of the BPS model is an appreciation that the various components are interconnected in ways that can change as the person develops and responds to new experiences. Thus, the model depicts a system of relevant variables that not only interact with but also mutually influence each other. Accordingly, systems model is another term used by some authors (e.g., Cottone, 1987) to refer to this framework. Although some authors in psychology (e.g., Bronfenbrenner, 1979; Moos, 1979) and rehabilitation counseling (e.g., Hershenson, 1998; Szymanski, 1998) have used the term ecological in their publication titles and explanations of this conceptual perspective, it is not yet a common descriptor in our field. Nonetheless, we prefer the label ecological model because we believe it more clearly emphasizes the dynamic, interconnected web of influence of the components on each other and on the synthesized outcome.

Another reason why we prefer the more concise term ecological for this model is that it has continued to expand, as various authors argue for the specification of new components. Those who have added a cultural component and critique to the BPS model include Molina (1983); Jackson, Antonucci, and Brown (2003); and Hatala (2012). There is also a growing movement of scholars and practitioners who argue for incorporating the spiritual dimension of clients’ lives and concerns in any holistic approach to counseling (Bruno, 1999; McCarthy, 1995, 2007; Mijares, 2014; Nosek & Hughes, 2001; Stebnicki, 2016; Vash, 1994). In 2009, the Association for Spiritual, Ethical, and Religious Values in Counseling developed and approved a list of spirituality competencies for counselors (www.counseling.org/knowledge-center/competencies). If these advancements were to become broadly accepted, we would then be using the cumbersome term, the bio-psycho-social-cultural-spiritual model.

The ecological model is the most popular and pervasive in current clinical and research endeavors. A prime example of this point is the International Classification of Functioning, Disability and Health (ICF; World Health Organization, 2001; also see Chapter 12 in this book and Peterson, 2016). ICF is the product of a global effort to devise a universal system for measuring the impact of disability on a person (the clinical application) and, more frequently, on a national or regional population (the public health research application). One notable quality of the ICF is that it conceptualizes the constructs of
disability and health not as a dichotomy but as a continuum. Another is that it provides a multidimensional structure for categories of personal and environmental variables, each with multiple components and levels. However, a close examination of the substructure of this assessment tool does expose a definite preponderance of personal function and disability variables, compared to its identification of potentially influential environmental variables (McCarthy, 2014, pp. 4–5). For a more balanced application of the ICF and the ecological model, readers should review Millington’s (2016) excellent explanation of the paradigm of community-based rehabilitation (CBR).

UNCONVENTIONAL MODELS THAT ARE CHANGING HOW THE DISABILITY EXPERIENCE IS UNDERSTOOD AND APPRECIATED

This section explains four newer models that propose alternative interpretations and responses to the stimuli that disabilities represent. The models in this section are also presented in historical order. However, because they have rather recently emerged, the later ones have not benefited from as much time in the marketplace of ideas to be developed and discussed. In large measure, these models represent the perspectives of the insiders to the disability experience or innovators, as they look out at the world and its interface with disability, and work to reformulate that relationship.

The Social Model

Perhaps the most dramatic shift in thinking about disability over the past 50 years is represented by the social model of disability. This viewpoint strongly opposes the medical model’s narrow and oppressive definition of disability as a problem within the person and the consequent solution as correcting or changing the person with a disability. From the social model perspective, the problem is not paralyzed legs but environments, buildings, and transportation systems that are not accessible to wheelchairs. The problem is not the inability of a person to see, hear, or stand for extended periods of time. It is the discriminatory refusal of people in the workplace to allow those with disabilities to perform the job duties in an accommodated way and with the assistive devices that enable them.

At least as early as Barker (1948), there were scholarly propositions suggestive of the social model of disability, noting a “minority parallel” with regard to biased preconceptions of and unjust discrimination against people with disabilities similar to what happens from racism against ethnic groups. Thus, some scholars refer to this framework as the minority model. However, it was the independent living (IL) movement about two decades later that became the powerful impetus for demonstrating this paradigm shift in analyzing disability. The leaders of the IL movement demonstrated that they were not “confined to a wheelchair” (an erroneous phrase often used to describe people who actively use wheelchairs as their regular mode of mobility). Rather, they were confined by unnecessary physical barriers and social policies or expectations that kept them in the parental homes where they were raised or in the nursing homes where they were placed, secluded from mainstream life. Readers are strongly encouraged to learn about the IL movement and the movers and shakers who started and further fueled it. The most extensive source is the Oral Histories/Archives project on Disability Rights and Independent Living Movement (www.bancroft.berkeley.edu/collections/drilm/index.html). Other informative and interesting accounts include Charlton (1998), Davis (2015), Fleischer and
Zames (2011), McCarthy (2003), McMahon and Shaw (2000), and Pelka (2012). Inspired by the wave of civil rights movements in the 1960s and 1970s by African American, feminist, and gay activists, early disability rights self-advocates forged their own liberation agenda and successes. Accordingly, we believe a clearer descriptor for the perspective known as the social model is the self-determination philosophy of the IL movement or the civil rights model of disability. Others choose to highlight the social power dynamics of this model and call it the politics of disability (e.g., Hahn, 1985; Stubbins, 1988) or the sociopolitical model (e.g., Smart & Smart, 2006).

The Disability Culture Model

An often-unacknowledged alternative in the collection of conceptual frameworks is the disability pride and culture model. There are lots of similarities in the perspectives of those who embrace this model and those who assert the civil rights model. Differences are primarily in (a) how and when the models developed historically and (b) their chosen emphases. At the risk of reducing the contrasts to a few phrases, one could say that the construct of disability culture emerged from ideological, psychological, and sociological discourse in academia and the arts, starting around 1990. Significant references and resources on disability culture include Brown (2003), Linton (1998), and Riddell and Watson (2003). By comparison, the rights model grew out of political engagement and “in the streets” activism for pragmatic changes in social policy and community access, starting in the 1960s with the IL movement. Perusing the following two selected websites will also help readers grasp the commonalities and differences between disability culture organizations (e.g., www.instituteondisabilityculture.org) and disability rights organizations (e.g., www.adapt.org). The academic discipline of disability studies and its flagship organization, the Society for Disability Studies (www.disstudies.org), are the main engines of scholarship and mentoring that have successfully promoted both of these models of disability.

Putnam (2005) hypothesized that disability pride is one component of disability identity; and that it consists of four affective–cognitive elements. These are (a) “claiming” disability (a term that contrasts with the typical therapeutic goal of “accepting” one’s disability); (b) seeing impairments as a natural part of the human condition; (c) believing disability is not inherently negative, although it is frequently interpreted so; and (d) experiencing disability as creating the consciousness of a cultural minority group. She explains feelings of disability pride in these ways (Putnam, 2005, p. 191):

[they] run counter to social and cultural beliefs that disability is tragedy and that persons with physical or mental disabilities would rather not be who they are . . . identify as part of a collective group of individuals who have both struggled within and contributed to the development of their home nation.

Actually, there are three distinguishable subpopulations of the disability pride model that share fundamental commonalities but usually operate within their own networks. One is composed primarily of people with obvious physical disabilities. For them, wheelchair access and accommodations for blindness have been major issues; assertive personalities and communication skills have been their notable strengths. This group is predominant among the trailblazers and current participants in the IL movement and adapted competitive sports such as the Paralympics. There are several publications that reflect this community’s perspectives and agendas. Prominent among them is the monthly magazine, New Mobility, that publishes provocative and pragmatic articles. A second
group is the Deaf culture, made up of people whose primary language is American Sign Language (ASL). (Note that deaf is the common adjective and diagnostic label for a significant hearing impairment, whereas Deaf with a capital “D” refers to the subgroup of that population who psychosocially self-identify with that culture.) Their disability is hidden, so these people do not have the experience of immediate reactions of being avoided, stared at, or given unwanted help that many people with visible physical disabilities have to handle. Instead, they experience significant isolation from mainstream culture because ability to communicate fluently in ASL among the nondeaf population is very rare.

People with chronic mental illness or past psychiatric histories comprise the third group. Typically, they do not encounter the physical or communication barriers just described. However, they bear the brunt of the deepest discrimination from the general population, in the form of social stigma, fearful rejection, and unreasonable or cruel treatment, even in allegedly therapeutic institutions. Schrader, Jones, and Shattell (2013) explained the evolution in self-advocacy priorities of this segment of the disability pride community, which they refer to as the consumer/survivor/ex-patient (c/s/x) movement:

articulate a broader culture of madness . . . have emphasized the connections between madness and art, theater, spirituality, and a valuable sensitivity to individual and collective pain . . . supports interventions that target the social exclusion, poverty, trauma, and grief that contribute to distress and block positive adaptation. (pp. 62–63)

The Technology Model

Technology has had and will continue to have a significant influence on those in both developed and developing countries in many domains of their daily life. Increasingly, its impact on the disability experience has been even greater. Indeed, some predict it may ultimately lead to the dissolution of physical disability as a functional classification. Yet discourse about technology and disability has rarely risen to the level of conceptually organizing the viewpoints and strategies associated with perceiving disability as an intriguing engineering opportunity into a unique technology model of disability. Nonetheless, this perspective does have a very respected evidence base in the innovative research and product development conducted in the fields of assistive technology (e.g., Lenker & Paquet, 2003) and rehabilitation engineering (see www.resna.org). In an unpublished presentation, Susan Daniels (2009) contrasted three paradigms for understanding disability that she labeled as (a) individual defect, (b) human rights, and (c) eco-tech models. The first two were her renditions of the medical model and social model, respectively. The third could be considered an alternative version of the ecological model, but it was delineated distinctively enough around technology to warrant designation and explanation here as its own model of disability. She presented her comparisons cogently and succinctly by posing and answering the following questions. Because the other two models have already been discussed, only her answer captions to the defining questions for the eco-tech model are given (in parentheses) to explain the main ideas and implications of the technology model.

• Where is the problem? (The interface between individuals and the environment)
• What is the source of the problem? (Lack of fit between the variation in human capabilities and the requirements in the environment)
• How is the solution defined? (Modification of the interface to achieve a better fit)
• What solution strategies are used? (Improvements in technology, integrated delivery systems, knowledge transfer, market research, and systems design)
• How does society benefit? (More effective and efficient performance; more individual choice and control)
• Who are the experts? (Engineers, technologists, designers, manufacturers, users)
• What are the consequences for the individual? (Identification with the engineer role; motivation to create high-performance scenarios)

Her brief answers to the last, telling question highlight the different impact for people with disabilities when these conceptual models are applied in daily living. For the eco-tech model, the consequences are energizing. They contrast sharply with the disempowering consequences Daniels listed for the individual-defect model: internalization of a deviant role; acceptance of inferior status; endless effort to overcome in order to be socially acceptable.

The topic of technology related to people with disabilities is discussed more fully in Chapter 21. Here, we conclude our explanation of the technology model with the example of one practical assessment instrument that has been developed to optimize the use and effectiveness of assistive technology for people with disabilities. The website for the Matching Person and Technology (MPT) Assessment Process (www.matchingpersonandtechnology.com/index.html) provides a wealth of information on this approach, its various tools, and published evaluation research. It was developed by Marcia Scherer and several colleagues. MPT has a definite mission to collaborate with the user in all phases of the processes of assessment, selection, training, and adoption of assistive technology. Due attention is given to psychological, physical, and technical factors of potential influence (Scherer & Craddock, 2002). For example, MPT measures characteristics of the milieu, the attitudinal and physical characteristics of the multifaceted environment where the technology will be used, as well as personal preferences and capacities of the user. Another strength of this resource is its diversity of applications to the needs of consumers with either physical or mental disabilities and related to many performance domains, such as education, employment, and IL (Kirsch & Scherer, 2009).

The Consumer Economic Model

Perceiving people with disabilities as a growing market niche heretofore disregarded or unimagined by the retail industry is the premise of the consumer economic model. This is a perspective that has been discussed not in the counseling or rehabilitation literature, but to date almost exclusively in the media of a sector of the disability community. One good, brief explanation is provided in a blog posted (January 16, 2012) on the Audio Accessibility website (www.audio-accessibility.com/news/2012/01/economic-model-of-disability). Rather than starting with a focus on reducing the disadvantages of disability as a medical problem or functional deficit or stigmatized status deserving of legislative protection from unjust treatment, this perspective begins with positive expectations about people with disabilities. It positions these individuals as typical, active adults: consumers in search of better products, having money to spend, wanting to go on vacation, bringing along their friends and family. Furthermore, it openly acknowledges that by effectively responding to the purchase desires and consumer needs of people with disabilities, business and industry also benefit. This is true not only in terms of their increased revenue, but also in terms of learning ways of becoming a more inclusive and responsive business. In contrast, the mission of traditional human service organizations...
is assumed and expressed to be only serving the good of the client. Indeed, this is enshrined in the primary ethical principle of beneficence (i.e., to do good) that counselors and other helping professionals are obligated to follow. Certainly, service organizations provide benefits to many clients on a daily basis. However, these helping organizations and the practitioners who staff them also gain advantages from their professional work—financially, psychologically, and socially. Interested readers are referred to Szymanski, Parker, and Patterson (2012, pp. 375–381) for a thought-provoking presentation on this dilemma of the formal, bureaucratic relationship between professionals and clients in the “business of disability.”

The expressed goal of the consumer-economic model is to create an inclusive culture through appealing to the growing population of people with disabilities and their loved ones as a competitive advantage in the marketplace. The proponents of this perspective rely on the principles of universal design, economic integration through market forces, and facilitated participation in all domains of living as the strategies for achieving social inclusion. People with disabilities are targeted as one of the groups of humanity to be included; therefore, they should be cultivated as desired consumers. Although its conceptual framework and mission are broader, this model to date has been primarily applied to the tourism and recreation business, which is an obvious launch pad for an approach that is based on the design of environments and products for universal access. The following description (Travability, 2011, pp. 3–4) capsulizes how the proponents of this model distinguish their marketing approach from the enforcement strategy of the civil rights model of disability:

The shortcoming of the social model is that change has been driven as compliance . . . seen as a cost that society demands of a business . . . driven by social expectations and translated by rule makers. At that point it . . . just becomes another problem for organizations . . . and is handed across to their risk management departments.

Relatively recently, like other groups (e.g., ethnic and sexual minorities) that have been misrepresented or ignored, the disability community has begun to gain more attention and gradual understanding from the corporate sector. Accordingly, whereas once the voices and interests of people with disabilities were restricted to small-scale publications or organizations dedicated specifically to expressing their message or advancing their agendas, they are now beginning to be recognized in the mainstream media and marketplace (Rucker, 2016). This change is progress, albeit slow. Furthermore, as the disability community becomes more acknowledged by corporations, it is crucial that they not treat this sector as a single entity. It is a diverse population, with many intragroup differences in priorities and preferences.

CONCLUSION

This chapter delineated the quite straightforward value-based orientations of rehabilitation counseling. It also presented a diversity of conceptual frameworks that have shaped the complex context of societal expectations and structures within which RCs and people with disabilities work together. Part of the complexity uncovered was the contrast between traditional and unconventional models for understanding disability on both personal and societal levels. The following analysis of the goal of “independence” is designed not just to exemplify this difference, but also to suggest how each perspective
has some pieces of “the truth” and reality of achieving the goal. The Functional Independence Measurement (FIM) system is a well-developed clinical and research tool commonly used to assess the current functioning of patients with physical disabilities in hospital rehabilitation programs (Uniform Data System for Medical Rehabilitation, 1997; www.rehabmeasures.org/lists/rehabmeasures/dispform.aspx?id=889). The tool is used to record therapeutic progress and to justify requests to health insurers to pay for further treatments by allied health staff, who complete the FIM form. It measures how independently the people with a disability can perform activities of daily living (ADLs) such as bathing, dressing, toileting, talking, and walking. The rating scale for each activity ranges from 1 (total assistance) to 7 (complete independence). The instructions for assigning someone a score of 7 read: “All of the tasks making up the activity are typically performed safely, without modification, assistive devices, or aids, and within a reasonable amount of time; no helper required.” By this criterion, most people with disabilities would never reach independence. Actually, no person could be classified as independent in the activity of watching TV (if it were on the form!) because we all use the assistive device of a remote control—we just don't think of it in that way. An interesting alternative to the stringent FIM criteria is the broad concept of independence expressed by people with disabilities who endorse the philosophy of the IL movement: “independence, to them, does not imply being able to survive without the help of other people or assistive devices; it simply means freedom of decision making and the power of self-determination” (Vash, 1981, pp. 38–39). As an example, consider people with high-level quadriplegia (i.e., having no control of all four limbs). FIMs would categorize them as having “complete dependence” because they require “total assistance.” However, if they embrace the IL ideology, the same people would define themselves (and could be understood by others) as independent, because they are in charge of the personal assistants whom they hire or manage. They are in control of the people and equipment that they use to accomplish their ADLs, go where they want to go, and do what they choose to do, when they desire.

Recommended references to help readers further grasp the potential implications of viewing disability issues from different conceptual frameworks include the following: Smart and Smart (2006), which focuses on counseling practice; Buntinx and Schalock (2010), which provides useful insights regarding the interpretation of intellectual disability; and Olkin (2016). The latter author’s recommendations for disability-affirmative therapy are useful and needed because, “[a]s most therapists cannot become truly culturally competent in disability, they need to be culturally aware, informed, and receptive” (p. 222).

The following quote is a powerful message with which to conclude our discussion of these conceptual models—the diverse ways that disability has been interpreted and managed by society, often to the disregard and detriment of the insiders who actually experience disability day in and day out. Although the authors were speaking specifically about psychiatric survivors, the advice is an apt caveat for all counselors working with people who have any unusual differences and stigmatized characteristics. Schrader et al. (2013) recommend that human service professionals:

suspend their assumptions about . . . clients’ experiences (i.e., assumptions of disease, distress, and impairment), opening up both parties to deeper explorations of the desirable but neglected aspects of clients’ experiences and personhood. Clinicians need to be aware of the impact that their own explanatory frameworks may have . . . [and] endeavor to facilitate individualized processes of meaning-making. (p. 63)
We encourage you to continue exploring the yin and yang of theory and practice, questioning and applying conceptual models to guide your mutual learning and collaborative work with people with disabilities and colleagues, now and in the future.

**CONTENT REVIEW QUESTIONS**

- Summarize the similarities and differences among the five strategic A’s (awareness, accessibility, accommodation, advocacy, and asking before acting) for promoting equal opportunity and inclusion for people with disabilities in all spheres of society.
- Select the model of disability that best matches your own thinking and explain five reasons why.
- Review the section on the technology model and the set of questions that Daniels (2009) posed and answered to describe that model. Choose one of the other models of disability presented and answer each of the eight questions with respect to your chosen model.

**REFERENCES**


Daniels, S. (2009, October 24). Paradigms of disability. Workshop presented at the Louisiana State University Health Sciences Center, New Orleans, LA.


