Michael J. Millington, PhD, 
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Presents an innovative family-based approach to rehabilitation counseling that can be put to use immediately!

While the family has traditionally been a secondary consideration in rehabilitation, this graduate text presents an innovative approach to rehabilitation counseling that focuses on the family as the center of a person-centered model, rather than as an adjunct to individual counseling.

It advocates counseling in the context of community, requiring the recognition of social transaction as the primary focus of all interventions. The book provides the tools and knowledge base to effectively work with the family and within the community, delivering a new inclusive model of care and establishing best practices in research, practice, training, and management.

The text examines the rationale for embracing family values in rehabilitation counseling and provides a framework that redefines the relationship between counselor and client in the context of family and community.

It describes the community-based rehabilitation model in detail according to the international classification of function (ICF) and presents a series of illustrative disability profiles—distilled from systematic reviews of the literature—reflecting this framework.

In each case, the impact upon family participation is illustrated and optimal service and support resources are identified. The role and function of the rehabilitation counselor provide the integrative conclusion to each chapter. The book also describes grassroots initiatives, the role of family in community-based rehabilitation in developing countries, family policy across rehabilitation systems, and best practices in research, training, and management.

Additionally, the text comes with access to an instructor’s manual that includes case study discussion questions, classroom activities, and multiple-choice questions.

Key Features:
• Describes an innovative family-/community-focused approach to rehabilitation counseling, framed in ICF taxonomy
• Presents a pragmatic model that can be put to use immediately
• Describes an array of family experiences across disability contexts, providing an opportunity to critique current practice through the lens of community-based constructs
• Provides plentiful case studies based on family narratives
• Broadens the scope of practice with service initiatives from around the world
• Includes an instructor’s manual with case study discussion questions, classroom activities, and multiple-choice questions
Families in Rehabilitation Counseling
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Families in Rehabilitation Counseling
A Community-Based Rehabilitation Approach

Michael J. Millington, PhD, CRC
Irmo Marini, PhD, DSc, CRC, CLCP

Editors
This book is dedicated to my family. You know who you are. You know what you mean to me. In this constellation, there is one who shines for me. Thank you for the light, Dori Ashton. Thank you for us.

MJM

What an appropriate topic for me to have the opportunity to dedicate to my family and the wonderful community of people inside my and Darlene’s life space at some point over our lives. To my parents Cecile and Oresto, who I know would be pleased that things didn’t turn out so bad for me after all. To the love and support of my sisters Diane, Carole, Connie, and Darlene—it was mostly good but sometimes bad being the only Italian boy in the family. Thank you for the pleasant memories of extended family, being blessed with four brothers-in-law, nine nieces, and now great nieces and nephews. To godparents, aunts and uncles, lifelong friends—too many to be named but for sure Dave Krasnichuck and Jamie Coady, who helped my parents after I no longer could. And to the rest of you, like Dave Shannon, who know what you did for us before and after my injury. To Darlene’s parents, four sisters and brothers-in-law, seven nieces and nephews, and her extended family, thank you all for your unconditional caring, love, and support. It is difficult living 2,000 miles away from you all but we are comforted knowing you are there. Then, in no particular order, for their unconditional kindness, to our American community support system: Love and thanks to Karen and Preston McGill, Karen Pell, the Auburn Randy and Nancy McDaniel and the Jonesboro Bobby and Tonya McDaniel, Mark and Bonnie Stebnicki, John and Gina Slate, Marty and Claudia Diebold, Lynn Howerton, Paula and Bill Kimball, Martin and Lisa Furtado, Noel Ysasi, Noreen Glover-Graf, and apologetically to the many more I am not naming, but who touched us and helped us along the way. This book is for and about you, and it is my way of saying thank you for a life fully lived. Finally, to my wife Darlene: I can find no words in any dictionary that can express my love and gratitude for you seeing something in me so long ago that convinced you to want to spend your life with me. We have lived life large because of you, and I have millions of happy pictures in my mind that make me smile when I look at them.

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I was both honored and pleased that Drs. Millington and Marini asked me to write the Foreword for this important area of study that continues to be an integral part of the ongoing dialog in health and human care with a focus on rehabilitation counseling. My interest in the family began on a personal level, similar to the experiences of the authors. As a child, I experienced the peaks and valleys of living and growing up in a family that, like most others, had its share of illness and disability-related defeats and victories. These early and ongoing personal family experiences most certainly created my sensitivity to the impact of the human challenges on all family members when disability occurs.

Families are complex, emerging as well as evolving systems. They live in a world with an environmental atmosphere composed of past, present, and future fears, hopes, dreams, and aspirations. Under the most ideal circumstances, even the most resourceful and resilient families can be tested and challenged by the demands and uncertainties of the life and living experience. Factor in the enormity of illness, disability, loss, and change, and there is now a potentially toxic environment that can challenge and overwhelm most families. In fact, given what many families have to deal with, it is amazing that as many manage as well as they do!

It is with the understanding of the family from a theoretical, practical, systemic, and personal perspective that the authors have conceptualized and written this most timely and important book. The authors have set a stage on which the family can be presented, appreciated, and understood to be better served by a health and human care system that is often limited not only by resources but also by lack of vision and creativity.

Often, it takes personal experiences to create the conditions for insightful learning and meaningful action. This point was driven home by a mother who was working with me in my rehabilitation counselor years to develop services, meaningful interventions, and supports for her young adult daughter who was living with a brain injury. After several visits, I had prepared what I thought was the most appropriate

Foreword
plan and presented it to this mother, who followed through with all the listed tasks and expectations. When I received a call that she wanted a follow-up meeting, I was anticipating some positive news regarding the gains being made related to the rehabilitation plan. To my surprise, this mother told me that many of the facilities and programs I had suggested were not relevant to the current and emerging needs of her daughter. She further stated that she would do something about the resources that existed and that she would change the system. This was in 1979 when the treatment and rehabilitation options for people and families living with brain injury were very limited. The mother was Marilyn Price Spivack, cofounder of the Brain Injury Association, an international organization that today has a major impact on policy and service delivery for people and families living with not only brain injury, but other life-altering conditions as well. While I did the best I could with the resources that were available, as a professional I did not have the educational preparation, vision, and perhaps the desperation that this mother and countless other parents and families have when their needs are not met or even understood or appreciated by the systems or personnel that provide support and care.

As an academic, I worked with Bob Marinelli on our series of psychosocial books. We began to realize the need to expand the vista of improved quality services to include the family. This work began with the research of Dr. Paul Power, who was working with families of veterans living with Huntington’s disease. After many discussions of the need for family involvement and the ongoing issues and challenges not only for veterans and their families but others as well, Paul suggested that we offer a course on the family and rehabilitation as well as write a book. This was in 1975. The course, at Boston University, was the first step in organizing and preparing the material that took shape in our first family book, *The Role of the Family*, in 1980. This book was the foundation for our ongoing work with the family that occurred in the classroom and our clinical work. With the publication of additional books and presentations, we began to expand our understanding of the family and its ongoing developmental needs and issues.

A major force in our journey was the support and input from many in the consumer movement who were on the front line of the battle and were the true voice for the family, and the realistic dreamers of what could and should be in meaningful and relevant treatment and rehabilitation services. Millington and Marini have further focused on how an effective and efficient community-based approach inclusive of families should work, while concomitantly addressing the realities of where policies, services, and support fall short.

Before reviewing their book, I had realized that while my colleagues and I were expanding our understanding of the family back then, we were not fully attending to the more complex evolving issues that families were facing in navigating their environment, the quagmire of gaps in medical services, and the need for better policies and more resources. Many of these issues are addressed in this book, which presents the family in a comprehensive and emerging context. Key to this work is addressing the critical issues families live with on a daily basis in a dynamically changing world.
A major concern for all is that while the needs and concerns of the family will be better understood, there may not be adequate traditional resources to meet the growing and ongoing needs of families. A major premise of the Millington and Marini book is their recognition of the need for a community-based approach where the family is a central player in establishing, advocating, and securing the best of care for its loved one with a disability.

There are many similar stories and situations that reflect how consumers of health care and rehabilitation services have made the effort to become partners in their treatment and care while supporting the ongoing development of meaningful, competent, and caring services for them and their family members. Millington, Marini, and associates cover a gamut of disabling conditions in this book by providing actual case stories that discuss the families’ lived experience of caring for a loved one with a disability and the reciprocal relationship families face with community-based resources. Regardless of whether community resources are abundant or scarce, families are the first line of support. While it may be somewhat easier to identify the ongoing problems faced by families engaged in treatment and rehabilitation while living with the reality of illness and/or disability, it is often a much greater challenge to conceptualize and implement those policies and interventions that help families to stabilize and survive the loneliness, isolation, abandonment, heartache, and disappointment that is often the norm of their day-to-day lives.

A critical factor in the process to maximize benefits to families is the realization and appreciation that families are distinct and unique in some dimensions of their life experiences, financial resources, values, and cultural norms, to name a few. However, they are very similar in their desire to have meaningful health care and rehabilitation services and a realistic hope for what is possible and what is not. Too often families and providers have the expectation that if we have and provide the very best care and the most expensive resources, the family member or they themselves will improve or return the person to his or her preinjury state of functioning. The very harsh and often unacceptable reality for too many families is that many human conditions are not treatable, preventable, or improvable. Sometimes things will deteriorate and just get worse. Consequently, some families are faced with a situation in which no matter what they do or how hard they try, their goals may not be achieved. This does not imply that families or their members cannot have a meaningful or improved quality of life.

I admire Drs. Millington and Marini for taking on the task of trying to synthesize and present the multitude of issues—past, present, and future—that are the foundation of a comprehensive and emerging system of community-based care for a very diverse group of people from very different backgrounds and unique life experiences, and with very different options. It is important to mention that many families are not functioning with adequate resources. Often they enter the health care and rehabilitation system in a state of emotional, financial, and spiritual bankruptcy. Consequently, the authors address the concepts of family identity, power, and capital. The resilience of families at all levels of status is explored, noting the particular adversities of those who are oppressed and discriminated against.
This book is a creative and practical attempt to not only connect the dots but also add the dots that provide the connections to a clearer understanding and relevant responses to the current and emerging needs, as well as the reality families live with and within. It also challenges health and human care systems, those who are responsible for them, and those who are served by them to look beyond what is and reach for what could and should be. The ongoing challenge addressed by the authors is not only to explore the needs of the present, but also to anticipate the emerging needs of the future. While this may seem to be a most difficult task, just compare the role of the family and the health care and rehabilitation process 50 years ago with what it is today. The present and the future welfare of families and their loved ones with a disability requires rehabilitation counselors to have a complete understanding of their holistic needs and to provide community-based rehabilitation services in the least restrictive ways feasible. It also requires rehabilitation professionals to become advocates for and with families.

Drs. Millington and Marini and I have all lived disability experiences with our families in addition to working with other families who have experienced health-altering conditions. We have also had the opportunity to witness the resilience and gratitude of families who are well supported by community-based resources, and conversely become equally as frustrated and angered by the lack of resources that often leaves families to fend for themselves. Ensuring family inclusion and effective community services is the intergenerational legacy that we all share and must continue to aspire toward. What we may also share are those mentors, friends, clients, and strangers who have been role models on how to live with and in spite of extraordinary life challenges. Thankfully, many of these people have become the leaders and advocates for other people and their families by challenging and improving community-based systems designed to help and not hinder the rehabilitation process. Congratulations to Millington and Marini for their dedication and expertise in addressing this critical topic of family inclusion about which we continue to have much to learn.

Arthur Dell Orto, PhD
Preface

My brother and I sit alone in a crowded mental health clinic waiting room. The plastic chairs are bolted to a metal rail in an immovable semicircle with all eyes trained on the nurse behind the bulletproof glass. There is a magazine rack full of old *Golf Digests* and *Condé Nast Travelers* that no one ever reads because no one golfs or has vacations. The waiting room rules are simple: (1) arrive on time, (2) wait, and (3) do not disrupt the system. If you are late, your appointment will be canceled. If you cannot wait, you can leave—this will be noted in your records. Disruption will not be tolerated. The waiting room is full. No one talks. The psychiatrist arrives late through a private entrance and takes her post behind the barricade. The billing commences as the names are called. “MILLER,” calls the nurse behind the glass. She sits at eye level in her elevated post and commands a clear view of the room. Every 30 minutes the buzz-click of the security lock opens the door to therapy. A patient enters on the right and a person exits on the left and the circle is complete. “JAMES.” Buzz-click. . . “VALIANT.” Buzz-click. . . Suddenly, the numbing routine is interrupted by a frantic interlude. A woman darts breathlessly to the desk. She is here for her husband. Yes, she is aware that she is 10 minutes late. Yes, she knows he’s supposed to come, but he is too sick, and he’s out of medication. She apologizes repeatedly and pleads her case again. The families in the room can all hear her desperation and you can literally watch it wash over them. We all know how this ends. For her, tonight will involve the police and more traumas for the kids. Now on the verge of tears, she wails, “I don’t know why y’all treat us this way. We just need a little help is all.” Jeannie is her name. Her husband is Ray. They are just names in a chart that goes back on the shelf. The nurse stands up, now towering over the woman, now turning her back to signal the end of negotiations. Jeannie dares not continue, lest the nurse call security (on speed dial), but instead turns to leave. She is defeated and looking very small. The room is full of families, in twos and threes. You could feel them rise slightly when the woman spoke, and then shrink back down in their chairs when she left. But the worst part was how casually the nurse turned back to the routine, how
quickly she turned to share a small jest with the file clerk, apparently at the patient’s expense.

This book was written because my brother and I were there, a family of our own, taking care of the caring business that families do so well. Later that night, while Jeannie dealt with the crisis in her life, we worked on an ethics chapter called, “What is Required of Us? Rethinking Ethical Conduct in the Practice and Profession of Vocational Rehabilitation.” It was in recalling this room of victimized families and our inability to formulate a meaningful response to the shame and humiliation we observed that David and I first proposed a lived philosophy for rehabilitation counseling: “We must actively work against isolation, alienation, and disenfranchisement of those we serve. In doing so, we must actively fight the non-beneficence and lack of cooperation, the maleficence and deprivation of autonomy, the betrayal and injustice present in the community that excludes them” (Miller & Millington, 2002, pp. 291–292).

For better and worse, I have tried to live that philosophy ever since, and I have tried to turn that philosophy into rehabilitation counseling practice and real social justice outcomes. The pieces have come together slowly. I found the family–community connection in the aftermath of Hurricane Katrina. I saw how communities respond to tragedy by opening their homes, how the great diaspora of the poor atomized families, and how the search for family brought people back together again. I sat with colleagues in a makeshift command center in a blown-out library in Metairie. I found some sense of family among them as we shared our refugee stories. I saw the repercussions of generations of oppression gathered with armed guards at the Superdome. I heard stories of people with disabilities abandoned by attendants and drowning in their homes and people with psychiatric disabilities being turned away from the shelter and care of the Red Cross tents. Thank God, I also saw the redeeming grace of people and professionals pulling together to save whom they could.

I found the professional–community connection in the communities of practice that we established in the National Clearinghouse of Rehabilitation Training Materials. This connection to family was obscure at first. I found the power of social networks and social identities rising out of the shared aspiration and collaborative work of a small group of committed professionals. They started the Summit Group, which grew from a knot of true believers to a professional movement toward quality assurance and excellence in management strategy. If you look at the model they profess, you will find the consumer and the family at the center of their outcome measures.

But the synthesis of theory and practice did not begin until I confronted the conundrum of family counseling in the profession through my contribution to Marini, Glover-Graf, and Millington (2012). The chapter on family counseling ended with the question: How do we, as rehabilitation counselors, address the profound influence that families have on process and outcomes when we are not family counselors? This book is my first attempt to synthesize my experiences and provide an answer to that question.
The dialog established with Irmo as coeditor and author became the process for working through this existential issue. My vision was philosophical. I sought to establish a reasoned basis for practice that grew out of our values and moved from values to models to theory and practice. Irmo’s vision was grounded in the practical. He established the family stories as experiential scaffolding for the book. Irmo brought the “insider perspective” to the dialog, reconciling my idealistic yin with his visceral yang. He insisted on the importance of anchoring aspirations and theory to the lives of people with disabilities and to remember “never about us, without us.” Irmo and I developed a relationship through this dialog and over the shared work it produced. In the trade of our small community of practice (expanding with contributing authors) we learned to trust. In trust, we took chances. The rough ideas I had going in were transformed and the vision of the book is fully shared. We made integration across chapters a priority. Thus each chapter contribution has informed the model and each author shares ownership of the larger proposition.

The answer that the book posits is that the reason family has been so poorly served by rehabilitation counseling is due to structural, fundamental flaws in the way the profession conceives of itself in relationship to its client, and the way it perceives the client in relationship to the environment. The implication of this explanation is that practice is not likely to advance until these problems are addressed.

Part I—“A Community-Based Approach”—makes the case from philosophy to praxis for an alternative to current rehabilitation counseling paradigms. Nothing of our current practice is lost, but much is gained in its translation into a social model that places community at the center of a client-centered practice. This approach creates the appropriate space to bring rehabilitation counseling and the family together. Read in synthesis, the first five chapters present the framework for a community-based approach to rehabilitation counseling beyond the family.

Part II—“Family Experience of Disability and Rehabilitation”—recounts the family disability experience across disability contexts. Each chapter provides a unique profile that maps the current relationship between rehabilitation counseling and the family experience. These chapters can be read alone as the state of practice and a guide to current rehabilitation counseling interventions. They can also be read in light of the community-based approach that is insinuated in chapter structures and that resonates in the case study narratives. Obviously, the community approach thus framed has not been intentionally implemented at this point in history, but by framing the chapters in the family experience, we can see the features of community that have been there all along. Themes emerge across these chapters that await the reader’s discovery.

Part III—“Selected Issues for Community-Based Rehabilitation Counseling”—considers a sampling of the professional implications and considerations of moving forward with a community-based model. The culture chapter is adapted from Marini, Glover-Graf, and Millington (2012) but it takes on new meanings in light of the revealed strength of our advocacy roots (see Chapter 3). Assessment and management chapters focus on what we measure in our profession and how we use this.
information from organizational and service perspectives. The final chapter reaffirms the discursive nature of the family theme of the book. It is written as a conversation between Irmo and me, reflecting on the practice and science of rehabilitation counseling at the threshold of community.

An Instructor’s Manual is also available to supplement the text. **To obtain an electronic copy of the Instructor’s Manual, faculty should contact Springer Publishing Company at textbook@springerpub.com.**

This book is written for anyone who wishes to bridge family practice and rehabilitation counseling. It is written primarily for graduate-level studies. The argument for a community-based model would be excellent fodder for debate in seminar—on its merits or in its implementation. The book stands as a primary text in disability studies on the family and a supporting text in applications with rehabilitation counseling. The emphasis on community opens its value to practitioners, managers, and policy advocates. This book is an approach, not a model. It is the humble, if insightful, beginning of a public conversation on the future of the family in rehabilitation counseling and, by extension, the future of the profession itself. It does not assume to have the answers, but sets the stage to pursue them. If it fills its purpose, it will bring people together to have this conversation and a community will form around the proceedings. In the middle of this community, dictating the next edition and leading the discussion, will be the families and the persons with disabilities who live within them. In the end, this is the fundamental target audience.

*Michael J. Millington, PhD, CRC*

**REFERENCES**


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CHAPTER 1

Finding the Family in Rehabilitation Counseling

MICHAEL J. MILLINGTON, BENJAMIN C. JENKINS, AND R. ROCCO COTTONE

The family is the natural and fundamental group unit of society and is entitled to protection by society and the State, and that persons with disabilities and their family members should receive the necessary protection and assistance to enable families to contribute towards the full and equal enjoyment of the rights of persons with disabilities.

—Preamble, UN Convention on the Rights of Persons with Disabilities (United Nations, 2006)

Defining the family presence in rehabilitation counseling has been a perennial issue—often engaged, but never fully resolved. Family members have been recognized for their influence on rehabilitation process and outcomes (Sutton, 1985; Westin & Reiss, 1979). Academics have argued the potential role of family therapy models within rehabilitation counseling (Millington, 2012; Power & Dell Orto, 2004). Family experience with service has been explored from a systems perspective (Cottone, 2012). Ecological models have been employed to justify families as partners in service and as service recipients (Kelley & Lambert, 1992; Power, Hershenson, & Fabian, 1991). The specialized knowledge of family counseling has become part of the qualified rehabilitation counselor identity (Leahy, 2012). Despite these advances, the family discourse has not translated into a sustained movement in research (Bryan, 2009), practice (Frain, Berven, Chan, & Tschopp, 2008; Freedman & Fesko, 1996), training (Riemer-Reiss & Morrissette, 2002), or policy (Kneipp & Bender, 1981).
What accounts for this gap between intent and achievement? The premise of this book is that rehabilitation counseling’s failing with the family is a problem of models. Originally shaped by the values and epistemology of a psychomedical model, rehabilitation counseling struggles with the residual effect of a worldview that it has ostensibly left behind. A new social construction is required to make sense of the proper relationship between service and family. The social movement has provided one on a global stage. Rights-based advocacy, as part of the movement, changed the meaning of disability and reoriented the relationship between family and care at an international level. Rehabilitation counseling has embraced this movement in principle, but has not addressed the conceptual work of constructing a new model for the family around movement values.

This chapter chronicles the emergence of the family ethos in rehabilitation counseling from values, to theory, to its model implications. Rehabilitation counseling for families is cast as community counseling, with family as first community. The discipline’s identity in this new context is explored through the applied values of the fundamental mission. An argument is made that rehabilitation counseling in the family has three distinct transactional expressions in identity, power, and capital.

FAMILY ETHOS IN REHABILITATION COUNSELING

Finding the family ethos in rehabilitation counseling begins with an understanding of community values. John Dewey, an American educational philosopher and contemporary of the psychologist William James, argued that ethical behavior is a social and humanistic pursuit. For the individual, it is the pursuit of a satisfying life within social institutions, that is, in community. For society, it is the pursuit of policy that provides a satisfying community life for its citizens. We pursue the good life through the moral behavior of the individual and the collective. The path is always a challenge. There is no simple concordance of the good, the right, and the virtuous; no imperative rule or immutable truth that precludes thinking (Field, 2005). Directed at living an ethical life or building an ethical profession, the path to moral behavior is always a social process of discovery. The ethos that emerges from experience is a rational, value-laden extension of our epistemology (see Tarvydas, 2012). Our professional identities are driven by our values and shaped by reflective praxis.

The special identity of rehabilitation counseling (Maki & Tarvydas, 2012) is negotiated in the lived community experience of disability. It is unique among counseling specialties in that it exists in the space of society’s ethical failure in this specific regard. The profession was legislated into being to address the exclusion of people with disabilities from society. Rehabilitation counseling is society’s ethical policy response to that injustice. Rehabilitation counselors are agents of social justice (see Marini, 2012), advancing an applied theory and practice of community values.

Miller and Millington (2002) described the ethos of the profession (the moral character of the profession as it is expressed through action) in terms of the historical
democratic ideals of equality, liberty, and fraternity. These values guide professional practice, infusing both process and outcome with meaning:

- **Equality** is a reciprocal respect and regard for the unique nature of the individual and a valued recognition for his or her distinctive contribution to the whole, without consideration of physical or mental function. Accordingly, all are valued equally. Due respect and regard are expressed through the equitable allotment of resources. Each person is provided what he or she needs and receives it such that he or she is able to utilize it in the expression and development of his or her potential—whatever that potential may be.

- **Liberty** is the space created by this transaction in equity that allows for the expression and development of individual potential. Liberty is the freedom to choose one’s path through one’s intentional and unencumbered actions. Through the expression and development of the individual’s potential, each person makes a distinctive contribution to the whole. Because it is only through cooperation that this becomes possible, both the individual and the community come to appreciate and desire that cooperation.

- **Fraternity** is that shared space beyond liberty where people are free to choose their associations, free to align their work with the cooperative of community. Fraternity directs our actions because what we seek to achieve together is viewed as worth achieving by each participant. It produces in us a desire to continue to work together in order to sustain what we have achieved. Disability legislation is an expression of these values writ large. To realize a democracy, however, legislation must find expression through the good work of local community action (Dewey, 1916). Rehabilitation counselors as agents of the democratic ideal on behalf of people with disabilities are citizen professionals (see Doherty, Mendenhall, & Berge, 2010) and the instruments of that good work. Rehabilitation counseling philosophy (Maki & Murray, 1995) is derived from these community values and this ethos. Rehabilitation counseling is a value-driven profession (Tarvydas, 2012) anchored in community by a fundamental mission of full community inclusion (Szymanski, 1985).

**Family Voice in Community**

The fundamental mission links rehabilitation counseling with an evolving, global social movement. The history of democracy in the United States is told in the narratives of marginalized and disenfranchised peoples who united in common cause to resist oppression; negotiate their identities; trade in the marketplace; and claim their share of liberty, equality, and fraternity. People with disabilities have been engaged in this political struggle for decades and family has figured prominently in their
action. As rehabilitation counseling has been a party to the movement, it is within this advocacy frame that the emerging family voice is most clearly heard.

Advocacy Roots for Rehabilitation Counseling

Counseling has its roots in the social reform movements of the 19th century (Sales, 2012) and the programmatic governmental response in the early 20th century (Elliott & Lueng, 2005). Vocational counseling was created to meet an urgent public need to facilitate the rapid shift of the population from rural/agriculture to urban/industrial life and work (Savickas & Baker, 2005). Rehabilitation counseling was an early offshoot of vocational counseling conceived in spirit as a government-sponsored alternative to charity for veterans with disabilities following World War I. It was established in principle under the Vocational Rehabilitation Act of 1920. A detailed account of vocational rehabilitation (VR) counseling in legislation is beyond the scope of this chapter. However, the political subtext of the profession’s evolution is clear: Community advocacy defines and advances rehabilitation counseling through the promise of inclusion.

Medical Model Obfuscates Family Role

The family connection to VR counseling was strained by the residual paternalism of the charity movement, the epistemological constraints of the psychomedical model (Cottone & Emener, 1990) that gave them legitimacy, and the subtle social oppression of a society that was designed to exclude. The language, structures, and functions of rehabilitation were forged in a medical model, and rehabilitation counseling was a party to the process. In the medical model, disability was pathology within the person that required a diagnosis and a “cure.” Assessment focused on a statistical approximation of normality to which the client, by definition, fell short. Strategies were arranged by experts. Treatment was meant to resolve shortcomings. Failure only proved the model’s assumptions of client inadequacy. Services in such a climate tended to institutionalize and segregate (Nosek, 2012) people with disabilities. Vocational evaluation often culled out those who required the most support for being “too disabled” (Cottone & Cottone, 1986). Sheltered workshops promised competitive employment, usually without success. People were warehoused in nursing homes and hospitals far from family and any sense of community. All of this was expertly done for the good of the client. Typically, neither the client nor the family was asked to define what “good” meant.

The medical model has no active role for the family. When disability is in the body, its impact on significant others is a tragedy that falls outside of service. When experts control the language, the client has no voice. When the science is reductive, the social network is invisible and the issues of family are not recognized. For all the good intent, the medical model falls short for all rehabilitation professions, but
particularly for rehabilitation counseling, which had democratic values in its theoretical bones (Wright, 1983).

**Social Movement, Social Model**

The social model arose as a rejection of the medical model (Stubbins, 1984). Disability was redefined as a social construction (Oliver, 1983) imposed on people as “systematic patterns of exclusion that were—quite literally—built into the social fabric” (Hughes & Patterson, 1997, p. 328). The social model reinterprets psychological wellness in terms of the relationship between impairment and the disabling effects of the environment. It focuses on the political, the importance of personal resistance, and group advocacy in claiming an identity within the community.

The initial social model was complete in its rejection of medical hegemony (Oliver, 1990). The confluence of interests across disability groups aligned in the rejection. A political community of practice arose with the movement; it was the shared vision, history, and emerging language of a true disability community based on civil rights. Rejecting the medical model was the beginning of the normalization of disability. Disability was embraced in the social model as an authentic part of the human experience, to be accepted on its own terms, and celebrated for what it contributes to community (Remley, 2012). The full meaning of disability, its value and its challenges, came from a complex of social relationships (Llewellyn & Hogan, 2000), not from the person in isolation. The medical perspective was eventually rehabilitated back into the social model’s worldview (Shakespeare, 2006), but without the power to ascribe meaning beyond the physical structure and function of impairment.

**The Family Voice Emerges**

The sociopolitical perspective recognized the importance of family and provided a platform and a voice. Family became a central theme in the disability studies literature. Family experiences across cultures, disabilities, and roles opened up the dialog to consider the impact of disability within the family and on the relationship between the family and the larger community. Families figured prominently in the collective response of the recovery movement in substance abuse (White & Savage, 2005) and mental health, giving rise to unprecedented family engagement in advocacy, treatment, and community-based peer support (Howe & Howe, 1987).

Family activism within the disability movement influenced the course of legislation. The Individuals with Disabilities Education Act and the Americans with Disabilities Act recognized the family support role in preserving the rights of the family member. Title 1 of the 1998 Amendments to the Rehabilitation Act identifies families as direct recipients of support services and training designed to empower them as informed consumers within the VR system (Section 103(a) [17]). Family access to services is contingent on instrumental impact on client employment.
(34 CFA 361.5(b) [23]), but offers extensive support and liberally inclusive family criteria. Compensable services include interpreters, support groups, information resources, peer networks, counseling (referrals to therapy beyond the scope of VR), day care, respite, financial management, and education. Family is defined as any person with a substantial interest in the client’s welfare who lives within the home.

The empowering family trend has continued. The Family Medical Leave Act advanced employment protections to families coping with emergency care. President Obama included family leadership in policy development around the “year of community living” initiative (ca. 2009–2010). Family efforts were key in advocating for improved access to information, one-on-one counseling, and streamlined services for home-based care (Perez, 2012).

Rehabilitation Counseling Responds to the Family Voice

Rehabilitation counseling has attempted to move in concert with policy trends. What should have been the watershed moment for systems change, the 26th Institute on Rehabilitation Issues (IRI, 2000) addressed the emerging family ethos in VR counseling and proposed a way forward to more family-integrated and family-responsive service. Families were to be supported in their caring roles. VR’s propensity for poor communication with family and the resulting unwarranted lowering of family expectations of VR service delivery were identified as systemic barriers to client success. The IRI recognized that client-centered service was not defined by the client in isolation, but the client embedded in family. The client had a right to choose who “family” was and to direct family roles in VR service partnership. As bona fide stakeholders in the VR process, family members had rights to informed choice and autonomy. Family was not simply to be recognized; it was to be understood. The family was to be respected in its diversity with sensitivity to its changing needs and accommodated accordingly. The family offered specialized knowledge, skills, connections, and resources that were essential for long-term successful employment outcomes. And with that, the family moved from the periphery to the core of rehabilitation counseling practice—at least in (emerging) theory.

Proclamation was the easy part. The 26th IRI was literally a summation of what was already expressed in legislation. Its recommendations were merely guidelines describing what the family in rehabilitation counseling should look like. What the recommendations did not include was any strategy for implementing family inclusion in VR practice. This shortcoming was recognized within the IRI and it foreshadowed the historic lack of progress made since:

Yet, even when we understand the value of and need for family involvement, even when we are empowered to act, we remain hesitant. Perhaps our hesitancy arises, in part, from confusion over the role and function of the rehabilitation counselor. Our profession continues to struggle with the limitations of the medical model, which focuses on disease and deficits. When such pathology dominates our thinking we continue to look for evidence of disease, deficiency, or malfunctioning when we should shift our primary focus
to family strengths. We should assess those strengths and work with the family rather
than working around the family or standing in opposition to the family. As vocational
rehabilitation enters the 21st century, our challenge must be to create a new model that
creates a true partnership between people with disabilities, families and rehabilitation
professionals. (IRI, 2000, p. 44)

FAMILY, THEORY, AND REHABILITATION COUNSELING

Rehabilitation counseling’s science and practice is predicated on the values of human
rights. Rehabilitation counseling transacts specifically in the gap between society’s
egalitarian aspirations for its citizenry and society’s failure in achieving these just
ends. Defined as it is by these community transactions, rehabilitation counseling’s
identity is differentially expressed across settings, developmental across time,
and always in the context of the gap. Rehabilitation counseling is embedded in a
social movement and defined by the search. It is a transitional profession (Miller &
Millington, 2002) with a dynamic identity that requires constant challenge and
revision.

The family conundrum at the center of this identity issue is not a feature
of rehabilitation counseling; it is a passing symptom of professional growth.
Rehabilitation counseling evolves in its role and function, albeit unevenly, in
response to societal change because rehabilitation counseling science is not simply a
description of the world as it is, but the investigation of what makes a more humane
world. Rehabilitation counseling is a science of social construction where empirical
observation is charged with meaning. The social construction of rehabilitation coun-
seling requires a social psychology that embraces liberation.

Social Construction of Disability and the Family

Lewin (1935) is known in rehabilitation counseling for the ubiquitous citations of
his conceptualization of behavior as a function of the person and the environment.
The gestalt of Lewin’s work reveals the deep connections of theory to rehabilitation
counseling values, to the pursuit of systems change, and to the irreducible nature of
family and community. Lewin’s understanding of the social nature of psychology is
a proper framework for engaging the family in rehabilitation counseling.

Lewin’s theoretical work was unified by his dedication to applied social science
in the service of advocacy. He was concerned with the issue of power and its ability
to eclipse social justice for the disenfranchised (Burnes, 2004). The origins of social
psychology are inseparable from the values of democracy in Lewin’s strongly held
belief; society’s complete commitment to democratic values was its only protection
from the worst extremes of social conflict (Burnes, 2004). Gordon Allport went as
far as to aver that Lewin’s corpus of theory was the epistemological complement to
Dewey’s educational philosophy. “Without knowledge of, and obedience to, the laws
of human nature in group settings, democracy cannot succeed. And without freedom for research and theory as provided only in a democratic environment, social science will surely fail” (Allport, 1948, p. xi). Lewin sought to improve the circumstances of the individual through planned change in the group and saw his theoretical themes of field theory, group dynamics, change theory, and action research as interdependent components of planned change at the individual, group, and societal levels.

**Field Theory**

Lewin’s famous $B = f(P, E)$ equation addresses the interdependent physical, psychological, and sociological characteristics of lived experience. The function establishes the inseparability of the individual and the “life spaces” he or she navigates (Hall & Lindzey, 1978). Behavior is enmeshed in a complex network of proximal and distal influences; that is, vector forces that push and pull on self-expression. We shape, and are shaped by, our environments through unceasing reflexive transactions.

**Group Dynamics**

The evolving social identity that binds individual to group manifests through group dynamics. Through “interdependence of fate and task,” individual behaviors coalesce in fraternal collaboration. A complex and reciprocal social system arises where identity is negotiated group-to-individual and individual-to-group (Smith, 2001).

**Change Theory**

Continuity of group behavior creates a social equilibrium not easily changed by individual action. Group change is best effected through collective action. Intentional change is initiated by a disruption of the status quo, a shared desire for transition to a new state, and a consensus that the effort to change is worth the risk (Schein, 1996). Change is accomplished as new models of behavior become engrained in habit; new structures and traditions crystalize around social transactions; equilibrium returns; and a new identity emerges for group and individual (Burnes, 2004).

**Action Research**

The means to direct intentional change in constructive ways is accomplished through action research. Action research was meant to empower (minority) groups to address and resolve local problems and to identify general laws of group life through the application of basic social research. Group members collaborate through a cyclical process of planning overall goal and incremental steps, implementing change, and evaluating outcomes. Outcomes have three purposes, to evaluate the action against the goal, provide an opportunity to learn from the experience, and inform the next iteration (Lewin, 1946).
Lewin interpreted Dewey’s educational philosophy into an applied science of advocacy for oppressed groups. The practice that followed would facilitate democratic social change toward fuller participation in a more democratic society (Smith, 2001). Lewin and Dewey shared the social constructionist view, later professed of the disability rights movement, that planned change is not authoritarian but egalitarian in a process that combines research, education, and management to community-enhancing ends (Hatch, 1997).

**Extension in Rehabilitation Psychology**

Lewin’s social psychology provided a systems alternative to the clinical appraisal of psychomedical tradition. Wright’s seminal work (1983) in the somatopsychological and psychosocial dynamics of physical disability was a turning point. She conceived a value-laden set of principles that recast disability as a complex phenomenon embedded in a social system (World Health Organization [WHO], 2002) and set the precepts for the nascent field of rehabilitation psychology.

**Impact of the Social Context**

Human beings are by nature social creatures that fail to thrive without care (Bowlby, 1969) and for whom isolation is the ultimate punishment. We seek out social attachment and negotiate who we are through social learning. We are constantly engaged in proximal social processes (Bronfenbrenner & Morris, 2006) with the people, things, and information that populate our environment. Through this sustained activity, we develop habits of behavior, thinking, and feeling that define our social identity (Sluzki, 2010). Our social identities are contextually dependent and constantly in flux. As we move from role to role, we find that social identities are the compromise between what we believe ourselves to be and what society will allow. We flourish where we are accepted, and we struggle to adapt where we are not.

People with disabilities find themselves assigned to an identity (Goffman, 1963) not of their choosing (Barker, Wright, Meyerson, & Gonick, 1953), historically one of stigma and devaluation (Dembo, 1982). The social lessons taught and learned are embedded in the disabling context, for example, the attitudes of others (Shontz, 1977), inaccessible physical environments, policies that create dependency, and language that denies respect. To these insults, add the pervasive professional negative bias (Dunn & Elliot, 2005) of a disability industry that reifies its assumptions of deviance in the population it purports to serve (see Cottone & Cottone, 1986; Tremain, 2005). These contextual barriers, often invisible to those who do not live the experience, are a far greater threat to positive adjustment than the functional aspects of impairment (Shontz, 1977).
Impact of Advocacy

Early researchers drew parallels between the struggle of people with disabilities and the marginalization and disenfranchisement of other minority groups (Barker et al., 1953). The minority meme resonated with people with disabilities and their families (Meyerson, 1988). It made empirical and intuitive sense and, for the first time, provided for an activist response to one’s position as outsider (Fine & Asch, 1988). This collective activist response is the impetus for action in Lewin’s action research. The disability rights movement moved special education into the mainstream, sheltered employment into competitive employment (with supports), and institutionalization into independent living. Research did not lead these movements, but responded to them as part of a larger system of change.

The disability rights movement has encouraged an epistemological shift from interindividual traits to intraindividual relationships; from psychological states to ecological processes; from individual counseling to counseling in systems. Theoretical constructs have evolved accordingly. Families are recognized as the most proximal of many nested and networked social systems (Bronfenbrenner, 1977) in which the person with a disability interfaces. They are constituted of a complex of social-emotional bonds (Dembo, Leviton, & Wright, 1975) interacting in dyadic (parents), tryadic (parents and child), and higher order exchanges (e.g., female members of the extended family) that provide the scaffold for group and individual identity and the tools for adapting to change (see Bateson, 1972; Minuchin, 1985).

Evolving Constructs

Systems thinking redefines disability in the social sphere. Impairment is a personal experience, but disability resides in the relationships that connect people. Disability happens to a family as well as an individual, and the response to it can be registered at both levels. For example, rehabilitation psychology was predicated on the psychosocial framework of coping with disability (Wright, 1983)—a construct with both inter- and intraindividual interpretations. An individual’s response to environmental stressors is dependent on cognitive appraisal (Lazarus, 1993) of the situation, the consequent perception of self-efficacy, and the choice and implementation of coping strategies. Each impacts the next in succession. Generalized practice of effective coping strategies across contexts and time (Maddux, 1995) creates psychologically resilient individuals. Self-appraisal of a supportive social network raises an individual’s perceived self-efficacy in problem solving and thereby encourages self-directed change-making in his or her world, and stress reduction (Bandura, 1997). Similarly, groups are collectively more effective when their members are confident in their abilities to overcome obstacles (Bandura, 1998). The concept of coping has expanded to strategies of social support (Pierce, Sarason, & Sarason, 1996). The perception of strong social support provides a degree of affective coping simply by its presence. Supportive relationships lead to more positive
and accurate assessment of self and support network efficacy. Support within specific dyadic relationships, especially spousal support, has been found to be effective in rehabilitation settings (Revenson & Majerovitz, 1990). Networks of supports, most notably families, enhance individual coping with challenges in the rehabilitation process (Porrit, 1979).

Resilience, once reserved to describe individual’s ability to “bounce back” following personal loss, has now taken on an additional systemic application in describing families (Walsh, 2003). Resilience is recognized in the synergistic relationship between the individual and the group. The person is simultaneously an extension of the family and feature of its resilience, and a recipient of family support and the resilience it affords. This is particularly poignant for people with disabilities and their families. The key to coping with the stressors around disability, foremost among these being community exclusion, is to find strength in the family and purpose in the community (Li & Moore, 1998).

**Systems in Rehabilitation Counseling**

Cottone’s (1987) systemic theory of VR represents the first steps taken in building a rehabilitation counseling framework that bridges family and service structure (Cottone, Handelsman, & Walters, 1986). The theory posited that the degree of “fit” between the service systems governing rehabilitation practice and the family systems governing client participation was an influential arbiter of rehabilitation success, perhaps more important that the person × environment fit that the system itself espoused. Cottone and Cottone (1986) proposed that VR actually functioned as a complex system for screening social deviance before it functioned in its formal capacity. In their critique of vocational evaluation, they suggested that vocational evaluation recommendations were heavily influenced by counselor expectations and agenda, making it more of a tool for preserving the organization than a resource for advancing the client’s goals (Cottone & Cottone, 1986).

Preliminary research suggested that social relationships were more influential in determining employability determinations than psychological evidence (Cottone, Grelle, & Wilson, 1988), specifically in regard to clients with nonphysical disabilities. It was Cottone’s contention that family-oriented rehabilitation counseling would provide a more effective point of client engagement in a self-serving service system. The professional community’s response to this call was underwhelming, despite the ethical questions raised for state VR and the implied need for organized family advocacy.

In 2012, Cottone renewed his call for systems applications in rehabilitation counseling in further explorations of the role of families. For Cottone, the inclusion of family in rehabilitation process requires a rejection of the psychomedical model and its Newtonian trait/factor worldview for the Lewinian-inspired relational worldview of field theory. Cottone saw systems theory leading to a true paradigmatic change for the profession, then and now. But paradigmatic change comes slowly and unevenly.
Today, systems theory has a broader appeal and a more receptive audience in rehabilitation counseling. With family in the vanguard, we have both an impetus and a framework for progress.

**Sense of Community: A System of Inclusion**

Moving to a systems model creates a language that includes the family in the social discourse of disability, but to what end? What is the relationship between the family experience of disability and the fundamental mission of full community inclusion? How is rehabilitation counseling supposed to engage this relationship on behalf of its client? Coming out of a quasipsychomedical worldview, these questions were difficult to even ask. Rehabilitation has adopted a biopsychosocial model to expand its explanatory power, but the activities and participation of the ICF (WHO, 2002) give us only the mechanics of inclusion. These advancements in construct do not yet capture the dynamics of the relationships through which community is actually expressed. Community is like music in this sense. It is expressed only in the moment of exchange between players. It is a subjective experience that lives in the collected and collective memory of those moments.

McMillan’s “sense of community” (2005) provides a vocabulary upon which we may build a “sense of family.” Sense of community reflects the basic human need for affiliation, group cohesion, psychological attachment, and personal bonding. Sense of community is an empirical theory rather than a normative one. Sense of community describes the phenomenon of people coming together. McMillan (1996) conceptualized the affective “sense” of community in psychosocial terms, revealing both its human nature and the demands humans place on it. Sense of community arises from lived experience of community inclusion, framed by four community transactions (McMillan, 1996; McMillan & Chavis, 1986): (a) membership/spirit, (b) influence/trust, (c) need fulfillment/trade, and (d) shared emotional connection/art.

**Membership/Spirit**

The first sense of community, or perhaps the deepest, is the sense of belonging to something larger than oneself. It is a primal drive (gemeinschaft), evident in every social gathering. Individuals derive their identity and a concordant sense of well-being from the safety and welcoming acceptance afforded by membership. Members share symbols and rituals that bind them in affiliation and mark them as insiders. Membership is the spirit in esprit de corps, and the allegiance to the corps can run very deep.

Spirit grows in finding common ground. The novice shares increasingly personal and sensitive information about him- or herself within the space of the community.
The community members share similar stories and secrets in turn. McMillan and Chavis (1986) referred to this as “freedom from shame.” Such sharing is a risk taken through a call and response. The individual reveals, “Here I am.” The community responds, “One of us.” The danger is when the community does not respond or rejects the call outright. Shame and humiliation are the death of community and the denial of identity. The more we risk in self-revelation, the higher the emotional stakes, the deeper the meaning of membership.

**Influence/Trust**

Communities exist to serve the membership. Structures and processes form around these intents as strategies and plans, rules and regulations, roles and functions. Structure and habit allow for specialization and more effective pursuit of community goals and impart a comfortable predictability and trust among members. People are drawn to order. It creates a framework for identity and makes relationships among members clear.

Order requires a subjugation of individual freedoms to the common good. It is part of the dues of membership and part of the assumed social identity. Order and community cohesion are sustained through the negotiation of authority and responsibility among members. Individuals are attracted to groups that can leverage their collective influence (e.g., labor unions, advocacy groups) in areas of individual interest. Members are more willing to acquiesce to authority when they believe they have input into its exercise. Community is most successful when authority is responsive to and works in service of the membership (McMillan & Chavis, 1986). Trust evolves from the perceived benefit of compliance, equity of power relationships, and the predictability of consequences. An individual’s sense of community is enhanced if he or she has a say in what the community does, sees the community as working in his or her interest, and believes that he or she is being treated fairly within it.

**Integration of Fulfillment of Needs/Trade**

Having established a sense of belonging and an orderly environment within which to act, the economic work of community may commence. Trade is the engine of community. It is the essence of Gesellschaft, that is, membership as personal benefit. Community action is shaped around the collective leveraging of individual resources.

Individuals exchange economic, social, psychological, and political capital in the internal community marketplace, which advances both community cohesion and individual prosperity in all dimensions. Cohesiveness comes from a proper matching of needs to resources. Sense of community is advanced when the individual’s
contribution is valued, he or she can fulfill his or her needs, and he or she is free to trade in equity.

**Shared Emotional Connection (1986)/Art (1996)**

Community is a process reified by its history and the artifacts it creates. Community histories are replete with origin stories, recollections of pivotal moments in history, the journeys of heroes, and cautionary tales of members gone wrong. Buildings and monuments are testament to the history. Celebration and ceremony mark the milestones of life, honor membership, and instill faith in the constancy and relevance of the group.

This is the fruition of the sense of community, the celebration of one’s part in the whole. In the sense of transaction, it circles back to the first sense, membership and spirit. But now the novice is the master. He or she transacts in wisdom as one who listens to the initiate’s story and responds with the group’s secret mythology to include the novice as “one of us.”

**Family as First Community: Implications for Rehabilitation Counseling**

Synomorphy describes the natural systems “fit” that occurs between standing patterns of group behavior (e.g., shopping) and the features of the nonbehavioral environments in which they occur (e.g., business hours, malls, advertisements, public transportation; Barker, 1968). Fit in this sense is a self-organizing process, where form follows function and function follows form. It is possible to deduce one knowing the other and to find them paired wherever either is found. Lewin (1951) used this concept to study measures of economic interdependence and demonstrated that synomorphy could be explored at multiple levels (e.g., the economic interdependence of city, neighborhood, or family). The same can be said for Dewey’s conceptualization of big “D” democracy’s dependence on small “d” participation of local communities, and the origins of democracy in the education of the individual within a democratic system. McMillan similarly bridged sense of community theory to couples (McMillan, 1997) and the families they evoke. Thus the thread of community runs unbroken from the broadest contexts of philosophy, to society and its problems, through professional praxis and its solutions, down to the family and its lived experience with disability. Family is the first synomorphic instance of community and thus the most immediate experience of inclusion available to the client or counselor. If community inclusion is the fundamental mission of rehabilitation counseling, the most sensible strategy for pursuing it would be to start with its function in the family and work outward.
**Strengthening Community in the Family**

The sense of family arises out of collaborative participation in instrumental tasks that achieve goals that are collectively valued (Verdonschott, de Witte, Reichraft, Buntinx, & Curfs, 2009). The degree and character of a family member’s active inclusion in the business of the family provide social learning content about his or her role and efficacy in the world. A client-centered approach to community inclusion begins with an evaluation of the familial relationships. How does the individual express her- or himself in family rituals of membership? How does the individual negotiate the authorities and obligations of his or her role within the family structure? How does the individual contribute to and draw from the collective family resources? For each of these issues add, “. . . and how does the family respond?” Unlike the questions and contexts that opened this chapter, these are questions that can now be entertained.

Each member of the family will experience the phenomenon of disability differently, but it is a shared experience that contributes to group identity. Deepening the sense of family requires sharing these personal experiences (in culturally appropriate ways), reflecting upon them, and responding to them in intentional and inclusive ways. A strong sense of family shared by all members is the optimal foundation for advancing the goals of rehabilitation counseling in the community at large.

**Strengthening Family in the Community**

Individual family members draw strength from their trade with multiple communities beyond the family. These may be communities of practice that revolve around work, school, or other shared interests. They may be geographically bound or virtual. These communities may be an individual pursuit of one family member, the family as a whole, or a subset. In every permutation, the experience of disability follows the individuals into other memberships, as it is a part of their identity. It is part of the stories they tell. When they negotiate their role in the organization, they negotiate within the experience of disability. When they trade in resources, the experience of disability contributes in some fashion for good, ill, or otherwise.

Families are nested and networked in a community of their own making. The groups they join, they join because it serves a family need. Peer and advocacy groups may trade in disability specific knowledge, support, and connections designed for individuals or families. Cooperatives may serve a broader mission (e.g., fair trade products, culture and the arts) that builds inclusion into service. Even strictly social groups (e.g., work-sponsored bowling teams) potentially provide linkages between the family and desired resources that may serve the client (e.g., job openings). Rehabilitation counseling in the community engages family efforts in marshaling existing community resources and expanding their social network to strategic advantage.
Family and the Rehabilitation Counseling Ethos

An unbroken thread runs from the values that unite the profession, community, and family, to the models that make sense of the disability experience, to the practice of rehabilitation counseling. Community values resonate through the relationship with the family. At the point of transaction, they take on the look of action research. The client invites the family and the counselor to collaborate on problems of mutual concern. Employment is often the proximal reason for the gathering, but the family’s perspective is complex and extends over the course of years. They see employment as the first step in a career. They see the career as part of a social life beyond work and home. They see the arc of a social life into old age. And each family member sees him- or herself in the family narrative . . . or he or she sees none of this, and that is the problem. The client and his or her family set about the task of visioning an objective and planning the steps required. They share, negotiate, and settle on something worth doing. They proceed, succeed or fail, and then share their perspectives in review. Then they repeat the process. Along the way, they acquire knowledge and learn new skills. This is what families do.

The rehabilitation counselor engages the family process as a resource designed to facilitate the work of families through three community-based transactions:

- **Identity** provides the working alliance and space for psychosocial support as persons with disability and their families negotiate life challenges. Identity is rooted in the democratic ideal of liberty. It asks, “Who am I (who are we) in the face of change?” It is realized in the exchange of the personal with the collective in search of belonging—the spirit of family and community.

- **Power** provides a voice for the family seeking social justice, alone and in the collective. Power is rooted in the democratic ideal of equality. It asks, “What do I (we) direct and what directs me (us)?” It is realized in the exchange of authority and responsibility in search of an empowered sense of justice—the sense of structure, stability, and trust.

- **Capital** provides networks and networked resources for the development, implementation, and evaluation of planned action. Value is rooted in the democratic ideal of fraternity. It asks, “What do I (we) have to offer and what is proffered in return?” It is realized in the exchange of capital, real and social, in search of sense of enrichment and quality of life.

We can recognize the familiar in these transactions as they track closely to traditional counseling, advocacy, and case management roles. Here the roles are unified in community values. Dealing with the family requires all three orchestrated in delivery. As we attend to each in the coming chapters, it will become apparent that they are facets of a single irreducible whole, much like the fundamental mission that drives them.
REFERENCES


I. A COMMUNITY-BASED APPROACH


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