A DESCRIPTION AND INTERPRETATION OF THE WORK OF EXEMPLARY PRIVATE REHABILITATION COUNSELORS IN MICHIGAN

By

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ABSTRACT

A DESCRIPTION AND INTERPRETATION OF THE WORK OF EXEMPLARY PRIVATE REHABILITATION COUNSELORS IN MICHIGAN

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The purpose of this study was to gain insight into the behaviors of exemplary private rehabilitation counselors, how they process their work, and how they interpret best practice. Private rehabilitation counselors, supervisors, and managers from the Michigan Bureau of Workers' Disability Compensation Approved Vocational Rehabilitation Facility provider list were contacted and requested to nominate private rehabilitation counselors they considered exemplary. Of the 51 rehabilitation counselors nominated as exemplary, 20 were selected to be interviewed using a semi-structured, conversational approach. With their consent, the interviews were tape recorded and transcribed. The transcripts were coded and sorted using NUD*IST© software. A general qualitative approach for identifying thematic lines was used to analyze the data. Findings revealed that the client-counselor relationship was emphasized as important to rehabilitation counseling by this group of exemplary counselors. This supports prior research in counseling outcome studies. Professional maturity emerged as the major theme. Two sub-themes identified were a belief in what constitutes fair and equitable treatment of clients and understanding the limitations of the roles and responsibilities of a private rehabilitation counselor. This research helps to further our understanding of the knowledge, skills, and abilities

required to work as a private rehabilitation counselor. Practitioners can use these exemplary rehabilitation counselors' perspectives in their search for employment that meets their views of how clients should be treated. As educators, we can incorporate teaching strategies to develop qualities such as professionalism, critical thinking, creativity, and risk taking skills to enhance a rehabilitation counselors effectiveness in private rehabilitation.

To my husband, Bill, daughter, Melissa, and parents, Bob and Joan Chapin

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Chapter 1

Introduction

The purpose of this research was to discover, from the perspective of exemplary rehabilitation counselors, their behaviors, how they process their work, and their interpretation of best practice. This was accomplished through the use of conversational interviews with these exemplary rehabilitation counselors. According to Janikowski (1990) we have thoroughly defined the job task or duties performed by rehabilitation counselors, but we have not been as effective in defining the characteristics of rehabilitation counselors. Boyatzis (1982) and Janikowski (1990) indicated this can be accomplished by identifying successful people in the field, learning what makes them successful, and determining how and why they do their job.

Boyatzis (1982) defined competency as the capabilities a person brings to a job that enables the person to perform the actions needed for results. The focus is on the person doing the job, not the job itself. Defining a competency requires finding out the actions, where they fit in a system and behavioral sequence, determining the results or effects, and the intent or meaning of the actions and results. He further suggested competencies are related to effective performance. Thus, possession of a characteristic precedes or leads to exemplary performance on that job (Boyatzis, 1982). Clarification of these competencies is one of the desired goals of this

research.

The motivation for this research was to provide information that would assist practitioners to enhance the effective delivery and outcome of vocational rehabilitation services to injured workers, thus increasing their likelihood of returning to work and realizing the benefits to all of the parties involved. This interest evolved from my 18 years experience as a rehabilitation counselor primarily in the private sector. The challenge in completing this research was to remain cognizant of my own potential biases as a former practitioner who is committed to the rehabilitation counseling profession. How this was accomplished will be addressed in subsequent portions of this thesis.

Role and function and competency related research has documented over the years the knowledge, skills, and abilities required to be an effective rehabilitation counselor (Emener & Rubin, 1980; Fraser & Clowers, 1978; Harrison & Lee, 1979; Jaques, 1959; Leahy, Shapson, & Wright, 1987a, 1987b; Muthard & Salomone, 1969; Rubin, et al., 1984). Today, validation of rehabilitation counselor knowledge areas continues with the support of The Foundation for Rehabilitation Education and Research (Leahy, Szymanski, & Linkowski, 1993) in order to validate and upgrade accreditation and certification standards in the rehabilitation counseling profession.

Additionally, the field has looked at outcomes in rehabilitation counseling in relation to counselor characteristics such as education and certification and client characteristics including type of disability, interventions, and benefits received (Abrams & Tucker, 1989; Bolton & Rubin, 1974; Cook & Bolton, 1992; LaForge &

Harrison, 1987; Szymanski, 1991; Szymanski & Danek, 1992; Szymanski & Parker, 1989). Research in private sector rehabilitation has focused on rehabilitation counselor credentials, skills, client variables, employer variables, and case cost (Beck, 1989; Corthell & deGroot, 1983; Headley, 1989; Lam, Bose, & Geist, 1989; Matkin, 1983a; Tate, Habeck, & Galvin, 1986). However, there is a paucity of research on private rehabilitation counselor behaviors, the case management process, and best practices related to outcomes.

We have not gone back to private rehabilitation counselors, who work day to day with the clients, to learn from them what contributes to their success in assisting clients to return to work and what additional barriers preclude successful case resolution. In addition, we have tended to view success as assisting injured workers to return to work, but there may be "quality of life" issues that counselors also feel constitutes success in their work.

When a person becomes injured on the job, their life role of worker is abruptly changed. Often relationships with work colleagues and the employer are affected. The injured worker may experience a diminished sense of security and self. Injuries occurring on the job may result in the person receiving benefits from a workers' compensation insurance carrier. These benefits include medical care, wage loss benefits, and vocational rehabilitation (Michigan Department of Labor, 1993). The medical benefits are designed to help cure or relieve the injured worker from the effects of the injury. Wage loss benefits are designed to help the injured worker survive financially while recovering from the injury (Michigan Department of Labor,

1993). Vocational rehabilitation services are designed to help persons with disabilities receive appropriate services to help them cope with the effects of the injury and are beneficial when the disability interferes with the injured workers' ability to return to work (Obermann, 1965).

Rehabilitation counselors can help injured workers understand their disability, its impact on work, and how to maximize their skills and abilities for return to work. However, some injured workers continue to have difficulty returning to work despite such assistance. These difficulties can be due to medical complications that preclude the injured worker from working. Or, there may be lack of understanding by the employer as to how to accommodate the injured worker for a return to work. The injured worker may need to consider work with a new employer or a different type of job and may have fears about employability in a new work setting, the availability of jobs, or about their ability to learn and succeed in a new type of job. Additionally, there may be financial disincentives for the injured worker to resume work (Rasch, 1985a). Workers' compensation wage loss benefits are tax-free income. Some injured workers are better off financially if they do not work because they avoid the usual costs associated with work such as child care, clothing, and transportation expenses. How can rehabilitation counselors help more injured workers to successfully return to work? Are some rehabilitation counselors more effective than others in facilitating a greater proportion of injured workers to transition back to work? If so, what factors account for their effectiveness? These are the questions that guided this study.

Statement and Significance of the Problem

Work is central to our lives and our culture (Obermann, 1965). Super (1991) described the influence of work on people's lives by introducing the concept of a Life Career Rainbow. This conceptualization indicates that a person has varying degrees of commitment to life roles such as child, student, citizen, worker and homemaker, throughout his or her life span. A person is generally involved in the role of worker from his or her late 20's through age 65 (Super, 1991). The Life Career Rainbow graphically represents that work is the most prominent role during the working years (Brown, 1991). In adulthood, work comprises nearly one-third of our day. Work defines a person's place in the community and creates a sense of belonging. It satisfies many basic instincts including safety and security needs (Obermann, 1965). Because of the significance of work in our lives, it is important that we do everything possible to assist people to return to work when an injury occurs.

According to the March 1991 Current Population Survey, 14,648,000 people in the United States have a work related disability. These disabilities may preclude working or limit the type and amount of work performed by these individuals. Full or part-time employment is maintained by 4,250,484 people, while 10,397,000 people are not employed (President's Committee on Employment of People with Disabilities, 1993). Adults with disabilities have an unemployment rate higher than any other segment of the population. According to a 1986 Harris Poll (as cited in DeLoach, 1992), working age people with disabilities have an unemployment rate of approximately 65%. This rate may be due, in part, to insufficient education and job

skills for today's labor market (Harris, 1986, as cited in DeLoach, 1992).

All states have agencies responsible for the administration of workers' compensation laws. Employee benefits for medical, wage loss, and vocational rehabilitation services vary by state. Generally, an employer pays for an injured worker's medical expenses. Wage loss benefits are usually two-thirds of the worker's preinjury wages (E. M. Welch, 1994). Workers' compensation affords workers the right to benefits without consideration of who was at fault. In exchange, the worker generally gives up the right to sue his or her employer for pain and suffering and loss of enjoyment of life following a work related injury in return for secure access to benefits (E. M. Welch, 1994).

Within the state agencies administering workers' compensation, some states have divisions that specifically oversee medical and vocational rehabilitation activities. The provision of rehabilitation services varies by state. Some units provide direct rehabilitation services to injured workers. Other units refer injured workers to state agencies or private providers or monitor vocational rehabilitation cases. Some states provide a combination of these services. Other states have no rehabilitation unit (E. M. Welch, 1994).

The Michigan Department of Consumer and Industry Services, Bureau of Workers' Disability Compensation (BWDC) administers workers' compensation in Michigan. This rehabilitation unit does not provide direct services but oversees the provision of vocational rehabilitation services from public and private sector providers on a fee-for-service basis (E. M. Welch, 1994). The majority (96%) of workers'

compensation cases referred for rehabilitation in Michigan are served by private rehabilitation providers. This study will focus on this population of providers.

According to the Michigan Bureau of Workers' Disability Compensation, most (95%) injured workers return to work within 180 days following an injury (D. Langham, personal communication, July 18, 1997). The five percent of injured workers who exceed this time could benefit from vocational rehabilitation services (Michigan Department of Consumer and Industry Services, 1995). During 1995, 8,593 new rehabilitation cases were opened and 7,941 remained active with rehabilitation agencies in Michigan. In 1995, 42% of the injured workers referred for vocational rehabilitation successfully returned to work (D. Langham, personal communication, February 16, 1996). Of the 42% who successfully returned to work, 87% went to work with the same employer, and 12% went to work with a new employer. When employment with a new employer was required, 84% of these workers returned to a job different from the one held at the time of injury (D. Langham, personal communication, February 16, 1996).

The overall return to work rate (42%) of those referred for vocational rehabilitation is considered to be favorable, because most referrals for vocational rehabilitation services were made after the average injured worker had already missed more than twelve months of work (Michigan Department of Commerce and Industry Services, 1995). Although these results are acceptable in relation to industry standards, they suggest room for improvement in the outcomes of vocational services and presumably in system-wide efforts to help injured workers return to work.

Additionally, vocational rehabilitation referrals have decreased in recent years. Some feel this decline can be partially attributed to employers' initiation of early return to work intervention programs. What has also occurred is an increase in the length of time an injured worker is off work before his or her case is referred for vocational rehabilitation (Langham, 1996). Currently, the average age of cases referred for vocational rehabilitation is 25.5 months post injury, which represents a 24% increase from 1993 (D. Langham, Personal Communication, April 11, 1996). This lag period and lack of attachment to the labor force may significantly reduce the chance for success due to an injured worker's fear about returning to work, increased likelihood of attorney involvement, and decreased rehabilitation potential (Langham, 1996).

Vocational rehabilitation is generally considered in the best interest of employers. The cost of services is often small compared to the cost of ongoing compensation of wage loss benefits (E. M. Welch, 1994) and of replacing the injured worker on the job. Rehabilitation success should reduce the employer's exposure to workers' compensation cost. Additionally, vocational rehabilitation should be beneficial to the injured worker who is never fully compensated for his or her loss. However, despite the apparent win-win situation in the provision of vocational rehabilitation in workers' compensation, evidence in recent years has arisen to the contrary. Rehabilitation is an added expense, and rehabilitation providers have not done an adequate job of demonstrating the benefits associated with this increased cost (Berkowitz & Berkowitz, 1991). The number of states with mandatory vocational rehabilitation

provisions is presently declining, particularly in situations where vocational rehabilitation has been considered a cost driver of workers' compensation. According to Habeck (1996), rehabilitation is often blamed as an ineffective cost driver because it is used after the critical, early intervention period for return to work and after the employee - employer relationship has ended. Thus, more services are required to assist the injured worker to return to work, and these increased costs are associated with rehabilitation service intervention. She suggests rehabilitation providers need to develop different effective competencies to be successful.

Additionally, today's managed care environment increasingly focuses on cost effectiveness and outcomes. Providers of vocational rehabilitation services need to become more accountable for services provided. Persons with disabilities and payers have a right to quality services and to hold rehabilitation service providers accountable for their work (Greenstein, 1993). Accountability is the norm in industry (Greenstein, 1993), where many injured workers will return to work with successful job placement. The more efficient and effective rehabilitation counselors work the more competitive they can be in today's marketplace. Vocational rehabilitation should provide a cost benefit for employer/payer and a functional benefit to clients (Albrink, 1995). With the provision of cost-effective services and successful case outcomes, the decline in workers' compensation referrals experienced by vocational rehabilitation providers may slow or reverse.

There is currently little research to guide the case management process in the provision of vocational rehabilitation services in workers' compensation. The goal of

case management in private rehabilitation is to return the injured worker to work. The three-step approach often used by practitioners in these settings suggests rehabilitation counselors' examine first, returning to work with the same employer in the same or a different job; second, returning to work with a new employer in the same or a different job (G. T. Welch, 1979); third, acquiring short term retraining to facilitate a return to work with the same or a new employer (Matkin, 1987). This three step approach is geared toward efficiency and successful case outcomes by focusing on the injured worker's current skills and abilities and preexisting work relationships (i.e. it is easier to return to work than to find a new job). The goal of this approach is to expedite an injured worker's return to work, thus reducing case cost and retaining the injured worker's attachment to the work world. Expeditious return to work increases the likelihood the injured worker will return to his or her preinjury income level. It increases the success rate of vocational rehabilitation and reduces the disruption to the injured worker's preinjury lifestyle (Matkin, 1986).

In addition to the three-step approach to rehabilitation, the literature primarily describes how to achieve this goal through contact with physicians, employers, and therapists, and through the use of vocational services and placement (Roessler & Rubin, 1992). Additionally the literature discusses the influence that counselor, client, and employer variables have on case outcomes (Bolton & Rubin, 1974; Cook & Bolton, 1992; Habeck, Hunt, Leahy, & Welch, 1989; Lam, Bose, & Geist, 1989; Lynch, 1979; Szymanski, 1991; Szymanski & Danek, 1992; Szymanski & Parker, 1989; Tate, Habeck, & Galvin, 1986). Even though there are many variables that

influence an injured workers' ability to return to work, some rehabilitation counselors are effective in accomplishing these goals. Thus, there is probably more to learn on how successful case outcomes are achieved by these rehabilitation counselors.

Evenson and Williamson (1995) completed a study of exemplary and average vocational rehabilitation counselors employed in state-federal rehabilitation. State agency central office staff were requested to identify five exemplary vocational rehabilitation counselors and five average counselors based on placement, client satisfaction, and supervisor ratings. Using these criteria, exemplary counselors were those who were ranked among the top 10% of vocational rehabilitation counselors within the state agency, while average counselors were those who were within the 40th to 59th percentile.

A modified version of the Rehabilitation Skills Inventory (RSI) (Leahy, et al., 1987a, 1987b) was used to rate responses. The counselors rated the importance of each skill to their role as a state agency rehabilitation counselor, while supervisors rated an identified counselor's current proficiency in the specific skill area. According to supervisors' ratings, exemplary vocational rehabilitation counselors performed at significantly higher levels in the majority of responsibilities associated with their role as state agency counselors. They were particularly superior in vocational counseling, case management, and job placement. There were no differences in education or experience. This study was not, however, able to ascertain what contributed to the exemplary rehabilitation counselors success.

The goal of this research was to gain increased understanding of what factors

exemplary rehabilitation counselors perceive to have contributed to their success. This knowledge will help move the profession further in its understanding of what makes rehabilitation counselors effective, particularly in the private sector. These behaviors are important to examine since not returning to work affects the injured worker's self-esteem and self-worth, increases the cost of products and services to consumers, and causes problems for society. Everyone loses when a person is injured, thus everyone wins when the injured worker is able to return to productivity (Pimentel, 1995).

Purpose of Study

Interviews were used to obtain information from the perspective of exemplary rehabilitation counselors in private rehabilitation about the practices and process of their work. The purpose of this study was: 1) to discover the behaviors that are predominant in the case services of exemplary rehabilitation counselors; 2) to elicit the process that characterizes the work of exemplary rehabilitation counselors; and 3) to clarify the exemplary rehabilitation counselors meaning of best practices.

The research questions were:

1) How do exemplary rehabilitation counselors describe behaviors associated with the client-counselor relationship that facilitates successful case outcome?

2) How do exemplary rehabilitation counselors describe the case management process and critical points that lead to successful case outcomes?

3) How do exemplary rehabilitation counselors interpret the behaviors, approaches,

and practices they use successfully to return injured workers to work?

Studying the insider perspective of exemplary rehabilitation counselors should help us further define the case management process and best practices in private rehabilitation. The insider perspective is important to learn, since these insiders work daily with injured workers and are familiar with the variables that impact on successfully placement. Additionally, these rehabilitation counselors will be nominated as exemplary by their peers, supervisors and managers.

Lewin and Zwany (1976) have reviewed the peer rating process. They noted people recall the perceptions of the behavior and characteristics of the person when rating peers. Friendship, observation time available, and interaction relevancy are all factors that influence a persons perception of others. Their review of this literature has shown that peer ratings have high validity in predicting future performance criteria. This nomination approach has also been found to be a useful approach to distinguish superior from average counselors in other research (Boyatzis & Burruss, 1977; McClelland, Klemp, & Miron, 1977). This investigation's results are expected to provide valuable contributions for rehabilitation counselor education, practice, and research.

The master's degree is the minimum preservice education considered acceptable to prepare a person for practice as a professional rehabilitation counselor. Preservice education and continuing education need to be relevant. This is critical as research introduces new knowledge and skills as employment settings change, as technology advances, and as practice becomes more specialized (Wright, Leahy, & Riedesel,

1987). Over the years, pressure has continued to increase for content and competency based training appropriate for specific work settings (Rasch, 1992), particularly in the private sector.

For example, in a study by Matkin and Riggar (1986), 75 academic rehabilitation counselor education programs on the 1984 National Council of Rehabilitation Educators (NCRE) roster were surveyed to determine the effect of the growth of private sector rehabilitation on the graduate level rehabilitation training program. Ninety-four percent of the respondents showed student interest in private rehabilitation was increasing (66.9%) or remaining stable (26.5%) (Matkin & Riggar, 1986). More than 84% of the respondents used private sector work sites for practicum and internship sites. However, less than 30% of the respondents had specific courses in private rehabilitation (Matkin & Riggar, 1986), although this number has likely increased since 1984. There was, however, no indication whether or not this content was covered in other courses.

Private rehabilitation continued to be an employment area in demand (Matkin & Riggar, 1986). Matkin and Riggar (1986) also contacted members listed in the August 1984 National Association of Rehabilitation Professionals in the Private Sector (NARPPS) roster to learn whether these professionals felt prepared for work in the private sector following their academic preparation in a rehabilitation counselor education program. More than two-thirds of the NARPPS respondents held a master's or doctoral degree in human service disciplines. A limitation to this study was that there was no indication as to what percent of these respondents had degrees

in rehabilitation counseling. Sixty-three and a half percent of the respondents suggested that academic rehabilitation education programs did not adequately prepare graduates for work in the private sector. Only 11.6% of the respondents felt graduates were adequately prepared (Matkin & Riggar, 1986). This research supports this study to provide information that can be used to improve and update preservice and continuing education efforts addressing private rehabilitation.

Additionally, Cassell and Mulkey (1992) reviewed graduate catalogs of 66 1990 - 1991 National Council on Rehabilitation Education (NCRE) institutional members to examine course content in counseling, casework/case management, and caseload management. Casework/case management included courses in client services, case practices, case studies, case services or case work management. The results showed that 83.3% of the programs had courses in counseling, 39.3% in casework/case management, and 1.5% in caseload management (Cassell & Mulkey, 1992). Their assumption was that course titles reflected emphasis on course content in these subject areas. Considering that case management is a competency area defined by rehabilitation counselors as highly important (Leahy et al., 1993; Leahy, et al., 1987b), one would expect more emphasis on this subject in the rehabilitation counselor education curriculum.

Thus, gaining knowledge of case management through interviewing exemplary rehabilitation counselors may contribute to further development of preservice education curriculum including case management practices and private sector rehabilitation. For example, new graduates could benefit from knowledge on

variables influencing outcome, and the tools and techniques to successfully transition an injured worker through the vocational rehabilitation process. If students have better defined processes that are based on practices known to help injured workers return to work, the number of clients successfully rehabilitated may increase. However, there are limitations to this approach, since we need to recognize that there are non-counselor variables that will continue to influence outcome and may defy counselor influence.

In summary, this research could provide the profession with increased knowledge about exemplary rehabilitation counselor behaviors and how they define best practice in the private sector. Further definition of case management practices can help us in further defining case management and move us toward best practice. Ideally, increased knowledge and expertise about case management practices should increase efficiency and effectiveness, thus increasing the proportion of injured workers returning to work. Given the current environment, it is important to continue to demonstrate that vocational rehabilitation is a viable intervention.

Definition of Terms

Approach - The style in which a rehabilitation counselor interacts with his or her client and others involved in the client's case file.

Behavior - Response to stimulation that is influenced by the person's interaction with others.

Best Practice - Using the most effective behaviors, approaches, and practices to

successfully return injured workers to work in an ethical and efficient manner.

Case Management - The process of meeting individual needs through the provision of timely, cost-effective services, including: (a) the assessment of individual needs; (b) the development of an individualized case management plan; (c) facilitation, implementation, and coordination of services; (d) evaluation and monitoring of services and outcomes; and (e) documentation of activity (Case Management Association Coalition, 1994; Leahy, 1994).

Client - A person with a work-related disability who is receiving services from a rehabilitation counselor.

Customer - Payers who purchase case management services for injured workers from private rehabilitation providers including employers, insurance carriers, and third party administrators.

Exemplary rehabilitation counselor - Rehabilitation counselors who are nominated by a manager, supervisor, or peer as being exemplary, where exemplary was specified as being successful in their work with injured workers.

Injured worker - A person with a work-related injury who currently receives workers' compensation benefits from his or her employer, the employer's insurance carrier, or third party administrator. Client is another name for an injured worker.

Practice - the usual way of handling a client's case file.

Private rehabilitation providers - Rehabilitation counselors or nurses who generate a net profit from their provision of case management services (Leahy, 1986). Generally, employers, insurance companies, or third party administrators contract

with these individuals or their firms to help persons with disabilities become medically stable and return to work.

Qualities - a distinguishing or special attribute, a characteristic (Gove, 1971).

Rehabilitation Counselor - A practitioner with a master's degree who uses the counseling process to assist persons with physical, mental, developmental, cognitive, and emotional disabilities achieve personal, career, and independent living goals (Commission on Rehabilitation Counselor Certification, 1995).

Successful case outcome - The placement of injured workers either back to work with the employer where the injury occurred or with a new employer. Successful case outcomes should also consider timely and cost-effective rehabilitation and quality closures including wages closely comparable to preinjury status and job obtained.

Chapter 2

A Context for Inquiry

To provide a context for the present study and examine previous research in an effort to inform the design and focus of this investigation, literature was reviewed in the following three primary domains. These domains included: (a) the development and maturation of workers' compensation in this country; (b) roles and required competencies of rehabilitation counselors, including credentialing issues; and (c) variables impacting on workers' compensation outcomes.

First, this literature review provides the historical framework of the development of workers' compensation and its commitment to rehabilitate injured workers. Initially, rehabilitation services for injured workers were provided by the publicly funded system of state-federal vocational rehabilitation. Federal mandates changed the focus of this public program to serving persons with severe disabilities. This shift created a void in vocational rehabilitation services available to injured workers which resulted in the emergence of fee-for-service private rehabilitation.

Second, the role and required competencies of the rehabilitation counselor and empirical support for the education and credentialing requirements maintained by the rehabilitation counselors interviewed in the present study is reviewed. As the rehabilitation counseling field has evolved, the knowledge, skills, and abilities necessary to practice in this profession have been defined. This research was used to

develop graduate rehabilitation counseling education curricula, guidelines for preservice accreditation, and professional credentials.

Finally, the literature review also was conducted to inform the research and to provide a context for the investigation under study by studying the variables that may impact the interactions between the rehabilitation counselor and the client, thus influencing a client's successful transition back to work. Because private rehabilitation is a complex field with multiple stakeholders, it is important to show some of the primary variables - counselor, client, and employer - that may influence case outcome. This knowledge was useful in developing interview questions to be asked of the exemplary rehabilitation counselors and to assess how their responses supported or differed from the literature.

Historical Overview

Workers' compensation

Taking care of a person injured in the employ of another has been around since the beginning of master-servant relationships. The expectation was that the master was responsible for the servant's recovery from an injury occurring during employment. Recovery insured the servant could continue serving the master (Obermann, 1965). This concept was incorporated into English common law (Matkin, 1987) and eventually workers' compensation laws.

Colonists brought English common law to America at the beginning of the Industrial Revolution (Obermann, 1965). English common law created the idea of

justice, that a person injured because of another's actions can recover damages from that person. Common law allowed the injured worker to sue the employer for damages if hurt on the job. But, this did not prove to be an equitable recourse to the injured employee. Employers could afford the best legal assistance, while the injured employee could not afford to bring employers to court. The injured worker also found it difficult to find fellow employees willing to testify against their employer (Obermann, 1965).

Three kinds of defenses were used and accepted by the courts that precluded the injured employee from recovering damages: (a) An employee was assumed to have accepted the risks of a job if it could be proved the worker knew the job had risk; (b) If another worker was partially responsible for the accident or injury, the employee would not receive benefits; (c) If the injured worker was negligent and contributed to the injury, he was not entitled to recover benefits (Obermann, 1965; Rubin & Roessler, 1995). Employees' compensation for injuries began to improve in some American states in the early 1900's when the common law defenses used by employers were eliminated. However, the legal system remained the only recourse for an injury, thus delaying payments to injured workers who needed benefits for financial survival and rehabilitation (Obermann, 1965).

The United States imported workers' compensation laws from Germany and Austria, which enacted legislation in 1884 and 1887, respectively (Obermann, 1965; Wright, 1980). The initiation of workers' compensation laws in the United States is attributed to the Congressional enactment of the Federal Employers' Liability Act in

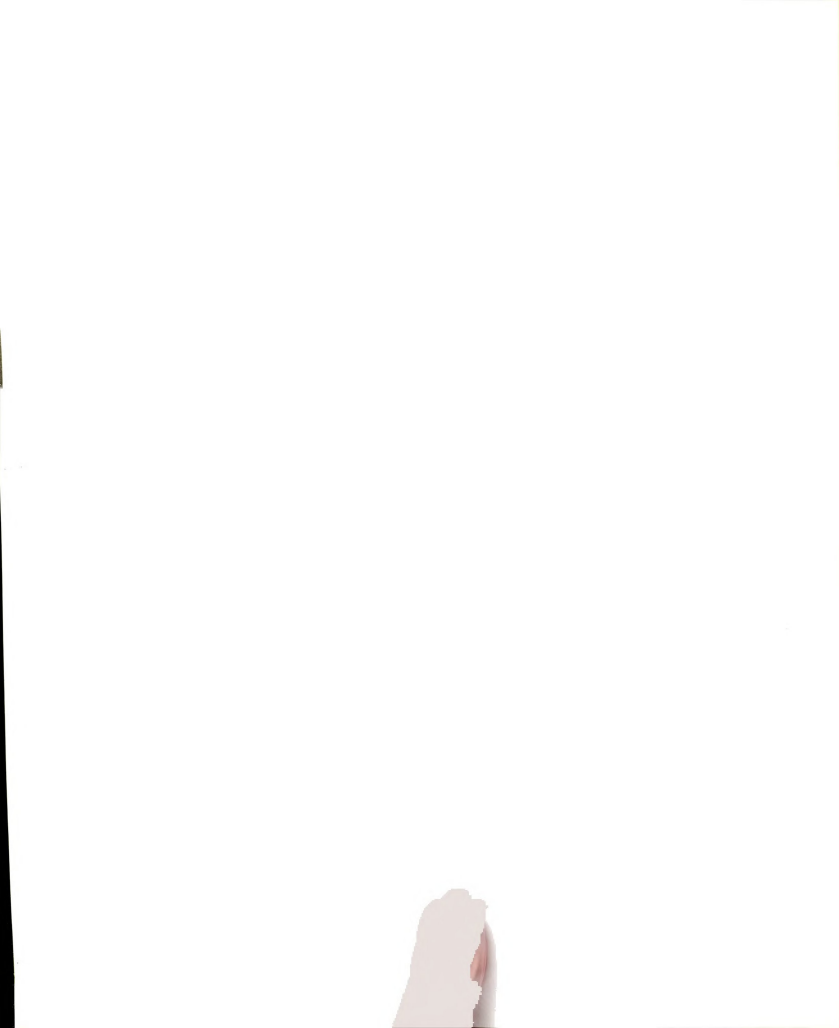
1908. This demonstrated a federal commitment to the principles of workers' compensation as it covered federal employees. In 1911, 10 states enacted workers' compensation laws that survived later constitutional challenges (Matkin, 1995). Workers' Disability Compensation was established in Michigan in 1912 by the Michigan Legislature.

Accident prevention and compensation for an injury were the first two steps in the process to protect America's work force. The third step required that injured workers be treated for injuries and prepared for a return to work (Obermann, 1965; Wright, 1980), thus making vocational rehabilitation a part of the process.

The inclusion of rehabilitation into workers' compensation

As early as 1916, the International Association of Industrial Accident Boards and Commissions was asked by its leaders to look at rehabilitating injured workers. The Smith-Hughes Act of 1917 recognized the federal government's role in vocational education. Members of the Federal Board for Vocational Education envisioned the use of vocational education in helping injured workers acquire needed skills to assist them in returning to work. Vocational rehabilitation initially focused on medical care and compensation to injured workers. The concept of rehabilitating injured workers to return to work developed following veterans' rehabilitation legislation in 1918 (Obermann, 1965).

The Vocational Rehabilitation Act of 1920, or the Smith-Fess Act, was the first time vocational rehabilitation services were offered to civilian workers. The Smith-



Fess Act's statement of purpose was to provide vocational rehabilitation services to persons injured on the job (Matkin, 1995). This Act required that cooperative arrangements be developed between workmen's compensation and rehabilitation program administration boards (Obermann, 1965). The Smith-Fess Act introduced the first rehabilitation counselors to the state-federal rehabilitation system but provided no federal funds for training (Kuehn, Crystal, & Ursprung, 1988).

State-federal rehabilitation programs grew between 1921 and 1926. Thirty-six states had rehabilitation programs in 1923. The remaining states acquired state-federal rehabilitation programs over the next 16 years (Obermann, 1965). Grants to colleges and universities for the training of professional rehabilitation workers were provided in the Vocational Rehabilitation Act of 1954 (Rubin & Roessler, 1995). Master's and doctoral level training was expected to improve the quality of services to persons with disabilities. Additionally, the number of counselors available to serve persons with disabilities in state-federal rehabilitation needed to increase (Kuehn, et al., 1988) as services expanded to include persons with mental retardation and mental illness. Although these groups were eligible for services in 1943, little progress was made in their vocational rehabilitation. The definition of handicapped expanded to include behavior disorders in the Vocational Rehabilitation Act Amendments of 1965 (Rubin & Roessler, 1995). This continued to increase the number of people with disabilities accessing state/federal rehabilitation.

In the 1970s, the disability consumer movement grew. Severely disabled consumers demanded integration into mainstream America. Subsequently, the

Rehabilitation Act of 1973 and its amendments in 1974 and 1976 increased services provided to clients diagnosed with severe physical, intellectual, and emotional disorders (Rubin & Roessler, 1995). Mandates to serve the severely disabled began to stress the state-federal system (Matkin, 1995). This population of consumers required more extensive services at a higher cost for integration into society. This resulted in less money and staff availability to serve injured workers who generally were not as severely disabled. Private rehabilitation grew because of the need for additional vocational rehabilitation providers to serve injured workers.

Private rehabilitation

Private rehabilitation's growth has been attributed to the passing of the 1970 Federal Occupational and Safety Health Act (OSHA) (PL 91-596). It recommended the development of a National Commission on State Workers' Compensation Laws, which supported vocational rehabilitation. Before this time, vocational rehabilitation had been provided by publicly funded and private non-profit agencies (Rubin & Roessler, 1995). The report suggested that workers' compensation was not doing enough to help injured workers in returning to work (National Commission on State Workmen's Compensation Laws, 1972). The commission recognized the historical problems inherent in attempting to serve the entire workers' compensation caseload through the state-federal system. This was reinforced by state-federal mandates that continued requiring the provision of rehabilitation services to specific disability groups in addition to injured workers (Matkin, 1995). The commission recommended the

creation of specific rehabilitation units with medical/rehabilitation divisions. Employers were supposed to fund vocational rehabilitation programs for injured workers. As a result of these recommendations many states enacted mandatory rehabilitation programs (Jenkins, Patterson, & Szymanski, 1992).

In addition, the Rehabilitation Act of 1973 and its subsequent amendments in 1978, 1984, and 1992 required the state-federal program to increase services to persons with severe disabilities. This decreased emphasis on services to injured workers (Matkin, 1995) resulted in the need for other rehabilitation providers to help industrially injured workers to return to work. As private rehabilitation expanded, the clientele they served also expanded to include recipients of other private disability compensation benefits. Services were provided to recipients of workers' compensation, auto no-fault, and long term disability benefits. With the extraordinary growth in private rehabilitation came an influx of professionals from many different employment settings - counseling, business and industry, and nursing. These professionals have helped define medical and vocational case management strategies in private rehabilitation.

As a newly evolving profession, private rehabilitation practitioners desired professional representation of their needs, which they felt were not being adequately addressed by current professional associations such as the National Rehabilitation Association (NRA). NRA's focus had traditionally been state-federal (public) rehabilitation. As private rehabilitation expanded in the 1970s, NRA's leadership did not understand workers' compensation reform, nor did they adequately address the

needs of private rehabilitation practitioners (Rasch, 1985). In addition, in the mid 1970s a policy statement was adopted by NRA recommending that all injured workers be served by the state-federal program. Private rehabilitation practitioners worked to be included in this policy statement in 1976. NRA's lack of understanding of private rehabilitation's needs resulted in the formation of the National Association of Rehabilitation Professionals in the Private Sector (NARPPS) in 1977 (Rasch, 1985).

NARPPS was developed to support practice in private rehabilitation and to advocate for these practitioners. It is an independent organization that continues to address issues of critical importance to the private sector. In late 1981, NARPPS' membership approved Standards and Ethics for services in the private sector. NARPPS also strongly advocated for a private sector certification that would be inclusive of their membership's diverse educational backgrounds and disciplines, such as nursing. Certification for private rehabilitation practitioners as a Certified Insurance Rehabilitation Specialist (now Certified Disability Management Specialist) was offered in 1983 (Leahy & Holt, 1993).

Defining the Profession

With the growth of vocational rehabilitation came the need to further define the rehabilitation counseling profession. This process included clarifying the role and function of rehabilitation counselors, identifying the competencies needed by practitioners in different work settings, and developing professional credentialing to ensure acceptable standards of quality in practice. The information gathered from this

research was used to develop preservice accreditation standards, the curriculum for rehabilitation counselor education programs, and certification standards for rehabilitation counselors. Role and function and competency research also has provided an empirical basis for professional identity and assisted in the assessment of training needs of practicing rehabilitation counselors (Leahy, et al., 1993; Szymanski, Linkowski, et al., 1993). Validation research continues to insure that the accreditation and certification content remain applicable to the changing field of rehabilitation counseling. This research provides information for reviewing and updating preservice and continuing education curriculums (Leahy, et al., 1993).

Knowledge, skills and abilities in rehabilitation counseling

Role and function (Emener & Rubin, 1980; Fraser & Clowers, 1978; Harrison & Lee, 1979; Jaques, 1959; Muthard & Salomone, 1969; Rubin, et al., 1984) and competency research (Leahy, et al., 1987a & 1987b) have documented the knowledge, skills and abilities perceived to be associated with being an effective rehabilitation counselor. The first comprehensive role and function study was undertaken by Muthard and Salomone (1969). This research was a seminal piece in the development of the profession of rehabilitation counseling. It was used as the foundation for the standards that guided accreditation in graduate rehabilitation counselor education programs and the content of the Commission on Rehabilitation Counselor Certification examination (Rubin, et al., 1984; Szymanski, Linkowski, et al., 1993).

Muthard and Salomone's (1969) study used counselors from public rehabilitation, services for the blind, and private non-profit facilities. A Task Inventory technique was the method used to collect data. Counselor work activities were classified into the following categories: counseling and guidance, recording, traveling, clerical work, public relations and program, planning of work, professional growth activities, reporting, resource, placement, and other. The results showed affective counseling, vocational counseling, and placement were the duties described by rehabilitation counselors as having the highest degree of importance. Counseling and guidance was the largest task of all counselors; however, the amount of time spent in that task varied among counselors in different employment settings. Placement, although described as important, only entailed seven percent of a counselor's time (Muthard & Salomone, 1969).

Counselors in all three settings supported the importance of a master's degree to prepare for the provision of affective counseling, group procedures, and test interpretation. The counselors also felt very few rehabilitation counselor tasks could or should be performed by support personnel. Delegated tasks would only be routine and repetitive job tasks. Muthard and Salomone's (1969) research supported a generic curriculum for counselor preparation rather than a specialist program, as counselors in different work settings have the same general job functions. However, with the expansion of employment settings and clients served, specific curriculum changes through electives were suggested to support changing job demands (Muthard & Salomone, 1969).

Matkin (1983a) addressed a specialized work setting when he examined the roles and functions of rehabilitation practitioners in the private-for-profit sector. This study included graduates of accredited rehabilitation programs, rehabilitation nurses, and other private rehabilitation practitioners. The Rehabilitation Specialist Task Inventory was developed for this study. Five major work role categories were identified: planning and coordinating client services, business and office management, job development and placement, diagnostic assessment, and other professional activities. In this study, business, office management and diagnostic assessment were the work roles that differed from Muthard and Salomone's (1969) study of public and non-profit facilities. This is not surprising considering that in the private sector practitioners need to record and bill professional time, which is not required in public or non-profit rehabilitation. Diagnostic assessment is evident with medical case management, which is emphasized more in private rehabilitation than in public and non-profit rehabilitation.

Matkin's (1983a) study supported the training model of the Council of Rehabilitation Education (CORE), the accreditating body for master's degree programs in rehabilitation counseling (Linkowski & Szymanski, 1993). His research suggested this training model provides adequate preparation for rehabilitation counselors to perform the roles and functions of private rehabilitation counseling. However, he suggested modifying the CORE content by the inclusion of information specific to insurance rehabilitation. This includes topics such as workers' compensation, self-insured employer needs, and vocational expert testimony (Matkin,

1983a).

In 1984, the roles and functions of Certified Rehabilitation Counselors (CRC) were studied to examine the work duties of CRC's employed in various work settings (Rubin, et al., 1984). Job tasks were again surveyed and categorized, this time using the Job Task Inventory. The job task categories included job development and placement, case management, profession/policy/test development, vocational counseling and assessment, and affective counseling (Rubin, et al., 1984). Their results confirmed earlier findings of Emener and Rubin (1980) and Matkin (1983a) that case management, vocational counseling, and affective counseling are important duties for rehabilitation counselors in the public and private sectors (Rubin, et al., 1984). The study suggested that job tasks are not unique and are generally more common to all work settings than unique. The results were also considered useful for examining item content relevancy and representativeness for the Commission on Rehabilitation Counselor Certification (CRCC) examination (Rubin, et al., 1984).

The importance and attainment of practitioner competencies in rehabilitation counseling, job placement, and vocational evaluation were examined by Leahy, et al. (1987b). This research was conducted to learn the shared and unique competencies important to the practice of rehabilitation. Additionally, this information was useful for deciding the minimum training required for practice in rehabilitation and for evaluating training programs (Danek, Wright, Leahy, & Shapson, 1987). The strengths of this research included the nationwide sample drawn from each of the specialized settings investigated. The Rehabilitation Skills Inventory (RSI) developed

for the study involved the use of expert judges, an advisory committee, field tryouts, and pretesting. The items selected for the RSI were chosen because of their psychometric qualities and their representation of professional competencies in the rehabilitation domain (Leahy, et al., 1987a). The RSI then allowed rehabilitation practitioners to respond to competence importance and attainment within their specialization and setting. The RSI items were grouped through a data reduction technique into 10 clusters: vocational counseling, assessment planning and interpretation, personal adjustment counseling, case management, job placement, group and behavioral techniques, professional and community involvement, job analysis, and assessment administration (Leahy, et al., 1987b). According to the demographic questionnaire, rehabilitation counselors spent their time in the following areas: "case management (26.7%), rehabilitation counseling (26.6%), assessment (13.4%), and job placement (9.5%)" (Leahy, et al., 1987b, p. 124). Rehabilitation counselors attributed greater importance to vocational and personal adjustment counseling, case management, job placement, group and behavioral techniques, professional and community involvement, and consultation (Leahy, et al., 1987b, p. 125) than did vocational evaluators. Personal adjustment counseling was also more important to rehabilitation counselors than to job placement specialists. Practitioners in the private-for-profit setting attributed more importance to vocational counseling, case management, job placement, consultation, and job analysis (Leahy, et al., 1987b, p. 126) than public and nonprofit facility practitioners.

Wright, et al. (1987) suggested this research could be used by practicing

rehabilitation counselors and their supervisors to assess the practitioner's strengths and weaknesses. Additionally, Regional Rehabilitation Counselor Education Programs, university rehabilitation counselor education programs, and CORE could use the results to review or modify current education curriculums. The results also provided a new subject list for CRCC test item construction (Wright, et al., 1987).

Shapson, et al. (1987) analyzed the survey on competency attainment. Their results suggested that competency attainment and certification status relate to the level and type of educational degree held. Respondents with master's degrees in rehabilitation counseling were more likely to be Certified Rehabilitation Counselors than respondents with other master's or bachelor's degrees. Higher satisfaction with preservice training and competency attainment was also found for persons with master's degrees in rehabilitation counseling. Persons with more than five years of work experience reported themselves as more competent than persons with five or less years of work experience. This research supported the value of graduate training in rehabilitation in producing more competent, committed professionals as measured by the Rehabilitation Skills Inventory.

Validation of rehabilitation counselor knowledge areas continued with the support of the Foundation for Rehabilitation Education and Research (Leahy, et al., 1993; Szymanski, Linkowski, et al., 1993). In 1993, a Special Joint Issue of the Journal of Applied Rehabilitation Counseling and the Rehabilitation Counseling Bulletin was published to address this topic, entitled "*Rehabilitation Counseling Credentialing: Research and Practice*" (Leahy & Szymanski, 1993). It is an ongoing study designed

to validate and update knowledge standards for rehabilitation counseling accreditation and certification. For this research the population studied were practitioners who applied for recertification through the Commission on Rehabilitation Counselor Certification (CRCC) (Leahy, et al., 1993; Szymanski, Leahy, et al., 1993; Szymanski, Linkowski, et al., 1993).

Szymanski, Linkowski, et al. (1993) examined the level of perceived importance in rehabilitation counseling knowledge areas. The participants rated ethical standards, case management, planning for vocational rehabilitation services to clients, individual counseling practices, theories, attitudinal barriers, vocational implications, medical aspects, and psychosocial and cultural impact of disabilities as the knowledge areas of highest importance. The results supported the validity of knowledge areas addressed in the rehabilitation counselor certification and accreditation process.

Knowledge important to the practice of rehabilitation counseling was studied by Leahy, et al. (1993). The results indicated there were significant differences in knowledge importance based on employment setting. For example, respondents from private rehabilitation rated workers' compensation knowledge as significantly more important than did respondents from state-federal, private nonprofit, college/university, public schools, medical/hospitals, mental health, or other employment sites. There were also some differences based on job title. Leahy, et al. (1993) suggested that knowledge importance will vary most when respondents are grouped according to employment setting and job title. Further, the differences are likely related to organizational climate, clientele served, and the rehabilitation process

used. Job title differences are likely related to the frame of reference of the participant. Overall, the results seem to reflect a common understanding of the knowledge important to the practice of rehabilitation counseling.

Szymanski, Leahy, et al. (1993) examined reported preparedness of certified rehabilitation counselors. The results indicated that certified rehabilitation counselors were at least moderately prepared in the majority of rehabilitation counseling knowledge areas. The areas revealed as moderately high were: Foundations of Rehabilitation, Medical and Psychosocial Aspects of Disability, Individual Counseling and Development, and Assessment. Szymanski, Leahy, et al. (1993) suggested these areas of perceived preparedness offered support for certification. Workers' Compensation, Employer Services, and Technology were the areas in which less than moderate preparedness was reported. Perceived preparedness differed in at least one rehabilitation counseling knowledge area by gender, preservice education, job setting, job title, and years of service. Additionally, the sustained effect of education on perceived preparedness was suggested in that persons with CORE master's degrees ranked themselves higher in six rehabilitation counseling knowledge areas than did those with unrelated master's or bachelor's degrees. According to Szymanski, Leahy, et al. (1993), this research offered support for the long term impact of education and is consistent with prior research relating education and perceived competency (Shapson, et al., 1993) to rehabilitation outcomes for clients with severe disabilities (Cook & Bolton, 1992; Szymanski, 1991; Szymanski & Danek, 1992; Szymanski & Parker, 1989). One limitation of this validation research is its applicability to non-

certified or inexperienced rehabilitation counselors. The sample included only certified rehabilitation counselors with at least five years of experience (Szymanski, Leahy, et al., 1993; Szymanski, Linkowski, et al., 1993).

Competency further defined

Boyatzis (1982) has completed extensive research in the competency area. To complete his research Boyatzis (1982) used the critical incident interviewing technique (Flanagan, 1954) or Behavioral Event Interviewing (McClelland, 1978). These techniques require the participant to provide a detailed description of several critical incidents on the job in which the participant's behavior, thoughts, and feelings are recorded. Competencies are then extrapolated from the information, recorded and coded. Coding is then related to performance criteria. Developing a list of competencies does not ensure everyone with these competencies will be effective in every situation (Boyatzis, 1982).

Boyatzis (1982) suggested the Job Competence Method is different from task and function analysis in three ways. First, it examines the person functioning within the job, as well as the job. Second, it results in a competency model not a list of characteristics. He indicated competencies reflect a person's capabilities which may or may not be used by the individual. Third, this model can also be evaluated using performance data. Additionally, it overcomes some potential problems that occur using theory or panel methods. Theory or panel methods determine what an individual or group of experts think is relevant and may identify characteristics that

are not behaviorally specific (Boyatzis, 1982).

Previous research on competency importance and attainment and role and function focused on the job tasks of a rehabilitation counselor, not the characteristics of the counselor doing the job. One exception was a study by Jaques (1959) that examined critical counseling behaviors in a rehabilitation setting. The study's purpose was to investigate the counseling process in rehabilitation as practiced by counselors in different rehabilitation settings or agencies. This study applied a Critical Incident Technique to the rehabilitation counselor's work.

Jaques (1959) sampled rehabilitation counselors and supervisors primarily from state-federal rehabilitation agencies in twenty states, plus some counselors and supervisors from the Veterans Administration and private rehabilitation agencies and facilities. Participants were asked to describe one effective and one ineffective counseling or supervisory incident. One goal of data analysis was to determine critical job requirements of counseling in rehabilitation settings. In data analysis, seven major classification units, called sub-roles, and 65 sub-classes, called categories, were developed. The sub-roles included (a) creation of a therapeutic climate; (b) structuring: arranging counseling sessions; (c) structuring: defining limits of counseling; (d) information gathering; (e) evaluating; (f) information giving; and (g) interacting (participating, advising, directing). Creation of a therapeutic climate ranked highest for both effective and ineffective behaviors in terms of numbers of behaviors reported. Jaques (1959) suggested this supports research on the importance of the client-counselor relationship. This included listening to the client

and providing an environment where the client felt safe to explore plans and problems. This interpersonal relationship was found critical to client movement. The second most important effective behavior was interacting, followed by information giving and defining limits (Jaques, 1959). Among total ineffective behaviors, evaluating was second. This is in contrast to its ranking as sixth among total effective behaviors. Jaques (1959) speculated that a counselor may take for granted or not be aware of the influence of an evaluation on an effective client interaction, but notices its influence and possible cause in an ineffective client contact.

Jaques' (1959) research assumed that rehabilitation counselors can judge counseling effectiveness and ineffectiveness in a rehabilitation setting and that these judgements are relevant and adequate. Additionally, since counselors interact with clients, they know when clients are moving toward or away from vocational rehabilitation goals. This research further assumes counselors can accurately and reliably report these incidents.

Credentialing

Professional credentials include academic degrees, certification, and licensure (Matkin, 1995). The master's degree in rehabilitation counseling was initially established as a viable training objective for rehabilitation counselors by the Vocational Rehabilitation Act of 1954 (Rubin & Roessler, 1995). This level of education was expected to improve the quality of services to persons with disabilities (Kuehn, et al., 1988). Since that time, it has evolved as the minimum education

standard for both certification and licensure.

Certification

The Certified Rehabilitation Counselor (CRC) represents an acceptable standard of quality in the rehabilitation counseling profession (Leahy & Holt, 1993). The CRC can be used to evaluate the qualifications of practicing rehabilitation counselors. Becoming certified requires meeting minimum standards of education, experience, and knowledge, and a willingness to meet the ethical standards of the profession. The minimum education requirement is a master's degree in rehabilitation counseling or a master's in a field related to rehabilitation counseling. The accrediting body for master's level rehabilitation counseling programs is the Council on Rehabilitation Education (CORE) (Leahy & Holt, 1993). For people with a master's degree in rehabilitation counseling from an accredited program with a 600-semester hour or 480 quarter hour internship, there is no work experience requirement. If their master's program is not fully accredited, students must show two years of work experience, with one year under the supervision of a CRC. For counselors with a related master's degree to become certified, they must take additional courses such as assessment, occupational information/job placement, medical/psychological aspects of disability, and community resources/delivery of rehabilitation services and obtain three years' work experience with one year under the supervision of a CRC (Commission on Rehabilitation Counselor Certification, 1993). Counselors with an unrelated master's degree require documentation of up to 60 months of acceptable

employment experience, and at least one year of supervision by a CRC is required to apply to take the certification examination (Commission on Rehabilitation Counselor Certification, 1993). Certification with a bachelor's degree was eliminated in 1992. Maintenance of certification requires continuing education or reexamination (Leahy & Holt, 1993).

CRC's who maintain their certification may be more likely to remain abreast of current technical knowledge than are non-CRC counselors, since continuing education is required for certification maintenance. Because of the requirements needed to become certified and the requirements of continuing education to remain certified, it is argued that rehabilitation counselors are likely to experience better client outcomes, on average, than practitioners who lack this credential. The Urban Institute suggested proponents of certification believed certification would enhance the quality of rehabilitation services provided to people with disabilities (as cited in Kuehn et al., 1988).

Since the inception of the CRC credential, professionals have debated its value. As mentioned above, the joint issue on rehabilitation counseling credentials published in 1993 generally supported CRC credentialing. However, Thomas (1993) questioned whether professionals who are credentialed are superior to professionals who are not. He interpreted the passing of the CRC examination as implying that these practitioners are more competent to practice than those who do not pass the examination. To date, the validity of credentialing as an index of professional competence has not been empirically investigated. In fact, there is no literature

specifically on the relationship between professional credentials and client outcomes. Documentation to support this assertion is needed and should be addressed in future studies.

In 1983, the Board for Rehabilitation Certification (currently The Foundation for Rehabilitation Certification, Education, and Research) developed certification for practitioners providing services to recipients of disability compensation system benefits. The credential was entitled Certified Insurance Rehabilitation Specialist. This credential has recently undergone a name change and is now Certified Disability Management Specialist, to be more inclusive of professionals working in the disability management field. The Certification of Disability Management Specialist Commission has developed a credentialing process for case managers. The Case Manager Certification "is an adjunct to a professional credential in a health and human service profession" (Certification of Insurance Rehabilitation Specialist Commission, 1992, p.1). This certification is for practitioners with a specialized area of knowledge in case management. Criteria for eligibility are being a Registered Nurse, maintaining a current professional license, or maintaining national certification in a health and human service profession.

CRC continues to be the most recognized credential for private rehabilitation professionals. The private rehabilitation sector currently has no standards regulating who may be providers of rehabilitation services (Matkin, 1983a). However, Gilbride (1993) indicated more private rehabilitation firms and their customers are requiring a master's degree, certification, and licensure. E. M. Welch (1994) recommends that

insurance carriers and other referral sources in workers' compensation should generally use rehabilitation professionals with the "highest possible level of approval or licensing" (p. 311). Some (e.g. Leahy & Holt, 1993) have suggested, that if we are to assist consumers with the recognition of quality rehabilitation services, than we need credentials such as certification and licensure.

Licensure

As of 1993, counselor licensure was available in 38 states; however, 24 of these 38 states have title laws, rather than practice laws (Tarvydas & Leahy, 1993). Title-only legislation allows only those individuals who have met the qualifications established by the bill and who have achieved licensure to use the specific title of counselor designated in the bill. It does not, however, restrict individuals from providing counseling services, provided they avoid the restricted language in their job titles. Practice laws, the more stringent approach, preclude anyone from providing counseling services, regardless of their title, unless they are fully qualified as a counselor. The exceptions are persons who are already licensed in the same state and have counseling included in their scope of practice. This would include psychologists and social workers. Title and practice laws prohibit anyone from providing counseling services regardless of formal professional title with the exceptions noted. Many counselor licensure title laws will change to title and practice laws over the next few years (Tarvydas & Leahy, 1993). According to Tarvydas and Leahy (1993) these changes will affect private rehabilitation firms who have previously avoided

licensure by changing staff job titles, then carrying on business as usual. CRC designation is the key differentiating factor to let consumers know which Licensed Professional Counselors have expertise in working with persons with disabilities (Tarvydas & Leahy, 1993).

Using credentials to define qualified rehabilitation counselors has not been empirically supported, but is supported within the profession. Credentials are also standard designations specified in third party payer guidelines to define the rehabilitation counselor qualified to handle case files. Generally, the CRC, CDMS, and counselor licensure are recognized within the industry as designating that a professional has met the accepted professional standards for rehabilitation counselors (Lynch, Lynch, Beck, 1992).

Outcome Research

There are many variables that influence an injured worker successfully returning to work. These include the counselor, the injured worker, the disability, the job, and the employer. Counseling literature has focused on the counseling relationship and its influence on case outcome. Rehabilitation research has focused on case outcomes based on counselor, client, employer, and other variables. Research on the case management process has been limited. This variable is significant to examine as it will influence rehabilitation counselors interaction with their clients and must be considered when exploring rehabilitation counselor behavior and interpretation of best practice.

Counseling outcome studies

Therapeutic outcome studies have provided support for the general effectiveness of counseling (Lambert & Bergin, 1994; Strupp, 1995). Empathy, warmth, and unconditional positive regard have been established as the core elements of counseling (Lambert & Cattani-Thompson, 1996). Common factors that may account for positive changes in therapy included the therapeutic relationship, creating hope, and an opportunity for emotional release (Garfield & Bergin, 1994).

Characteristics of the client are the strongest predictors of outcomes in therapy (Bergin & Garfield, 1994; Bergin & Lambert, 1978). If the client doesn't follow through or use the information learned through therapy, nothing will happen (Bergin & Garfield, 1994; Bergin & Lambert, 1978). Counseling helps clients solve problems, decrease symptoms, and enhance interpersonal functioning (Lambert & Cattani-Thompson, 1996).

When the therapist has been examined, client gain has been noted with the skillful, wise, and stable therapist. The therapist needs to be a person who can relate well with the client (Lambert & Bergin, 1994) and has the ability to manage a complex human relationship (Strupp, 1995). Research has shown that the individual therapist has an important role in therapy, but it is not totally clear when and how the therapist makes a difference, or when the therapist makes more of a difference than the techniques used by the therapist (Lambert & Bergin, 1994; Strupp, 1995).

The literature has recommended we determine which counseling components are most helpful and most likely will improve counseling effectiveness (Lambert, Masters

& Ogles, 1991 as cited in Sexton, 1996), especially between the process and outcome of counseling (Lambert & Bergin, 1994). Hill and Corbett (1993) suggested that the timing, quality, and competence in therapy need to be studied. They indicated that if competence can be assessed, there is a greater opportunity to link process with outcome. We would then know more about what occurred in counseling and the quality of the occurrence (Hill and Corbett, 1993).

Counselor education level's influence on outcome

Several studies (Cook & Bolton, 1992; Szymanski, 1991; Szymanski & Danek, 1992; Szymanski & Parker, 1989) of the state-federal rehabilitation system have examined the relationship of rehabilitation client outcome to level of rehabilitation counselor education. These results suggested that counselors with a master's degree in rehabilitation counseling and a related master's degree have achieved significantly better client outcomes for persons with severe disabilities than counselors with an unrelated master's and bachelor's degree (Cook & Bolton, 1992; Szymanski, 1991; Szymanski & Danek, 1992; Szymanski & Parker, 1989). However, no significant differences were found between rehabilitation counselors with masters' degrees in rehabilitation counseling and those with related masters' degrees (Szymanski, 1991; Szymanski & Danek, 1992; Szymanski & Parker, 1989). Related masters' degrees were defined as degrees in guidance and counseling, agency counseling, or any counseling or special education related discipline (Szymanski & Parker, 1989).

Szymanski and Parker (1989) and Szymanski (1991) found that experience

moderated the relationship between counselor education and successful case closure. Specifically, master's level rehabilitation counselors and counselors with related masters' degrees had higher rates of successful case closures of severely disabled clients than did counselors with unrelated bachelors' and masters' degrees (Szymanski & Parker, 1989; Szymanski, 1991). For counselors with masters' degrees in rehabilitation, experience ranged from 1 to 14.17 years (Szymanski, 1991). For counselors with related masters' degrees, the range was from 1 to 13.53 years (Szymanski, 1991).

Abrams and Tucker (1989) reported different results in their study of the Florida State-Federal Vocational Rehabilitation Program. They investigated the level of education and degree focus as predictors of job performance measured by the rehabilitation rate. Rehabilitation rate was defined as "the number of successful case closures divided by the sum of the number of successful case closures plus the number of unsuccessful case closures" (Abrams & Tucker, 1989, p.196). Unsuccessful case closures comprised those cases in which a client who was determined eligible for services dropped out before being placed in a job. A limitation of this study was the narrow, agency-imposed definition of unsuccessful case closure. They found no difference in overall rehabilitation rate between counselors with and without a degree in rehabilitation. Nor was there a difference in client rehabilitation rate between persons with only a bachelor's degree versus at least a master's degree. Job tenure was excluded from the analysis. The authors commented that this raised questions about the reliability and validity of the

rehabilitation rate as a measure of counselor job performance. This difference in measurement could also have accounted for the differences between the results of their research and the other studies of the level of counselor education on rehabilitation client outcome (Cook & Bolton, 1992; Szymanski, 1991; Szymanski & Danek, 1992; Szymanski & Parker, 1989). Abrams and Tucker recommended specific examination of the quality and quantity of successful rehabilitation.

Rehabilitation case process

The ultimate goal in private rehabilitation is to return the injured worker to productivity. The standard process used within the industry is often called the three step approach to rehabilitation. The three step approach suggests that rehabilitation counselors examine first, returning to work with the same employer in the same or a different job; second, returning to work with a new employer in the same or a different job (G. T. Welch, 1979); then third, acquiring short term retraining to facilitate a return to work with the same or a new employer (Matkin, 1995). In some workers' compensation arenas, self-employment is considered an option (Matkin, 1995). Returning to work with the same employer is emphasized because this usually expedites returning to work and the reestablishment of a wage earning capacity for the injured worker. It is likely to be the easiest, least expensive, and the most successful rehabilitation alternative (G. T. Welch, 1994). Clearly defining the steps of the rehabilitation process should help rehabilitation counselors maximize their success in rehabilitating injured workers.

Client variables

An injury or illness can be a devastating experience for an individual. It can affect a person's physical, psychological, social, and emotional well-being, and his or her financial stability (Lynch, 1979). These factors can be barriers to a return to work for some injured workers. How a person reacts to an injury is very individualized. For many people, medical recovery follows typical time lines determined by a particular medical diagnosis. If no intervening variables delay the injured worker's return to work, they have a "normal" adjustment to their disability and return to work. Most injured workers in Michigan can return to work after only a short period of medical treatment and job accommodations, if needed. In Michigan in 1995 (D. Langham, Annual Report of 1995), only 5% of injured workers remained off work after six months.

When return to work does not occur within expected time parameters based on medical aspects of the specific disabling condition, other factors are examined. For this minority of injured workers, variables that may preclude return to work include the psychosocial impact of disability on individuals and their response to the disability process, the inadequate or inappropriate use of disability support systems, and disincentives to return to work (Tate, Habeck, & Galvin, 1986, p. 9).

When delays in return to work are related to certain personality characteristics within the person, they are labeled as delayed recovery (Headley, 1989), secondary gain, or malingering. Headley (1989) described delayed recovery as an interactive process occurring in a person who has "increased stress and/or vulnerability (p. 63)"

and is affected by external factors that sustain an injury. These factors are presumed to exist prior to the work related injury and preclude the injured worker from effectively coping with the disability and returning to work. The factors include depression; a hysterical personality; dependent, immature people; older workers; alcoholics; and sociopaths (Killian, 1988). Thus, Headley suggested using a biopsychosocial model for intervention in these cases. This model requires gaining knowledge of individual, societal, environmental, and system barriers. All are essential elements required to understand thoroughly what potential factors could influence an injured worker's recovery.

Malingering is defined as a deliberate and conscious attempt to manipulate a system for personal gain. Malingers often have poor prior attendance records at work and have performed poorly (Killian, 1988). Most workers' compensation recipients do not experience this phenomenon (Derebery & Tullis, 1983). Corthell and de Groot (1983) state that conscious malingering exists in only two percent of all work related injuries. There is little empirical evidence to support or refute these ideas. Further research is needed to assess the impact of these variables on recovery and return to work.

Bolton and Rubin (1974) reviewed rehabilitation outcome literature to determine rehabilitation client demographic variables that predict employment. Age, marital status, amount of education, and age at onset of disability were the most significant predictors. Clients who were difficult to rehabilitate were not married, had little formal education, and were older when they became disabled. Less frequently noted

variables that increased client difficulties in return to work were few dependents, less healthy family relationships, poor health, less formal vocational training, no home ownership, and people who were socially disadvantaged (Bolton & Rubin, 1974).

Lynch (1979) also reviewed the literature as part of a Workers' Compensation Rehabilitation Task Force for the Wisconsin Division of Vocational Rehabilitation. Pain was common to workers with low-back injuries. Common personality characteristics included hostility, resentfulness, uncooperativeness, chronic maladjustment, frustrated ambition, fear, depression, and dependency (Lynch, 1979).

Beck (1989) studied injured worker outcomes in Wisconsin. He reported external locus of control, lengthy healing period (over six months), and high unemployment rates in the local labor market as additional variables increasing the likelihood of unsuccessful case outcome (Beck, 1989).

Lam, Bose, and Geist (1989) examined employment outcomes of private rehabilitation clients. They concluded that the preinjury physical demands of the job and the residual physical capacities were the major differences among outcome groups. Injured workers who were most successful in returning to work had the least physically demanding preinjury jobs and the highest residual physical capacities following an injury.

From the perspective of the rehabilitation counselor, counseling the injured worker may require focusing on the impact of the injury or illness, his or her feelings toward the employer, and the job performed at the time of injury. The counselor needs to be aware of and focus on the obstacles to rehabilitation. This may include

the need to clarify the injured worker's understanding about the rehabilitation process as misperceptions may exist. Resolving obstacles and clarifying understanding may help the injured worker remove barriers that are in the way of a successful transition back to work (Eaton, 1979). Rehabilitation counselors need to help injured workers effectively overcome disincentives and barriers to rehabilitation and facilitate communication and participation of parties with conflicting interest (Tate et al., 1986).

Employer variables

The impact of employer variables on workers' compensation claims has been studied (Habeck, Leahy, Hunt, Chan, & Welch, 1991). This study supported the assumption that a significant portion of a company's workers' compensation experience can be influenced or controlled by internal factors. Employers with a low number of workers' compensation claims had significantly greater involvement in (a) promoting employee health and well-being, (b) facilitating return to work through modified duty, and (c) implementing procedures to insure supervisory participation in return-to-work practices. These same employers also maintained a corporate culture and managerial style consistent with a high quality work life and health and human resource orientation (Habeck et al., 1991).

Habeck, Hunt, Leahy, & Welch (1989) found employers with higher workers' compensation claim frequencies had higher turnover rates, absenteeism, and grievances, although only turnover rate was statistically significant. These are

generally assumed to be considered signs of worker dissatisfaction. Habeck et al. (1989) also noted that new employees tend to have more injuries.

Return to work for injured employees will continue to focus on returning employees to the employer where the injury occurred as opposed to alternate job placement (Habeck et al., 1991). It has been the most cost effective and successful course for injured workers.

The employer - employee relationship may also be a barrier to return to work. Injured workers may not return to work because key players, the union and employers, do not always have a clear understanding of the rehabilitation services that will facilitate return to work. Prior to the American with Disabilities Act (ADA) some employer and union policies precluded the provision of return to work with restrictions or job accommodations. The problems occurred because of fear of lawsuits, reinjury, and a concern for setting precedents that would not be open to able-bodied employees. Additionally, labor union's focus historically had been on providing access to jobs based on seniority levels (Eaton, 1979; Tate, et al., 1986). According to Galvin (1983), (as cited in Tate, et al., 1986), this need for accommodation or job restructuring may have supported employers' misperceptions that accommodating persons with disabilities is an obstacle, especially when business methods and processes require rapid changes in technology to stay abreast of competition. Thus, employers may not return injured workers to work when they have restrictions or may use the pension/disability benefit rather than consider retraining and/or reassignment (Tate et al., 1986).

Shrey and Olsheski (1992) discussed how employer avoidance behaviors can be similar to an injured worker who resists returning to work. These behaviors include "avoiding responsibility, projecting blame on others for one's problems, and engaging in self-defeating actions" (Shrey & Olsheski, 1992, p. 305). Closely related to this is the employer who questions the future performance and motivation to return to work of the employee with a prior injury or illnesses. This type of attitude can create a significant barrier to the injured worker returning to work (Tate et al., 1986). Successful return to work programs focus on a genuine, caring, and trusting relationship with the injured worker. The employer helps the injured worker achieve recovery and retain economic security and personal well-being. Manipulation of employees has not been successful (Tate et al., 1986).

It is anticipated that the ADA will have a positive impact on injured workers' ability to return to work. Employers may be less fearful of reinjury as the injured worker has to be capable of performing the essential functions of the job. This aspect of return to work will help injured workers return to work with restrictions. It will also allow the injured worker to assess whether they are physically capable of returning to work in a specific job (Crystal, 1993).

Research has shown placement and employer contacts are not given sufficient priority in rehabilitation practice (Gilbride, Stensrud, & Johnson, 1994). Gilbride and Stensrud (1993) said that success in placement of persons with disabilities will occur when we learn appropriate and cost-effective strategies in complying with the Americans with Disabilities Act. Rehabilitation counselors can help this process by

educating employers. To do so, they need an accurate understanding of the personnel and disability management needs of employers. Additionally, rehabilitation counselors need an understanding of job analysis, job modification and accommodation, transferable skills analysis, accessibility evaluation, and job placement. Employer concerns are recruiting potential employees with disabilities, building accessibility, interviewing employees with disabilities, disabilities impact on workers' compensation, affirmative action planning, and labor relations (Gilbride & Stensrud, 1993).

Return to work with the same employer is the key to labor force participation by persons who obtain a work related disability. Once this tie has been broken, the injured employee may settle into the "income transfer system" (Tate et al., 1986, p. 6), which may make it difficult if not impossible for the injured employee to return to work. Many people interpret wage replacement benefits as a financial disincentive because not working results in a cash incentive (Eaton, 1979; Headley, 1989; Tate, et al., 1986). Helping an injured worker return to work with a new employer is more difficult than convincing an employer to return this person to work in their former position. This process makes sense based on the cost of disability at the workplace. These costs include the loss of productivity of the injured worker, the cost of hiring a replacement employee, and retraining this new employee (Tate et al., 1986). These cost are even higher if the injured employee must now be retrained in order to locate alternate employment. Other non-monetary costs to the employer but direct costs to the injured employee include loss of self-esteem, emotional and psychological distress,

feelings of worthlessness, and being unable to return to one's former occupational role (Tate et al., 1986).

To facilitate return to work of injured workers, the injured employees must continue to see themselves as valued employees (Shrey & Olsheski, 1992), or the relationship between the employees and employers must be present. The workplace should be used to its fullest advantage to help the injured worker return to work. This means using the physical, psychological, social, and environmental components of the workplace (Shrey & Olsheski, 1992).

Summary

In summary, providing assistance to persons injured on the job has been around since master-servant relationships began. This assistance became known as workers' compensation and included accident prevention, compensation for lost wages and medical and vocational rehabilitation services. Vocational rehabilitation services were initially provided by state-federal rehabilitation counselors. In the 1970s, changes in federal mandates required that state-federal rehabilitation counselors give priority attention to assisting persons with severe disabilities. Private rehabilitation providers then began assisting injured workers who had private sources of benefits for vocational rehabilitation services including workers' compensation, auto no-fault, and long term disability benefits.

As the profession of rehabilitation counseling grew, there was a need to further define the profession. This included clarifying the roles and functions of

rehabilitation counselors, understanding the competencies required to practice in specific work settings, and ensuring acceptable standards of practice. As a result, the master's degree in rehabilitation counseling or a related counseling area became the minimum standard for both certification as a rehabilitation counselor and licensure. Certification and licensure have been used to designate the professional who has met acceptable professional standards (Lynch et al., 1992).

A proactive case process for injured workers is a multidimensional process with a significant number of variables that need to be considered. Empirical research to date has not pinpointed any single variable that predicts vocational rehabilitation success (Lynch, 1979). Success is influenced by a variety of factors (Lynch, 1979). Counselor, client and employer variables provide insight into the complexity of the rehabilitation process and the parameters that need to be examined to successfully return an injured worker to work. In spite of all the influences on injured worker rehabilitation, a majority of injured workers successfully return to work.

Multiple stakeholders are involved in an injured worker's rehabilitation and return to work. With multiple issues and stakeholders, there is a need for a person with specific interpersonal qualities to help the injured worker move through the complex workers' compensation system. One professional who has assisted injured workers in maneuvering through this maze is the rehabilitation counselor. These professionals have improved communication through advice, arbitration and consensus building, and attentive follow-through, thus facilitating expediency in the return to work process (Pimentel, 1995).

The literature was reviewed to provide background information about the environment in which private rehabilitation counselors practice. The profession currently has recommendations with regard to education and credentials for these rehabilitation counselors. This was reviewed to use as a standard for comparing the background of the exemplary rehabilitation counselors studied for this research. Literature on workers' compensation gives an example of the rules and regulations that influence their work. Their work is also affected by counselor, client, employer and other variables which may increase or decrease their ability to assist clients in returning to work. The influence of these issues on private rehabilitation counselors will be discussed throughout the findings of this research.

Because private rehabilitation counselors have been the primary providers of vocational rehabilitation services for workers' compensation cases in Michigan, this group of rehabilitation counselors was selected as the focus of this study. A qualitative study was conducted with private rehabilitation counselors who were identified as exemplary by their managers, supervisors, or peers to determine how they describe and interpret their job of returning clients to work. Interviewing these exemplary private rehabilitation counselors provided an opportunity to learn what factors they perceive as influencing successful case outcomes.

Chapter 3

Design and Analysis

This study explored the insider perspective of exemplary rehabilitation counselors in the private sector and how they define best practice. The purpose of this study was 1) to discover the behaviors that are predominant in the case services of exemplary rehabilitation counselors; 2) to elicit the process that characterizes the work of exemplary rehabilitation counselors; and 3) to clarify the exemplary rehabilitation counselors meaning of best practice.

The research questions were:

1) How do exemplary rehabilitation counselors describe behaviors associated with the client-counselor relationship that facilitates successful case outcome?

2) How do exemplary rehabilitation counselors describe the case management process and critical points that lead to successful case outcomes?

3) How do exemplary rehabilitation counselors interpret the behaviors, approaches, and practices they use to successfully return injured workers to work?

To address these research questions a qualitative design was selected and employed, in order to understand the perspectives of exemplary private rehabilitation counselors.

Qualitative Research

Qualitative research generally attempts to interpret phenomena by the meanings people give to events (Denzin & Lincoln, 1994). Defining the informants' subjective meaning helps make explicit the rules and meanings, activities, and beliefs and thoughts of the people being studied (Singer, 1995). The researcher must enter the defining process to understand the interpretation of people's acts. Through interaction with others, a person makes interpretations that help him or her construct meaning.

Qualitative research occurs in the participant's own setting (Bogdan & Biklen, 1992). In the case of these interviews, the majority occurred in either the participant's office or my own office. Participant observation and review of artifacts such as client case files was considered for inclusion in this study, but were not used because of client confidentiality issues that would need to be resolved before collection of this type of data. Prior to observations and file reviews, private rehabilitation firms would have to be approached and asked to contact clients to request their written permission to be included in this study. The complexity of this approach would likely decrease the number of rehabilitation counselors available for this study. Thus, interviews with exemplary rehabilitation counselors was selected as the singular approach for this study.

The data in this qualitative research were interview notes and transcripts. Data analysis was through induction and the identification of themes. Themes developed after in depth exposure to the phenomena under study. In this study, the participants' interview transcripts were reviewed, then explanatory categories were constructed that

explained the phenomena developed (Hagner & Helm, 1994). To illustrate and substantiate the presentation of these themes the individual's own words in the form of quotes were used to describe the phenomena developed (Bogdan & Biklen, 1992).

Bogdan and Biklen (1992) suggested that common definitions, known as shared perspectives, often develop for people in similar settings, because these people share experiences, problems and background. They also suggested that people with shared perspective may interact regularly; however, this is not true for all private rehabilitation counselors whose shared perspective relates to shared experiences, problems, customers, similar backgrounds, rules and regulations.

Qualitative versus Quantitative Approaches

The use of a qualitative approach was the methodology of choice for this research. Specifically, I followed a general qualitative approach for identifying thematic lines to analyze the data, which was a limitation to this research. According to Jacob (1987), qualitative research has generally been treated as a single approach as opposed to a variety of alternative approaches such as holistic ethnography, cognitive anthropology, and symbolic interactionism (Jacob, 1987; 1988). Without a specific tradition, there is no defined way of looking at the world and the assumptions people have about that world (Bogdan & Biklen, 1992). However, Atkinson, Delamont and Hammersley (1988) have argued that classifying research into "traditions" is counterproductive because traditions are not self-contained paradigms. They gave the following reasons for this argument: (a) internal disagreement exist

regarding the primary aspects of a tradition and regarding whose work represents the tradition, (b) philosophical and methodological assumptions are shared by other traditions, (c) assumptions that distinguish traditions are incomplete or unclear and do not offer a complete methodology, (d) research exist that implicitly or explicitly combines traditions without seeking to develop a new "tradition". Further, they considered traditions as general frameworks for research as opposed to clearly defined entities. Although the use of a general qualitative approach does not provide a clearly defined framework for this research, it does use general qualitative assumptions frequently considered when reviewing qualitative research which are defined in this chapter.

Qualitative and quantitative research differ in several areas. These differences reflect different ways of addressing the same set of issues (Denzin & Lincoln, 1994). The design in qualitative research is evolving and flexible rather than structured and predetermined as in quantitative research. Qualitative research is open-ended regarding direction and details and may proceed with a hunch, whereas quantitative research is more predetermined, with the plan of research specified in advance (Bogdan & Biklen, 1992).

In qualitative research, the individual is examined in the context of a group, event, or situation. Individuals interpret with others' help. Through these interactions the individual constructs meaning. Often people in a group will develop a shared perspective because of the interaction, or shared experiences, problems, and backgrounds; however, this shared perspective is not guaranteed (Bogdan & Biklen,

1992). Of interest is the insider's perspective. In data collection, the insider's perspective is learned through detailed interviewing and observation. Audio and video tape recordings are often made and transcribed. Analysis of data involves explicit interpretation of meanings which are expressed in the form of verbal description and explanation. Quantitative and statistical analysis are less frequently used if at all (Hammersley & Atkinson, 1994). Events observed are coded and inferences are made from these recordings (Patton, 1991).

In quantitative analysis, researchers study the outer perspective. In data collection, the individual's perspective is measured through operationalized variables and quantifiable coding (Bogdan & Biklen, 1992). Inferences are made from these recordings. Quantitative researchers see themselves as detached, objective observers.

Sample sizes in qualitative research are usually small and nonrepresentative. Theoretical sampling may be used. Quantitative sampling is generally large and stratified. Control groups may be used. Random selection is often used, as is control of extraneous variables.

Qualitative research tries to understand how people give meaning to their and others behaviors (Patton, 1991). Qualitative research emphasizes process and meaning. The researcher and the study are closely entwined and shaped by the situation in which the study occurs (Denzin & Lincoln, 1994). Quantitative research generally emphasizes measurement and the analysis of casual relationships, not processes (Denzin & Lincoln, 1994; Heppner, Kivlighan, & Wampold, 1992; Patton, 1991).

The qualitative approach provides the opportunity to gain a greater grasp of the participant's perspective (Banister, Burman, Parker, Taylor, & Tindall, 1994) through open-ended questioning (Krahn, Hohn, & Kime, 1995). This type of format allows participants to respond from their own perspective versus the prearranged structure evident in questionnaires (Bogdan & Biklen, 1992), which have been predominately utilized in role and function research. Questionnaires limit a person's response by providing them with a set selection of responses. Qualitative methodology allows for the exploration of issues too complex to investigate quantitatively (Banister, et al., 1994 & Hagner & Helm, 1994).

The literature review has documented the complexity of the work of a rehabilitation counselor. Rehabilitation counselors must consider client and employer factors and are influenced by their own competencies in achieving successful outcomes for injured workers. However, prior research has not explored the insider's perspective and how rehabilitation counselors describe their behaviors and characteristics that lead to successful case outcomes. Since this research has exemplary rehabilitation counselors describe how they achieve success, it allows for the discovery of new connections or insights (Hagner & Helm, 1994) into exemplary rehabilitation counselors.

Interview Question Development

According to Weiss (1994), before an interview the researcher develops topics of interest that suggest lines of inquiry to pursue with respondents. An interview guide

develops from these lines of inquiry. The interview guide lists areas to be covered during the interview and topics or questions that denote lines of inquiry. The function of the interview guide is that of a prompter (Weiss, 1994). The interviewer wants to stay flexible, thus allowing the discussion to flow naturally. However, the interviewer needs to be an active listener, by listening to what is said to assess its relationship to the research focus (Hammersley & Atkinson, 1995). Questions and responses may evolve as interviews and analysis occur and additional lines of inquiry emerge. The interviewer must have a general idea of the desired learning to decide what other information brought up by the respondent may be useful for the study. Additionally, the researcher wants to listen for and address markers that occur when respondents refer to an important event or feeling state.

Weiss (1994) further suggests that one goal of the interview is to have respondents provide concrete descriptions of activities they have observed. Included in this description should be the respondent's thoughts, feelings, scenes, and external events. This is accomplished by asking respondents to provide a specific incident or further detail about a particular event of interest to the research. Additionally, the respondent can be asked if this occurrence was different from previous occurrences. A concrete description has been obtained if the interviewer can visualize the scene, the key players, and what happened during the interaction based on the description.

The interview questions for this study were developed by synthesizing information from McClelland's (1977, 1978) work on Behavioral Event Interviewing, Boyatzis (1982) model of management, and the case management process (Rubin & Roessler,

1992). McClelland (1977, 1978) described the goal of behavioral event interviewing as identification of the competencies needed to perform a specific job. McClelland focused on what was required to perform a given job well or what characterized good performers. He suggested acquiring this knowledge by obtaining detailed descriptions of how a person performs his/her job on a day-to-day basis. The interviewer wants the interviewee to describe in detail a critical event in their work. The critical event includes descriptions of when the interviewee was effective and ineffective in performing his or her job. The concentration is on the description of behaviors, thoughts, and actions that the interviewee used on the occasion being described. Additionally, the interviewer is interested in the perception of the people and the situation, the acts, feelings, and conclusions for future reference. This description of a critical event will help the interviewer better understand how the job is done and the characteristics required to perform the job well. Most important in this process is learning what it takes to do the job (McClelland, 1977, 1978).

The process begins by allowing the interviewee to start at the beginning of the critical event and to let the story unfold providing as detailed a description as possible. According to Flanagan (1954), data collection is flexible, not rigid, allowing for adaptation to the specific situation. At the conclusion of the interview, the interviewee should be asked what characteristics he or she thinks are required for a person to do well on the job (McClelland, 1977, 1978).

Boyatzis (1982) also used behavioral event interviewing in his research. He described the interview process as journalistic inquiry. The interviewer wants to ask

probing, yet nondirective questions that request specificity, clarification, and examples.

In adapting Boyatzis (1982) and McClelland's (1977, 1978) work to this research, the procedures used in case management were reviewed. Roessler and Rubin's (1992) text on case management was consulted. Following a review of role and function research, Roessler and Rubin (1992) described the role and function of the rehabilitation counselor as including four job task areas: (a) case management, (b) vocational counseling and assessment, (c) affective counseling, and (d) job placement.

In developing questions for use in exemplary rehabilitation counselor interviews, all of the above information was considered. The interview format was developed using the behavioral event interview described by McClelland (1977, 1978) and Boyatzis (1982). The questions stimulated discussion with the exemplary rehabilitation counselors. They were asked to discuss case outcomes where they felt successful and unsuccessful with the results and to discuss a case of their choice. The question themes related to core skills used by rehabilitation counselors as described by Roessler and Rubin (1992). Case management skills were incorporated in questions on the initial interview and interview style. Vocational counseling and assessment skills related to vocational evaluation and testing questions. Affective counseling skills were addressed with questions of clients grieving about the loss caused by their injury and the rehabilitation counselors interactions during the initial interview. Questions addressing return to work and placement were included in job placement skills. Questions regarding conflict resolution and prioritization were developed

because they are caseload management skills required by rehabilitation counselors (Greenwood, 1992). Additionally, all of these questions were available to be addressed by the exemplary rehabilitation counselor as they described specific cases.

Participants

Participants were rehabilitation counselors employed in the private sector of vocational rehabilitation in Michigan. Managers, supervisors, and peers were asked to nominate rehabilitation counselors who they considered to be exemplary. The supervisor and peer nominators defined the criteria for these exemplary rehabilitation counselors. These criteria are reviewed at the conclusion of this study.

Sampling Procedure

The November 21, 1996, list of Approved Vocational Rehabilitation Facilities maintained by the Michigan Bureau of Workers Disability Compensation was used to develop a contact list of people who could potentially nominate exemplary rehabilitation counselors. There were 207 offices on this list. Twenty-one were excluded because they were designated as private nonprofit facilities or a public rehabilitation facility. The remaining 186 offices included 141 companies, because many companies have multiple sites. In order to obtain a list of names of the manager, supervisor, and all rehabilitation/vocational counselors employed by each firm, telephone calls were made to 138 private rehabilitation offices on the list. Some offices provided the names of rehabilitation counselors, supervisors and managers for

multiple sites. The person contacted was informed of the purpose of the call (see Appendix A) and was asked to provide a list of the names of the manager, supervisors, and all rehabilitation counselors employed by the firm. Additionally, some supervisors and managers were responsible for supervising multiple sites. When a firm would not provide the names of the rehabilitation counselors on staff, the supervisors or manager's name was requested and multiple correspondence packets were directed to their attention. Two attempted telephone calls were made to each office to obtain the names of the rehabilitation counselors, supervisors, and managers on staff. From these telephone calls a contact list of 201 rehabilitation counselors, supervisors, and managers was developed and a list of 117 companies. This list of companies was reduced from 141 because companies had closed, been bought out, did not perform case management, or the company owners worked for another private rehabilitation firm.

A letter was sent to all names on the list requesting nominations for exemplary rehabilitation counselors (see Appendix B). All mailings were sent via first class mail. In the first mailing, each contact was mailed a transmittal letter (see Appendix B) and three nomination forms (see Appendix C). The transmittal letter requested a return response within two weeks, even if no nomination was made.

The only criterion for nominating was that the nominee be a private rehabilitation counselor who was successful in their work with injured workers. Respondents were requested to make no more than three nominations for exemplary rehabilitation counselor and to state their reason for each nomination. The nominees could be

employed in their own firm or another private rehabilitation firm. Respondents were informed their nominations would be kept confidential. The nomination forms had a tracking code to aid in confidentiality and allow for follow-up mailings.

There were 201 letters mailed to rehabilitation counselors, supervisors, and managers. Of the 201 letters mailed, 165 letters were sent to individuals and 36 letters included multiple copies of the correspondence. These multiple letter packets were mailed to companies where names of rehabilitation counselors on staff were not available, return telephone calls were not received, or multiple packets were requested. These packets usually included five copies of the correspondence with each letter to a supervisor or manager unless a company specified the number of copies needed. The initial letter in the packet also had a label placed in the top right-hand corner asking that they "Please distribute to all rehabilitation counselors."

Return of the nomination forms was monitored daily. Return response dates were tracked and whether or not a nomination was provided. Approximately two weeks after the response due date shown on the transmittal letter, a second mailing was sent to nonrespondents. This mailing included an identical transmittal letter which stated that this was a "Second notice" (see Appendix D), three nomination forms (see Appendix C), and a stamped self-addressed return envelope. Again, all nomination forms returned were monitored daily.

One week after the response due date for the second mailing, telephone calls were made to all nonrespondents. During the telephone call, the nonrespondent was asked, if they had not already completed their nomination form, if they would be willing to

respond by telephone. When possible, the nomination forms were completed by telephone. If it was not possible to speak with the rehabilitation counselor, supervisor, or manager, a message was left for the nonrespondent who was asked to return the nomination form or to call and complete the nomination form over the telephone. Some responses were received on an answering machine.

One week after the telephone calls were made, the nominees to be interviewed were selected from the pool of nominees. First, all 12 nominees who received multiple nominations were selected from the pool. Multiple nominations are considered good indicators of outstanding performers (Boyatzis, 1982; McClelland, 1977, 1978). Persons receiving only one nomination were pooled into groups according to whether they were nominated by someone outside the firm (19), within the firm (14), or a self-referral (1). Outside referrals received two points, inside referrals received one point, and self-referrals received one-half point. The remaining nominees for the sample were then randomly selected from all nominees receiving outside nominations. Outside nominations were selected because they seemed more likely to produce names of truly exemplary rehabilitation counselors rather than nominations made due to friendship or close collegial relationships that may not relate to the nominee being exemplary.

Response Rate

Of the 201 letters mailed to rehabilitation counselors, supervisors, and managers, one was returned as undeliverable, but was remailed to a deliverable address. From

the first mailing, 33 responses were returned. Of the 117 companies represented in the mailing, 28 different companies responded. Of the 33 responses received, 20 recommended nominees, 11 had no recommendations. Two companies said they did not wish to participate, in the study.

In the second mailing a total of 167 letters were mailed. Sixty responses were received. Thirty-seven additional companies responded. Of the 60 responses received, 15 recommended nominees, 40 did not. Four companies said they did not wish to participate and one company said there were no rehabilitation counselors on staff.

Telephone contact was attempted with the remaining 104 rehabilitation counselors, supervisors, and managers. Thirty-seven actual contacts were made. Seven calls were not completed due to disconnected telephones, wrong numbers, mechanical problems, and a person on medical leave. One additional response by telephone was received in reply to the second mailing which increased the total responses to 38. Twenty-three additional companies responded. Nine recommended nominees, and 24 had no one to recommend. Two companies said they did not wish to participate in the research, two rehabilitation counselors were on medical leave, one person received a multiple mailing, and one person was inappropriate for the study because she was not working as a rehabilitation counselor. (See Appendix E for a summary of these figures.)

Babbie's (1983) research on surveys was examined with regard to response rate, because the letter requesting a nominee could be viewed as a one item survey.

According to Babbie (1983) the acceptable response rate varies in survey research. A response rate of at least 60% is considered good, and 70% is considered very good. The overall response rate for all correspondence and telephone calls was 131 out of 201 or 65%. The total number of companies responding was 88 out of 117 for an overall company response rate of 75%. Further review of the responses showed 13 of the rehabilitation counselors and/or companies contacted could be excluded from the study. They did not wish to participate, had no rehabilitation counselors on staff, were inappropriate for the study, received multiple mailings, or were on medical leave. This would decrease the number of people available for a response to 188, which would increase the overall response rate to 70%. Babbie (1983) considers this a very good response rate. The total number of companies available for a response would be reduced by eight, for a total of 109 companies. The overall response rate for companies would increase to 81%, which exceeds Babbie's (1983) estimation of a very good response rate. The overall response rate may have been affected by the requirement that nominators recommend someone else for research which required the nominee to give of their time, which is particularly critical in private rehabilitation where weekly billable hour goals must be met.

Some explanations were received on returned nomination forms and during subsequent telephone calls regarding non response and nominations. There was concern that the initial calls requesting rehabilitation counselor names was a strategy being used to obtain names to pirate staff away from the firm. Medium to large private rehabilitation firms expressed concerns that trade secrets might be revealed

during interviews that could provide a competitor with a marketplace edge. Additionally, some companies felt rehabilitation counselor names were confidential information. If this research had guaranteed the rehabilitation counselors anonymity to the researcher, other rehabilitation counselors may have been nominated. Frequently, nominees were not recommended by sole proprietorships because the rehabilitation counselor did not know other rehabilitation counselors or was not familiar with their work. Some of these same rehabilitation counselors felt they were exemplary but did not wish to nominate themselves. These rehabilitation counselors preferred to offer their availability to answer questions from the researcher.

Characteristics of the Nominee Pool

There were 51 rehabilitation counselors nominated as exemplary rehabilitation counselors. Twenty-four (47%) nominees were male and 27 (53%) were female. Five were excluded from the nominee pool because they were not employed with private rehabilitation firms. Thus, the final nominee pool consisted of 46 rehabilitation counselors. Twenty-four (52%) were male and 22 (48%) female. The 20 exemplary rehabilitation counselors selected included all multiply nominated rehabilitation counselors. Of the 51 rehabilitation counselors nominated as exemplary, 12 (41%) rehabilitation counselors received multiple nominations, which ranged from two to four nominations. Eleven of the rehabilitation counselors with multiple nominations agreed to participate. Nineteen rehabilitation counselors received nominations by rehabilitation counselors, supervisors, and managers outside

their rehabilitation firm. It was from these nineteen rehabilitation counselors that the remaining nine rehabilitation counselors were randomly selected to complete the sample size of twenty.

Design

Qualitative research methodology was used to assess the behavioral characteristics of exemplary rehabilitation counselors and their interpretation of best practice. This methodology is useful for telling what something is like. It helps describe meaning, processes, and similarities among members of the same type. In depth exploratory interviews allow for broader knowledge about how success occurs and is defined from the insider's perspective. Interviewing shows if consistency in interpretation emerge across many exemplary rehabilitation counselors.

Data Collection Procedures

After the exemplary rehabilitation counselors were selected, they were contacted by telephone. The research study was described and they were asked to participate in the study. Eleven of the 12 multiply nominated rehabilitation counselors and all nine of the randomly selected rehabilitation counselors agreed to participate. Upon consent, an interview date and time was scheduled. Prior to the interviews the audio tapes and field notes of the exemplary rehabilitation counselors were given a numerical tracking code in place of their name to insure confidentiality. Before the interview, the participants were given a consent form outlining the requirements,

risks, and benefits of the research (see Appendix F). The consent form was signed by the participant before the commencement of the in-person interview. In-person interviews were then conducted.

The rehabilitation counselors were asked to complete a demographic survey at the time of the interview (see Appendix G). Information in the survey included gender, age, education level, education type, certification status, licensure status, type and length of work experience. This information both provided a description of the overall sample selected and allowed for the exploration of these factors in the analysis of findings obtained.

The exemplary rehabilitation counselors were interviewed using a conversational approach (Goetz & LeCompte, 1984). Prior to their use in this study the interview questions (see Appendix H) were pilot tested to evaluate their effectiveness with two rehabilitation colleagues employed in public rehabilitation who are considered exemplary. As a result of the pilot testing, the interview questions were revised for clarity and conciseness (see Appendix I). Interview questions were also reordered to go from broad questions where the rehabilitation counselors were asked to discuss specific case examples to specific questions about the case management process. Pilot testing provided insight into the interview length which was initially projected to require one to two interviews lasting one to three hours. In the pilot testing, an interview could be completed in one session lasting one to three hours. The consent form (see Appendix F) was also revised following pilot testing to further assure the confidentiality of the clients discussed by the rehabilitation counselors. After the pilot

test interviews were transcribed, initial coding categories for data analysis were developed beginning with coding by interview question.

One in-person interview was conducted with each participant. The length of the interviews ranged from 45 minutes to 2 hours and were semi-structured. Exemplary rehabilitation counselors were asked to tell their stories of successful and unsuccessful case files (Boyatzis, 1982; McClelland, 1977, 1978), plus a case of their choice. These broad questions were asked to learn the insider's perspective on best practice and how successful case outcomes were achieved. Interviews were conducted in the counselor's office or a mutually convenient location. A tape recorder was used to record the interviews, and field notes were taken during the interviews. Pseudonyms were used to identify the counselor's tape recording and field notes for confidentiality. The interviews occurred over a seven week period (February 24, 1997 to April 13, 1997).

Data Analysis Procedures

Reflection on the interviews of the exemplary rehabilitation counselors occurred following each interview. The entire interview was transcribed, using pseudonyms as identifiers. The transcription system was developed by Gail Jefferson (1973) as adapted by Jim Schenkein (1978) and Douglas Campbell (1980) (see Appendix J). Half of the transcripts were then reviewed while listening to the tapes to correct for accuracy of the transcription, because several transcriptionists were initially used. The most accurate transcriptionist was selected and she completed 15 of the 20

transcripts. All segments of the transcripts used within the text of this thesis were reviewed while listening to the tapes and corrected for accuracy, if necessary.

Transcription delays prevented review of transcripts during the interview process; however, field notes of the first ten interviews were reviewed to begin developing themes. At the completion of all interviews, each tape was listened to in the order in which the interviews occurred. The taped interviews totaled 25 hours and 14 minutes in length. Notes were taken during this process to assist further in the development of patterns and themes and as a refresher on the interview experience.

QSR NUD*IST 4 software was used to assist in coding and retrieval of data. NUD*IST means Non-numerical Unstructured Data Indexing Searching and Theorizing (Qualitative Solutions and Research Pty Ltd, 1997). Planning for coding began with the completion of the pilot studies. Initially, data was coded and sorted by responses to the semi-structured interview questions. Text was also searched for recurrent key phrases and words. These were highlighted and tallied to assess the consistency of the response.

Bogdan and Biklen's (1992) coding system was used. The pages of the transcribed audiotapes and field notes were numbered chronologically and sequentially in NUD*IST. The data was then thoroughly searched in NUD*IST to develop a preliminary list of patterns and themes to organize data for analysis (Bogdan & Biklen, 1992). Coding required examining the data for words, patterns of behavior, subjective ways of thinking, and repetitious events that stood out (Bogdan & Biklen, 1992). The purpose of categorizing the information was to look for recurring themes

and abstract categories across data (Krahn, et al., 1995). Coding categories allowed the descriptive data to be sorted (Bogdan & Biklen, 1992).

The coding categories included context codes, situational codes, informant perspectives, informants' thoughts about people and objects, activity codes, and strategy codes (Bogdan & Biklen, 1992). Their definitions of these codes and there use with this data are described next. Context codes describe the subject. Descriptive data about the nominee pool was included here. Situational codes allow the informant to define themselves within the setting or topic of interest. Responses to the rehabilitation counselors' background, perceptions of why they are successful, exemplary, and the qualities of the exemplary rehabilitation counselors were addressed in this code. Informant perspectives are codes that define the rules and norms shared by the informants in the setting under study. These evolved into the two sub-themes with the study data: fair and equitable treatment of clients and understanding the limits of their roles and responsibilities. Informants' thoughts about people and objects are codes that describe how the subjects view each other, outsiders, and objects used in their world. This included information on how rehabilitation counselors viewed the receiver of services versus the payer of services. Additionally, it included responses to the research question regarding their behaviors in the client-counselor relationship. Activity codes are codes that identify customary occurrences within the setting. Strategy codes address the approaches or techniques used by informants to accomplish activities. Responses related to the case management process were addressed in these two codes.

When the codes were finalized, the transcripts were divided by categories and reviewed to detect themes (Bogdan & Biklen, 1992). Coding categories allowed for studying ideas and concepts. They helped provide a different way of viewing data to examine the interconnectedness between peoples' beliefs and their actions in successful case outcomes. As data was reviewed, they were reformulated and refined for the final analysis and interpretation (Bogdan & Biklen, 1992) into themes. Inductive reasoning (Singer, 1995) occurred as patterns were recognized and themes constructed (Hagner & Helm, 1994). The theme of professional maturity and the sub-themes of fair and equitable treatment of clients and understanding the limits of their roles and responsibilities are discussed in Chapter 5.

The nominators provided reasons for nominating the exemplary rehabilitation counselors. These reasons were not reviewed until the completion of the analysis, except for those nominations taken by telephone. They were then reviewed to see how they compared to the analysis. The results are reviewed at the end of Chapter 5.

Descriptive statistics were computed on the demographic information collected. Calculations of frequencies and percentages were done. This data included gender, education level, education type, certifications status, and licensure status. Group means and standard deviations were computed for age, work experience, and length. This information provided further description of the nominee pool.

Assumptions and Limitations

Exemplary rehabilitation counselors were nominated by peers, supervisors, and managers. Peer ratings were shown to have high validity in predicting future performance criteria (Lewin & Zwany, 1976) as discussed in Chapter 1. This approach, however, assumed that peers, supervisors and/or managers can accurately appraise the exemplary performance of rehabilitation counselors, as other researchers (Boyatzis & Burruss, 1977; McClelland, Klemp, & Miron, 1977) have indicated in the selection of counselors and managers. However, their research focused only on counselors and managers who received multiple nominations. This research also selected people who did not receive multiple nominations. Rehabilitation counselors nominated by persons outside the rehabilitation firm were selected to address any potential bias this issue might raise. A potential limitation to the nomination process is that the supervisor or manager may nominate the firm's best rehabilitation counselor in terms of financial results for the firm, but this counselor may not be exemplary in the professional sense of the term. However, based on past research this nomination process still seemed to be the best option to access these exemplary counselors.

This study was narrowed in scope by interviewing only exemplary rehabilitation counselors. This approach assumed that a sufficient analysis can be completed without having a comparison group of representative or novice counselors. Most research emphasis in the past has been on the perceptions of representative rehabilitation counselors. Samples included rehabilitation counselors of all skill and

competency levels generally without knowledge of whether they were average or exemplary. Interviewing exemplary rehabilitation counselors assumed that the people nominated are truly exemplary and can provide this perspective on the research questions of interest. It also assumed that interviewing exemplary rehabilitation counselors was an effective method to learn more about their behaviors, the case management process, and how they interpret best practice. Qualitative methodology was used to gain understanding of the perspectives of exemplary rehabilitation counselors through their interpretation of the processes leading to successful case outcome. There was an assumption that the analysis will produce valid results on behaviors, approaches, and practices that lead to successful case outcomes.

Related to this concept, another assumption made was that exemplary rehabilitation counselors would provide an accurate assessment of their work with clients and not provide the socially desirable responses expected of counselors. The length of the interviews, the conversational approach used, and the questions asked ideally provided an environment that would have decreased this effect or shown inconsistencies in responses.

Another limitation to this approach was that it depended on rehabilitation counselors' perception of how client and employer factors influence successful case outcomes. Further, innate characteristics or competencies may not be within the awareness of respondents and if determined may not be teachable in preservice or continuing education; however, they may be useful in the student and employment selection process.

Another limitation to this study was that clients were not consulted to provide their perspective on the work of these exemplary rehabilitation counselors. This would have added additional insight into the exemplary rehabilitation counselors work including similarities and differences in perceptions about the effectiveness of the rehabilitation services provided.

My knowledge and experience of the private rehabilitation field was also a limitation to this research. Although I tried to remain objective in my review of the exemplary rehabilitation counselor responses, it is not realistic to assume that I completely eliminated all potential bias. This could have been reduced further by collaborating with someone who had less familiarity with private rehabilitation.

An additional limitation was not using triangulation in this study. Triangulation is combining methodologies to study the same phenomena (Denzin, 1978a). It provides the researcher with different vantage points to view data (Banister, et al., 1994). Denzin (1978a) suggested that every investigation should use multiple methods to study a phenomenon since no method is free of rival interpretation. This study did not use multiple methods to study phenomena. Multiple methods may have provided support for the interpretations made or suggested rival interpretations.

Reliability and validity are viewed differently in qualitative research. The ability of individual researchers to discover similar phenomena or constructs in the same or similar settings is external reliability (Goetz & LeCompte, 1984a). According to Goetz and LeCompte (1984a), external reliability can be enhanced in qualitative research by the following methods: (a) clarifying the researcher's role and position

within the group; (b) carefully describing the rationale for selecting informants and characterizing the informants who were studied; (c) defining the social context in which data was gathered; (d) specifying the theoretical context and constructs used within the study, including refinements made throughout the research process; and (e) thoroughly describing data collection techniques and the analysis process. Reliability will also be enhanced by tape recording all interviews and supporting conclusions with verbatim accounts of informant conversations (Goetz & LeCompte, 1984a) to document ideas and rationale. These methods were followed in this research; however, there still may be limitations as to whether the information provided is sufficient to answer all the questions of a subsequent researcher.

According to Eisenhart and Howe (1992) validity is "the trustworthiness of inferences that were drawn from the data" (p. 644). Maxwell (1992) further stated that validity relates to the conclusions "in a particular context for a particular purpose" (p.284) He also said that it is relative to the perspective of the community of inquirers upon which the account is based.

Maxwell (1992) described descriptive validity as the factual accuracy of the data. In this study, all interviews were recorded and transcribed in their entirety to address this concern. To insure the accuracy of the text quoted in this thesis, the typed transcript was checked against the tapes to correct any errors of the transcriptionist. Additionally, when phenomena were described, simple counts were used to provide a more accurate account of the phenomena being described. It could be argued that the text is not completely accurate since some words in the tapes could not be understood

and transcribed. Additionally, some comments by the respondents were paraphrased, which could possibly reduce descriptive validity.

Maxwell (1992) defined interpretive validity as focusing on what "objects, events, and behaviors mean to the people engaged with them" (p. 288). Meaning includes "intention, cognition, affect, belief, evaluation and anything else that could be encompassed" (p. 288) in the "participants' perspective". Capturing the participants' perspective is the focus of the researcher rather than what the researcher thinks. The described accounts of the participants are based on their language and rely on their words and actions. This has been accomplished in this study by using direct quotes from the participants and allowing their words to assist in the interpretation. Additionally, assertions and counter assertions were presented to provide a broader interpretation. Since these accounts were constructed by this researcher, there may be limitations in how the participants' perspective were captured. Other limitations to theoretical validity relate to the participants' own lack of unawareness about their own feelings or views, recalling events incorrectly, or consciously or unconsciously distorting or concealing their views (Maxwell, 1992).

Theoretical validity "refers to an account's validity as a theory of some phenomena" (Maxwell, 1992, p. 291). There were also limitations in theoretical validity, since this study did not address constructing a theory either brought to the study or developed from the study.

Maxwell (1992) describes generalizability as examining whether the research can be applied to persons, times, or settings other than those studied. Internal

generalizability looks at extending the accounts to others within the same community, i.e., to persons not directly interviewed. These results may extend to the rehabilitation counselors that were nominated as exemplary but not interviewed, because these exemplary rehabilitation counselors are more likely to be exposed to the shared perspectives of the exemplary rehabilitation interviewed than persons outside the State of Michigan.

Interviewing only exemplary rehabilitation counselors in Michigan may decrease generalizability as each state has different workers' compensation and auto no-fault laws that may influence rehabilitation counselors' actions with injured workers. Information from this study may generalize to states with similar workers' compensation and auto no-fault laws, although caution should be used due to the small sample size. Some of the results may be applicable to private rehabilitation counselors handling Social Security and Federal Workers' Compensation casework, although these cases were mentioned much less frequently.

Many private rehabilitation firms are national and some have offices in Michigan. There are also national private rehabilitation associations such as the National Association of Rehabilitation Professionals in the Private Sector and the National Association of Service Providers in Private Rehabilitation. This would lend support that there is some consistency among private rehabilitation service provisions in different states, thus improving generalizability.

External generalizability extends the account to others outside the community studied (Maxwell, 1992). Claims of external generalizability are rarely made by

qualitative researchers and will not be made in this study.

Chapter 4

Characteristics of the Nominees

Of the 20 people selected for the sample of exemplary rehabilitation counselors, 11 (52%) were males and 9 (48%) were females. They ranged in age from 36 to 56, with a mean age of 46.35 and a standard deviation of 5.55 years. Twelve (60%) held master's degrees in rehabilitation counseling, 6 (30%) in counseling, and 2 (10%) other, student personnel and social work. One of these rehabilitation counselors also held a doctorate. Eighteen (90%) maintained at least one certification. One rehabilitation counselor's certification had recently lapsed, but this nominee intended to renew the certification. Fifteen (75%) were Certified Rehabilitation Counselors, four (20%) were Certified Disability Management Specialists, seven (35%) were Certified Case Managers, 4 (20%) were Certified Social Workers, and one (5%) was a National Certified Counselor. Eight (40%) held multiple certifications. All reported being Licensed Professional Counselors (LPC) in Michigan.

The length of rehabilitation work experience among exemplary rehabilitation counselors ranged from seven to 29.5 years with a mean of 17.92 years and a standard deviation of 6.00 years. Their years as private rehabilitation practitioners ranged from 1.5 to 21 years with a mean of 12.43 years and a standard deviation of 5.44 years.

All the exemplary rehabilitation counselors interviewed had a master's degree 12

in rehabilitation counseling. Ninety percent held some form of certification. Tarvydas and Leahy (1993) also suggested the CRC credential could designate Licensed Professional Counselors with expertise in working with persons with disabilities. Seventy-five percent held the CRC. The CDMS (20%) and CCM (35%) certifications also indicate knowledge of persons with disabilities. The exemplary rehabilitation counselors met the education and credentialing requirements suggested by the profession to assist clients with recognizing quality rehabilitation services (Leahy & Holt, 1993).

Although using credentials to define exemplary rehabilitation counselors has not been consistently empirically supported within the profession, credentials are used in third party payer guidelines to define the service providers who are qualified to handle case files. Generally, the CRC or CDMS certifications and counselor licensure are recognized within the industry as designating that a professional has met the accepted professional standards (Lynch et al., 1992). In 1993 the CCM was added to this list of acceptable credentials in private rehabilitation. Thomas (1993) questioned whether credentialed professionals have competence that is superior to professionals who are not credentialed. Yet, all of the counselors who were nominated as exemplary possessed the qualifications required for credentialing as a professional rehabilitation counselor. It seems reasonable to assume the success of these exemplary rehabilitation counselors can be attributed, at least in part, to the education and work experience necessary to become credentialed. Although information regarding the success rate of the exemplary rehabilitation counselors was not obtained, the education

level of these rehabilitation counselors parallels that of the state-federal rehabilitation counselors who had successful case outcomes that was discussed earlier (Cook & Bolton, 1992; Szymanski, 1991; Szymanski & Danek, 1992; Szymanski & Parker, 1989).

The studies by Szymanski (1991) and Szymanski and Parker (1989) found that experience moderated the relationship between counselor education and successful case closure. Rehabilitation counselors with a master's degree in rehabilitation counseling or a related counseling areas had higher successful case closure rates for persons with severe disabilities than did persons with an unrelated bachelor's and master's degree (Szymanski, 1991; Szymanski & Parker, 1989). The range of rehabilitation work experience of the exemplary private rehabilitation counselors in this study exceeded that of the state-federal rehabilitation counselors in the Szymanski studies. Within state-federal rehabilitation, the experience level for people with a master's degree in rehabilitation counseling ranged from 1 to 14 years (Szymanski, 1991). In this study, the experience level for private rehabilitation counselors with comparable education ranged from 6 to 20 years. In Szymanski's (1991) study, counselors with a related masters degree had rehabilitation work experience ranging from 1 to 13.53 years. In this study, counselors with comparable education had rehabilitation work experience ranging from 1.5 to 21 years.

If the results of these prior studies (Cook & Bolton, 1992; Szymanski, 1991; Szymanski & Danek, 1992; Szymanski & Parker, 1989) hold true for this study, the exemplary rehabilitation counselors may have been nominated in part due to their

relatively greater rate of successful outcomes. This can only be supported if it was addressed by the nominators in their nomination statement of why the rehabilitation counselor was considered exemplary. This will be addressed later when the characteristics of exemplary rehabilitation counselors as defined by the nominators are described.

Perspectives of the Private Rehabilitation Counselor

Introduction

I will begin with a discussion of my own reactions to the interview experience once the final list of nominees were obtained, then proceed with a discussion of the responses of the exemplary rehabilitation counselors to the broad interview questions. During the past 18 years I have worked as a rehabilitation counselor, primarily in the private sector. I had encountered some of these exemplary rehabilitation counselors through interactions in the course of my employment and through professional association conferences. When the list of final nominees was obtained, I was concerned about my capacity to be objective in interviewing rehabilitation counselors with whom I had knowledge and association. To address my own objectivity, I tried to be consistent by asking each person similar broad interview questions followed by appropriate probes. I went into each interview with an open-mind, interested in the perspective of the exemplary rehabilitation counselor. Although these techniques helped reduce potential bias, they did not eliminate all potential bias. Each tape and its transcript were given a respondent number to assure confidentiality for the

respondents and to assist in my own objectivity. However, I recalled the first and last few respondents and could recall comments from certain other respondents. Therefore, all data were sorted by responses to interview and research questions which allowed for all responses to one question to be considered in determining major themes. Using this approach it was easy to discern that the exemplary rehabilitation counselors expressed similar beliefs and values and that they were compassionate people. These findings will be illustrated in the analysis.

Beyond their similar personal qualities and contrary to what had been anticipated prior to the initiation of the research, this review uncovered a lack of consistency in the responses of the exemplary rehabilitation counselors. In part, this variation may have resulted from the methodology. Because of the limited number of rehabilitation counselors interviewed in this study and the semi-structured nature of the interview questions, not all rehabilitation counselors responded with the same thoroughness to each question. Some rehabilitation counselors did not answer the question, while others had more depth to their answers. The rehabilitation counselors lack of a response cannot be interpreted to mean that they do not support the responses of other rehabilitation counselors, only that they did not address that aspect of the question or did not give it the same significance as another rehabilitation counselor, which is important information to help in understanding their perspective.

But, the rehabilitation counselors' responses also relate to the individuality of casework. As one respondent said, "we don't have any real standard way that we treat each case. . . . . We look at each case individually, and we create ah, a strategy

or a plan for each case. . . . There's a whole menu of things that we can do, we just sort of pick off the menu" (Erin: 666-672). The rehabilitation counselor makes selections from the "menu" of medical and vocational options depending on the client's needs. Thus, there is no standard response to these questions. The response may depend on the clients they were thinking about as they responded to the question or the influence of recent events in the rehabilitation counselors' lives that may impact how they interpret the question.

All transcripts were reviewed to address the research questions. This analysis will begin with a review of the research questions, initially describing the development of the client-counselor relationship, which was emphasized by many of the exemplary rehabilitation counselors. The discussion proceeds to critical points and the behaviors, approaches and practices of these rehabilitation counselors as described from receipt of referral to facilitating return to work with the same employer or a new employer. As the review of the transcripts continued, themes emerged which are discussed in Chapter 5.

Process in a rehabilitation counseling session refers to what happens during the client-counselor interaction. It incorporates the rehabilitation counselor's and client's behaviors that may be overt or covert (Hill & Corbett, 1993). The interviewing that occurred during this study allowed this researcher to learn more about the covert behaviors of the rehabilitation counselors interviewed. The interviews provided insight into the thoughts, internal reactions, and experiences as the rehabilitation counselors described cases to answer questions related to specific components of the

case management process. For example, Peter described a client's thoughts prior to and following an injury at work and how he perceives the role of the rehabilitation counselor.

Peter: One of the ironies of life, in the workers comp rehab business, is that the day before the client was injured, in {MANY MANY} cases, that client is consistently been in a position where they are thinking {about} telling their boss to shove it=
I: [Uhuh.
Peter: =and go elsewhere.

I: Uhuh.

Peter: The day after the injury comes, they now perceive themselves as having no value anywhere. One {DOES} not make that quantum leap= [
I: No.
Peter: =overtly, unless something else is going on= [
I: Okay.
Peter: ={and} you have to break down those fears to help those clients see that they may not be able to stand as long as they used to, but they have the necessary skills, and talents, and desires and they can be effectuated = [
I: Right.
Peter: =with some modifications. (Peter: 452-476)

Not all rehabilitation counselors would agree with lines 1 - 7 about how the client perceives his or her job. Only one other rehabilitation counselor used this type of example. However, research by Habeck et al. (1989) indicated workers' compensation claims were more prevalent at employers with higher turnover rates, absenteeism, and grievances, although only turnover rate was statistically significant. These factors were generally assumed to indicate signs of "dissatisfaction among the work force" (p.16).

Lines 9 - 22 might receive more support from rehabilitation counselors. Lynch (1979) and others have concluded that an injury or illness can affect a person's physical, psychological, social, emotional, financial stability and well-being. These can present barriers to return to work for some clients. The issues and the fears must be assessed by the rehabilitation counselor and resolved if a successful resolution to the case is to occur. This occurs in some cases, but not in others, as will be discussed.

To explore the exemplary rehabilitation counselors experiences, we will begin with the area they stressed as important, developing a relationship with the client. This will also address the research question, "How do exemplary rehabilitation counselors describe behaviors associated with the client-counselor relationship that facilitate successful case outcomes?"

Client-Counselor Relationships

The first research question addressed the client-counselor relationship. These exemplary rehabilitation counselors believe in the importance of developing a relationship with their clients to facilitate successful case outcomes. Comments by the exemplary rehabilitation counselors in response to the interview questions generally lend support to prior research on "necessary and sufficient conditions" of counseling for client change (Lambert & Bergin, 1994). Although, they did not always use the terms empathy, warmth (unconditional positive regard), and genuineness (Rogers, 1957), half the rehabilitation counselors described the need and importance of

establishing trust and rapport with clients at the onset of the counseling relationship and throughout the process, as illustrated by this transcript text. "No client time is lost time . . . {you're} either establishing a relationship and trust or you're moving them [the client] along a continuum of adjustment and looking at the future" (Jared: 1039-1044). These conditions for counseling were essential to help the client feel comfortable sharing medical and vocational issues and expressing anger and their fears about returning to work and reinjury. The rehabilitation counselors' concern was whether the relationship with their client was sufficiently effective to implement change that could result in successful case resolution. This would support previous research that suggests client gain occurs when the therapist can relate well with the client (Lambert & Bergin, 1994). This lends further support that the counselors agreed with the importance of creating a therapeutic relationship with the client (Garfield & Bergin, 1994).

Creating hope has been another common factor accounting for positive change in therapeutic relationships (Garfield & Bergin, 1994). The exemplary rehabilitation counselors provided hope when they described providing their clients with information about the rehabilitation process and how to traverse through the insurance benefit system:

> I start off by educating them a little bit on the system, and I tell them what my goals are, {what} I'm interested in happening . . . . I want to get everything up front, out on the table, cause I want to establish a counseling relationship . . . trust . . . that's the only thing that's ever been proven to be a high indicator of

> success in counseling in general. . . . I establish that with most of my clients not all of them, and I think that's the secret to success in rehab I really do. Developing that trusting counseling {relationship}. They say things to me in confidence that I never repeat. . . . there's some things that I let them know that they shouldn't tell me . . . you've got to set the parameters on what's okay and {isn't} okay. (Jared: 808-854)

Jared discussed the importance of developing honesty and trust in a counseling relationship, as well as setting the parameters of the relationship. He indicated he is abreast of counseling research on the importance of establishing a trusting relationship. He was honest in indicating that he is not able to establish a trusting relationship with all of his clients. Although he discussed telling the client his goals and what he's interested in having occur in the case, in another portion of the transcript Jared described his desire to see that clients "get a fair shot," that clients receive sufficient information to make a decision about their own goals for rehabilitation even if they differ from what Jared sees as the clients' goals.

The exemplary rehabilitation counselors also provided information to the client which helped the client solve problems and may help decrease symptoms and enhance interpersonal functioning (Lambert & Cattani-Thompson, 1996). For example, several rehabilitation counselors commented that they believed in their clients:

> one rehabilitation counselor attributed his client's success to the fact that he was trying to convey the belief that I had in him . . . [I] built the importance of [the client] sticking with it [the training program] because all that you can do is

what you can do and that as long as he knew that, then he didn't have to {live up to} anybody else and just let{ting} him know I was there to help {(things?)}, however, {way I could}. (Claude: 436-50)

He provided his client with the support and encouragement the client needed to stay in his training program and was willing to help the client resolve any problem that arose. The rehabilitation counselor's only expectation of the client was that he do his best in training.

Another rehabilitation counselor pretended to believe in her client. This belief in the client could be interpreted as providing the client with the hope necessary to be successful in their rehabilitation program. Dawn described how this belief helped her worst client become her best success: "I pretended I believed in him, and I think that did help him a lot; I mean obviously he thought of me as an advisor, and he kept coming back" (Dawn: 325-30). Dawn gave the client homework assignments to assess his commitment to a self-employment venture. The client in turn used Dawn's expertise to solve problems encountered in achieving this rehabilitation goal.

Dawn felt she learned from this client to always believe in people. Now I believe whatever anybody says, but I check out everything everybody says by making phone calls, verifying employment, verifying experience. I don't assume that somebody has done something because they told me "I did it". (Dawn: 361-379).

Her belief in clients evolved from her experience with this client achieving his goal of self employment. The verification evolved from an experience with her worst client who was not honest with her about his past experiences. The above text shows

how Dawn's experience with a second client added a new dimension to how she now interprets this trust belief in her clients.

Helping clients cope

The interviews also supported common factors that may account for positive changes in the counseling relationship, including an opportunity for emotional release. The role of private rehabilitation counselors is often viewed as adversarial (Matkin & May, 1981). This is because clients are referred to rehabilitation counselors typically by third party payers, as opposed to seeking services on their own. In this role, the rehabilitation counselor can be the recipient of much of the displaced anger and hurt experienced by clients in the injury and claims process. The clients' ability to display these feelings provides an opportunity for emotional release which is another common factor associated with positive changes in therapy (Garfield & Bergin, 1994).

One specific question asked of rehabilitation counselors was "How do you assist clients who are grieving the loss of their injury and the job?" Half the rehabilitation counselors commented that they listened while clients vented their anger and frustration with their injury, the employer, and the insurance carrier. Although listening was not stated by the other rehabilitation counselors, it was implied in their comments about their work with clients. Almost half the rehabilitation counselors described using a dual process of initially listening to the client but then focusing on needed vocational rehabilitation services. Approximately one-third of the rehabilitation counselors stated they would refer clients for therapeutic intervention if

the client experienced anger and depression beyond their expertise.

Barry gave an opposing view with regard to helping clients grieve the loss caused by their injury:

> I'm probably not the most sympathetic person in the world in these kinds of situations . . . I'm more [into] reality therapy {kind of} stuff . . . [the injury is] bad, and we know it's bad but you know what, there's nothing we can do about that . . . now let's focus on the positive. (Barry: 4012-4027)

Barry recognized that neither sympathy nor empathy are his strengths when it comes to helping a client with his or her adjustment to disability. He said he would refer a client for psychological services, if warranted. His focus is on moving the client forward in the rehabilitation process toward their goals. And, yet, when Barry described a client with cognitive difficulties who needed his support in problem resolution, he asked that the insurance carrier not close the client's case file due to an increased likelihood of medical complications. So even though Barry may not be sympathetic, he sees himself as a facilitator and wants to be certain that his clients' basic needs are met.

In lines 1 - 19 Peter helped a client cope with his injury by helping the client reframe his situation to understand the benefit to insurance coverage:

1 Peter: I have found that the best source of helping anybody who is (.2) injured in
2 a work accident, or a compensatory accident.

3 I: Uhuh.

4 Peter: Is {pointing} out the {FACT} that that accident could have occurred
5 independent of those two {f}actors. Put things in perspective=
[

I: Okay.
Peter: =He could have been on a roof, repairing his shingle and fallen and ruptured those two discs.

I: Right.

Peter: And he would have to live off {his savings}.

I: Uhuh.

Peter: The fact of the matter is, he has a system that say{s} we will assist you in your physical recovery, your emotional recovery, in getting back to work, and pay you (.2) a percentage of your earnings while this is occurring. Is of itself, is a significant, unique benefit.

I: Uhuh.

Peter: I always pointed that out. I always said "It could have been worse." And they always say "How could it have been worse? " And I said,"You could have done it to yourself."

I: Yeah.

Peter: And they go OH, YEAH. Clients {like} any {other human being needs} reality.

I: Right.

Peter: Does that make it any better, any easier, any less painful? No. {Does it} provide for hope=
[
I: Uhuh.

Peter: =That their openly and willingly ready to accept assistance, the answer is unequivocally yes.

I: Right.

Peter: That's the best you can do sometimes. (Peter: 917-1007)

In lines 12 - 15 Peter was addressing the benefit of Michigan Workers' Compensation to clients. The insurance benefit coverage would differ under auto no-

fault or long term disability. Peter felt that reframing the client's circumstances in lines 24 - 27 gave the client hope, so the client was more likely to proceed with rehabilitation and had a chance to move forward with his life.

Rene has her own style to help client's reframe the lifestyle change resulting from the injury:

1 Rene: . . . listening a great deal about that first=
2 I: [Okay.
3 Rene: =Initially. Um, acknowledging {(.)} that it is so,=
4 I: [Okay.
5 Rene: =Um, that one of the things I, I find myself saying to many clients is that
6 you know, I think we all, in this world, tend to think we have a game plan
7 for our lives=
8 I: [Uhuh
9 Rene: =Even if it's not written, or formal, but somewhere in the back of our
10 mind, we figure that we're gonna do this, this, and this, and then we're
11 going to do these other things and ah, that's true with work, it's true with
12 you know, our family, and our friends, and our personal lives, and {(.2)}
13 we've never predicted this sudden turn of events=
14 I: [Uhuh.
15 Rene: =And so it kind of throws a monkey wrench so to speak, into the game
16 plan. So, I basically (.3) restate back to them . . . that they're just
17 shell-shocked.

18 I: Uhuh

19 Rene: About something they were not prepared to have happen in their lives.
20 And, so we do talk about that. And, um, the fact that what they call loss, I
21 try to help them later see as change.

22 I: Okay

23 Rene: It is loss, of course, but that we need to make the paradigm shift from
24 loss, which is a negative=
25 I: [Uhuh.

26 Rene: =connotation, to change, which certainly can be a positive one.

27 I: Okay.

28 Rene: Or at least a different course than what they're, ah, what they thought they
29 were on before. (.5) And we revisit it as needed, if it comes up again.
30 Although, to be honest, um, once we get involved, in either vocational
31 exploration, job placement, training, whatever avenue we're pursuing, um,
32 if they still are periodically burning it up, I try to um, ah, divert that=
[
33 I: Okay
34 Rene: =to something which is productive meaningful activity. Um, it isn't that I
35 don't listen anymore, but I'm not sure after a certain point that it's to their
36 benefit to keep rehashing it.

37 I: Okay.

38 Rene: And I explain to them that at some point, if I need to, that that keeps us
39 spinning our wheels, if we only simply talk about what happened, as
40 opposed to what we can do to change things for the future.

(Rene: 2432-2510)

Rene helps clients grieve by listening as stated in line 1. She then talks with the client about their expectations prior to the injury in lines 6 - 19. This emphasis on the sudden change in life events is one aspect of injury that makes it more difficult to cope, according to Matkin (1983b). In lines 20 - 29, Rene, like Peter, helped this client reframe his or her focus from the injury and its negative effects on the client's life to the changes or opportunities now open to the client. Rene also tried to get the client moving forward in his or her life, as opposed to remaining stationary, in lines 29 - 40. Finally, Tim followed a line of thinking similar to Peter and Rene to help clients cope with the loss resulting from an injury:

1 Tim: Well, the injury part, . . . I don't really try to deal with the acceptance
2 of the injury, {ah} many of them have accepted the fact that things are the
3 way they are, they don't like it, and they're angry about it, but I, I try to
4 tell [the client] . . . that in life, there are just certain things that you just

5 can't change.

6 I: Right.

7 Tim: And that if my job with you is to try to, to do something different, and to
8 make it a better set of circumstances, I have a philosophy I tell clients, my
9 philosophy is ah, in life you do not solve problems, you exchange them,
10 and you hope like hell the exchange value is better. (Tim: 1135-1149)

Tim's style of reframing the client's circumstances is different from that of Peter and Rene; however, all three discussed with their clients the changes evident in their lives following an injury. They all try to help the client find positive outcomes from what some would perceive as a negative situation. The end result is to help the client cope with the current situation so that the client can move forward with his or her life.

The exemplary rehabilitation counselors followed the recommendations of prior counseling research. They attempted to establish the necessary and sufficient conditions for counseling (Lambert & Bergin, 1994; Rogers, 1957), worked to develop a therapeutic relationship with clients, created hope, and provided clients with opportunities for emotional release (Garfield & Bergin, 1994). Additionally, the exemplary rehabilitation counselors provided information to clients to help them solve problems, decrease symptoms, and enhance interpersonal functioning (Lambert & Cattani-Thompson, 1996).

The Case Management Process

The second research question addresses the case management process and critical points in that process that influence successful case outcomes. "How do exemplary

rehabilitation counselors describe the case management process and critical points that lead to successful case outcomes?" I will begin by discussing the rehabilitation counselors' responses to broad interview questions which provide a review of their day to day activities. Included will be examples of how these rehabilitation counselors handled critical points in the rehabilitation process.

Typical day

The rehabilitation counselors were asked to walk me through a typical day. Most of the rehabilitation counselors implied that there is no typical day in private rehabilitation. As one rehabilitation counselor said, "The only thing typical about my day is that it's not typical" (Rene: 106-107). They spend their day in the office either completing telephone calls, writing reports, or meeting with clients. When they are travelling to appointments ("on the road") they average two to four appointments per day. These include appointments with clients, employers, physicians, and other members of the client's treatment team.

With regard to prioritizing their casework, 30% commented that they schedule client services according to the client's rehabilitation needs, customer guidelines, and the policy of the rehabilitation counseling firm with whom they are employed. Thirty percent also emphasized time management was the key to prioritizing casework. One rehabilitation counselor indicated that there is a natural priority to casework and that work on the files generates more work that needs to be done to resolve the case file.

Referral

Rehabilitation counselors were asked how they contact clients following receipt of a new referral. Not all rehabilitation counselors addressed this question in the same way. Three indicated that insurance companies frequently send a letter to the client informing the client that they will soon be contacted by a rehabilitation counselor. Four rehabilitation counselors indicated they send out the initial letter to clients indicating they have been referred for services. Three other rehabilitation counselors stated they call to schedule appointments. It is clear there is no consensus on how exemplary rehabilitation counselors make initial client contacts. However, once the initial contact has been made, 75% of the rehabilitation counselors described how they explained to clients the purpose of the referral and provided education regarding the objectives of rehabilitation. Twenty-five percent discussed establishing rapport during the initial interview, while 25% emphasized the importance of establishing rapport and/or a relationship with the client during their rehabilitation.

Two rehabilitation counselors commented that they never read a client's case file prior to the initial interview. Their rationale is that it might bias them during the interview, and it would allow them to confirm client data following the initial interview. One rehabilitation counselor said she had the client write out his or her work history prior to the initial interview. This allows her to focus on issues of concern to the client during the initial interview and gives the client time to recall dates and places of employment prior to their initial meeting. This rehabilitation counselor also uses the information to assess preliminarily the client's writing ability.

Two rehabilitation counselors talked about giving clients ideas during the initial interview. The purpose is to give the client an idea to think about until the next appointment or to give helpful information in return for the information the client has just given the rehabilitation counselor during the initial interview.

1 Erin: =. . . usually the first time I actually meet with a client, I try to give
2 them a little something before I leave, and usually their first meeting
3 you're trying to establish rapport, but you're also gathering information,
4 and you're asking them lots of questions, and I try to give them something
5 before I walk out the door, something that will, if they never met me
6 again, they would feel at least that they didn't just sit there and give me
7 something=
[
8 I: Uhuh.

9 Erin: =that I gave them something in return

10: I: like what?

11 Erin: An idea about maybe . . . a class or if it's an idea about Community
12 Service that might be available, um, anything, any kind of resource that
13 maybe I think might be helpful for them. (Erin: 680-696)

Besides mentioning the need to establish rapport with a client in line 3, Erin talked about her need to give the clients a resource that may be helpful in their life. In lines 3 - 7 she mentioned wanting the client to see the rehabilitation counseling relationship as an opportunity to exchange information in a give and take relationship. This prevents the relationship from being perceived as one-sided by the client.

Return to work with the same employer

Another broad interview question asked the exemplary rehabilitation counselors to describe how they coordinate a return to work with the same employer. One issue

discussed by 15% of the rehabilitation counselors was the need to contact the former employer in conjunction with the initial evaluation of the client. One rehabilitation counselor commented that the employer is often not contacted because the rehabilitation counselor is clarifying the client's medical status. However, the point was made that an employer's perception of a job is different from that of a rehabilitation counselor. Rehabilitation counselors analyze jobs, examining the physical, mental, and environmental demands of the job. If a rehabilitation counselor can visit the job site, it allows completion of a job analysis, thoroughly assessing creative job possibilities for the client, and learning the culture of the employer. Another commented that she recontacts the employer every six months during a client's medical recovery to assess whether changes have occurred at the job site that might now allow her client to return to work.

Much of the discussion on returning clients to work with their former employer focused on how the rehabilitation counselor interacts with the employer and the physician. Fifteen percent of the rehabilitation counselors talked about cultivating a relationship with the employer. Forty percent discussed the need to educate the employer regarding such things as the needs of the client in their return to work, the client's disability, and the client's capabilities as opposed to limitations. Sixty percent mentioned the need to complete a job analysis of the job at the time of injury or of a new position. Forty-five percent then suggested either sending the job analysis to the treating physician or meeting with the treating physician to review the results of the job analysis. An additional five percent recommended establishing a client's physical

capabilities.

Other suggestions to facilitate a return to work with the former employer included having the client contact the employer to state their interest in returning to work, keeping the client in the employer's view via an on the job training program, participating in a work experience program, or engaging in job shadowing. One rehabilitation counselor kept the client in the employer's thoughts through telephone contacts with the employer to update the employer on the client's status. One rehabilitation counselor suggested reviewing employer issues and concerns with the client to help the client better understand the employer's needs.

One rehabilitation counselor described facilitating a return to work with the former employer by emphasizing to the client that it was "his or her physician" who approved the job analysis and released the client to return to work. In addition, this rehabilitation counselor scheduled a return to work interview with himself, the client, and the employer to address any issues or concerns that might impact on a successful transition back to work. Another rehabilitation counselor went on the work site with his client to address any issues of concern to the client. This allowed the counselor's client the opportunity to discuss all the problems she was experiencing on the job. The issues of concern to the client were then resolved, and the client successfully maintained employment. He commented that many employers and their staff are frightened about a client returning to work and inadvertently sabotage that return by standing around watching the client, thus making the client uncomfortable and more self-conscious about mistakes and his or her injury. This inadvertent sabotage by an

employer has been documented by Shrey and Olsheski (1992). The exemplary rehabilitation counselors recognized the value of being in direct contact with the employer to facilitate the return to work of their client at the worksite.

Employer characteristics

The rehabilitation counselors were asked to describe characteristics of employers who were more likely to return injured workers to work. Forty-five percent described humanitarian characteristics of employers such as valuing employees, being open-minded and receptive, or having a commitment to assisting clients to return to work. Fifty percent of the rehabilitation counselors indicated business issues influenced an employer's willingness to assist clients in returning to work. These included an understanding of workers' compensation, saving money, knowledge of the American with Disabilities Act, and having an established return to work protocol. Fifteen percent commented that employers who returned clients to work have knowledge of disabilities. There was overlap in the responses of these rehabilitation counselors regarding the characteristics of employers who were more likely to return injured workers to work.

There were employee characteristics that these rehabilitation counselors felt influenced whether an employer would take the client back to work. These included length of time with the former employer, whether they were a good employee, and whether the employer's personnel record supported a client's positive work record.

The rehabilitation counselors commented that employers are less likely to return

people with disabilities back to work if they blame the client for the injury or if they feel other employees within the plant have objections to the person with an injury returning to work. Additionally, injured workers were less likely to return to work if the employer had used poor judgement in maintaining the employee whose performance had declined prior to the occurrence of the injury.

Formal vocational assessment

The rehabilitation counselors also described their use of interest and achievement tests with clients. Sixty percent do not use these tests frequently. These rehabilitation counselors indicated they administered testing when a client was unable to return to work with their former employer and when a new job was being pursued. Ten percent of the rehabilitation counselors test most of their clients. Only ten percent commented that they refer out for a vocational test battery on a regular basis. Twenty percent stated they refer clients out for testing when their clients have multiple or severe disabling conditions such as closed head injuries. A client may also be referred for vocational testing if training is being considered or when the rehabilitation counselor needs to clarify the client's profile.

According to one rehabilitation counselor, referring out for a vocational test battery allows the rehabilitation counselor to remain a neutral party when there is a conflict between the client's desire for training and the insurance carrier's desire to fund training. This method helps maintain the client-counselor relationship and the relationship with the customer. If the client does well the payer can be approached

about funding the training. If not, the client at least has suggestions of other vocational alternatives and does not feel he or she was "set up" for failure by the rehabilitation counselor or insurance carrier.

The type of testing used also varied by rehabilitation counselor. There were frequent overlaps in the types of tests given to clients. Thirty-five percent administered achievement tests to their clients, and five percent administered aptitude tests. One rehabilitation counselor referred out for either aptitude or achievement test. Forty percent of the rehabilitation counselors administered interest tests to their clients.

Vocational testing was not always seen as a solution to a problem. In one case, with the help of the training program the client had attended prior to his injury, Erin created an examination to test the knowledge the client had retained from training prior to the injury. This resulted in the client receiving a job paying more than his pre-injury wage and provided him with an excellent career path. Creativity and maximizing the use of community resources was also seen as a mechanism that could result in a successful outcome for a client, as illustrated by Erin:

1 Erin: . . . creativity is real important, . . . that evaluation, that assessment is
2 critical, and that you can't just rely on {what's} the standard out there you
3 know, your typical paper/pencil test=
[
4 I: Uhuh.
5 Erin: =there's a hundred things that you just learn in school, and you're dealing
6 with real people here, and you've gotta take a look at it, and you've got to
7 try to problem solve in different ways and be creative and um, (.4) and
8 that, it's not, it's not just good enough to, to give the person services to get
9 them to the ah, status that they were at prior to the injury, but if you have
10 an opportunity to get them beyond that=
[

11 I: Uhuh.
12 Erin: =You've got to take a look at doing that, even though you're in the private
13 sector=
[
14 I: Okay.
15 Erin: =and, by, by the laws that we're practicing within, you don't have to do
16 that=
[
17 I: Right.

18 Erin: =But if you can still do that you should.
.
.
.

22 Erin: Yeah, basically same cost perimeters but I was able, because we were
23 creative . . . I was able to do, do much more with her. (Erin: 917-1007)

Erin feels it is important to be creative and look at all possibilities for clients, as illustrated in lines 1 - 7. In addition, in lines 8 - 18 Erin suggested rehabilitation counselors should be aware of the laws and practice within them but not allow the laws to be so constricting that you don't consider all the viable options for the client that would in the end provide them with better employment opportunities.

Vocational evaluations are used to identify a client's aptitudes, interests, and behavioral repertoire (Roessler & Baker, 1992). Eighty percent of the rehabilitation counselors occasionally use vocational evaluations. Only one rehabilitation counselor indicated he never uses vocational evaluations. There are multiple reasons rehabilitation counselors would refer their clients for vocational evaluations. These included behavioral problems, severe disabilities such as closed head injuries, troubled work histories, or difficulty interacting with others. Ten percent use vocational evaluations to provide clients with a structured environment or to assess a client's

stamina over a longer period of time than the interaction with an administrator of a vocational test battery.

One rehabilitation counselor gave an excellent example of how her own skills and abilities, coupled with a vocational evaluation, resulted in a successful case that initially appeared likely to be unsuccessful. Harriet described a client with a severe disability whose original employment outlook was projected as non-competitive. Harriet obtained and reviewed a report from the neuropsychologist. In the report, the neuropsychologist described the client's assets, which had not been evaluated. Harriet took the neuropsychology results and, with the assistance of a vocational evaluation facility, designed a situational assessment that focused on the client's strengths. A work adjustment program was then pursued on site with an employer. Focusing on the client's assets resulted in the client being hired by the employer. Harriet attributed the client's success to the support and feedback the client received from the vocational evaluation facility. She followed up on the client's strengths, even though this was counter to pursuits of the client's treatment team.

Return to work with a new employer

Twenty-five percent of the rehabilitation counselors discussed the need to assist clients who are returning to work with a new employer in the development of job goals. Three mentioned using transferable skills analysis to assist in the development of the job goal. Thirty percent described the need to teach clients how to obtain a job using such skills as cold calls, completing employment applications, interviewing

skills, and completion of a resume. Some used labor market surveys to assess the feasibility of client job goals.

Sixty percent of the rehabilitation counselors indicated they have clients contact employers on their own behalf. One of the 12 rehabilitation counselors specifically stated that because his clients are actively involved in developing their own job goals and had located and maintained employment prior to becoming injured on the job, they can actively seek placement on their own behalf without his assistance. Six of these 12 rehabilitation counselors commented they also provide assistance to these clients in contacting employers. Twenty percent stated that they follow-up with employers after clients interview and after clients return to work. One stated that when he contacts employers on behalf of a client, he tells the employer he is helping his or her client look for a job. He asks the employer to "meet my guy and talk to him, see what you think?" (Ned: 1159-1160). He doesn't ask the employer for a job. When a client interviews with an employer, this rehabilitation counselor follows up with the employer to learn the employer's impressions of the client. This information is then discussed with the client. If the client is not putting forth his or her best effort in the job interview, and this rehabilitation counselor gets the impression the client is not actively seeking employment, the rehabilitation counselor will ask the client, "Why would the employer think you didn't want to work? Maybe you could tell me what gave them that impression" (Ned: 1252). He indicated that he uses this technique to get clients to make decisions regarding their job search efforts.

Fifteen percent of the rehabilitation counselors stated that they would assist clients

with severe disabilities, such as closed head injury, in locating employment. Several rehabilitation counselors commented that they will hire job coaches to assist their clients who have severe disabilities and may need additional support with their transition into the labor market.

Handling conflicts

When the exemplary rehabilitation counselors were asked to describe how they handle conflict, several wanted the term conflict defined. Generally, I described it as disagreements between the client and insurance carrier, client and employer, or rehabilitation counselor and client. Thirty-five percent described conflicts as communication breakdowns where their role is to act as a facilitator or mediator to open up the doors of communication between all parties. Three of the seven that answered focused their response on listening, using communication skills, and having a conference with all involved parties to lay out the issues of concern. Two described the importance of remaining neutral, but being persistent in their work to resolve conflicts. Additionally, three of these rehabilitation counselors described their role as problem-solvers.

Client characteristics

Client characteristics are considered the strongest predictors of outcomes in therapy. If a client does not follow through or use the information learned in therapy, nothing will happen (Bergin & Garfield, 1994; Bergin & Lambert, 1978). The

responses of the rehabilitation counselors interviewed imply agreement with this view.

There were client characteristics that these rehabilitation counselors felt enhanced a client's likelihood for success. They included strong family support and a good marriage. This has been supported in research by Bolton and Rubin (1974). A stable personality also was suggested as enhancing a client's success rate. Clients who actively participated in choosing their vocational goal and who enjoyed what they are doing were also seen as motivated to succeed.

Other clients who succeeded were initially seen as difficult or challenging. These clients may be fighters or may have been victims who decided to take back responsibility or control of their lives. The drive, or fight, seen in these clients relates to internal locus of control. Beck's (1989) research suggested clients with an external locus of control were more likely to have unsuccessful case outcomes. Conversely, those clients with an internal locus of control were more likely to be successful in their rehabilitation programs.

Athelstan and Crewe (1979) addressed adjustment and locus of control in their research on persons with spinal cord injuries. They found persons who were actively involved in the events leading to their injury were better adjusted psychologically, vocationally, and medically than persons with no responsibility at all for their injury. They suggested a person's locus of control may be altered following a major crisis such as a spinal cord injury. Thus, persons with an internal locus of control who are innocent victims may now feel their beliefs were in error, and fate rather than their own behavior controls their destiny. While persons who were actively involved in

their injury and are externally focused could still view the injury as bad luck, but because they realized they caused their disability, they can make decisions and control their own lives. These same views may be experienced by injured workers with comparable circumstances on how an injury occurred.

Critical points in the case management process

Some rehabilitation counselors' descriptions of cases included a critical point in the case management process that might have resulted in a different case outcome had it been handled differently. The challenge in describing the critical points mentioned by these rehabilitation counselors is that they are unique to the client and the situation. For example, Barry moved a client directly from a cognitive retraining program to a job club so the client could not dwell on issues of unemployment. Barry felt using this approach expedited his client's obtaining employment. When the client obtained a job, a job coach was used to provide the client with support so the client would not feel abandoned once employment was obtained. Additionally, Barry maintained close contact with the client and her employer and acted as a mediator when communication issues arose between them.

Other examples of critical points in the case management process included reviewing medical, vocational, and psychological information to be certain that the interventions being provided to the client were appropriate. The exemplary rehabilitation counselor also determined when professional intervention was required to resolve clients' medical, emotional, or behavioral problems. One rehabilitation

counselor stated, "The VALUE of a REHAB counselor isn't necessarily the SPECIFIC things you do as much as the specific people you pick to DO those things" (Matt: 438-442). He emphasizes the importance of locating appropriate resources to provide quality services for clients that will assist in stabilizing their medical condition and ideally facilitate their return to work.

Rehabilitation counselors carefully assess a client's vocational potential. They use creativity to develop appropriate intervention strategies to facilitate successful case resolution. Additionally, cases that on first glance appear non-feasible are not closed following the initial interview. They remain open at least briefly to provide clients with an opportunity to be successful.

During job placement, exemplary rehabilitation counselors are straightforward with employers about their client's physical capabilities. Employers are educated about the benefits to the employer of assisting the client to return to work. Gilbride, and Stensrud (1993) indicated the importance of educating employers regarding the American with Disabilities Act. Additionally, they state the importance of rehabilitation counselors having an accurate understanding of the personnel and disability management needs of the employer. This was mentioned as important by 25% of the exemplary rehabilitation counselors. In the discussion of employer characteristics, it was addressed as the business issues employers consider when returning employees to work.

In summary, the perspectives presented here give an overview of the activities performed by exemplary rehabilitation counselors. The activities are similar to those

of other rehabilitation counselors in the private sector, according to Roessler and Rubin (1992). Roessler and Rubin (1992) focused on the client-counselor relationship and individualizing the case management process for each client. The importance of developing a therapeutic relationship as stressed by the exemplary rehabilitation counselors supports the work of Jaques (1957). The exemplary rehabilitation counselors described the need to be an effective time manager and to be comfortable with change. At the time of the initial evaluation, the client should be informed of the purpose and objectives of rehabilitation. Education was emphasized as important in helping clients choose their own destiny and to help employers understand a client's injury and its impact on work. Listening and effective communication skills are keys to preventing and resolving conflicts with the client and other members of the client's rehabilitation treatment team.

Additionally, Jaques (1957) discussed collaboratively interacting with clients, giving information, and defining limits. She described the need to define the limits within which counseling occurs, including the nature of counseling and the responsibilities of clients and counselors. These activities were described by the exemplary rehabilitation counselors as important aspects of their work. The uniqueness of the emphasis on the client-counselor relationship will be discussed further in Chapter 5 where the themes and sub-themes developed from this research are presented and discussed.

Chapter 5

Reflections on the Findings

Introduction

The descriptions of behavior, approaches, and practices of exemplary rehabilitation counselors must now be interpreted to respond to the final research question. "How do exemplary rehabilitation counselors interpret the behaviors, approaches, and practices they use to return injured workers to work successfully?

I began analyzing the data searching for themes and by reviewing the field notes of the first ten exemplary rehabilitation counselors I had interviewed. During that analysis, several preliminary ideas developed which evolved into the theme of professional maturity. There are two assertions as part of this theme. One is that exemplary rehabilitation counselors have strong beliefs and values about what constitutes fair and equitable treatment of clients. The other assertion is that exemplary rehabilitation counselors understand the limits of their roles and responsibilities, as they relate both to clients and to the payer.

Professional Maturity

Eash (1967) suggested the professional should have a body of knowledge complex enough in its content that the professional's insight should be heard and respected. This insight is usually gained through educational programs. The exemplary

rehabilitation counselors interviewed have specialized knowledge, skills, and expertise based on their educational attainment and credentials. They have insight into their roles and responsibilities as a private rehabilitation counselor.

According to Wright (1980), people who call themselves "professional" state their "primary values lie in providing a needed service to society, rather than in income, power, and prestige" (p.22). This ideal is one a professional would strive to achieve. Further, "the practitioner must be mature and responsible, dedicated to personal growth, and be willing to take risk while exercising discretion" (Wright, 1980, p. 22).

This needed service to society does not, however, address whether these exemplary rehabilitation counselors are focused on the value of service or on income, power, and prestige. Those issues were addressed by the rehabilitation counselors themselves as they gave their perspectives on rehabilitation counseling in the private sector.

Here are the thoughts of one exemplary rehabilitation counselor as he discussed the qualities desired when hiring a rehabilitation counselor. He said rehabilitation counselors need "to truly care about what they're doing we're working with people who are not widgits . . . and to care that they're furthering . . . the . . . human relationship . . . that {we're here} more for service with . . . people than we are in business" (Claude: 1508-15, 1524-27). His focus is more on service to the client as opposed to making an income. It appears he wants the rehabilitation counselors he hires to hold similar beliefs.

Subsequent text will also support these rehabilitation counselors' concerns with

client choice at the risk of losing business and thus income. Their responses as to why they are exemplary and why they are successful demonstrates that power and prestige are not their primary focus in performing their jobs.

Additionally, these professionals are mature based on their knowledge and work experience. They are dedicated to personal growth, as evidenced by the 90% who maintain certification, which requires documentation of continuing education (CRCC, 1993) or retaking the certification examination.

Maturity, according to Super (1974), is defined "as the repertoire of coping behavior leading to outcomes, compared with the behavioral repertoire of the peer group, thus making it a developmental rather than an outcome construct" (p. 11). A related construct which is frequently confused with maturity is adjustment. According to Super (1974), adjustment is the outcome of behavior such as success and satisfaction. Super further states that degree of maturity and adjustment influence each other. For satisfactory outcomes, a correct behavioral repertoire must be developed and past adjustments can facilitate or impede behavioral development suitable to new life stages. I will demonstrate how the exemplary rehabilitation counselors have coped with handling difficult cases by redefining successful outcomes for both themselves and their clients different from the industry standard of return to work. Thus, they have achieved professional maturity. The same exemplary rehabilitation counselor who focuses on service to the client also has thoughts on the importance of maturity when hiring. "Work experience helps with maturation, vocational maturation" (Claude: 1576-79).

This concept of professional maturity is special for this population of rehabilitation counselors because it is counter to what many people expect of practitioners in the field of private rehabilitation. According to Matkin and May (1981), private rehabilitation practitioners work in an environment where they may experience many conflicts of interest. Two related issues frequently discussed are: 1) "Who is the client?" and 2) rehabilitation counselors serve many "masters."

The question regarding "Who is the client?" asks whether it is the referral source/customer or the person with an injury or illness. One shared perspective in rehabilitation counseling is that the person with the disability, the receiver of services, is the primary "client" (Matkin & May, 1981). Within the workers' compensation arena, the terms client and claimant have frequently been used to describe the injured worker. Recently in the field of rehabilitation the person with an injury or illness has been called the consumer. Ninety percent of the rehabilitation counselors interviewed have the shared perspective that "the client" is the person with an injury or illness as opposed to the payer. They have not adopted the term "consumer" used more frequently in public and non-profit rehabilitation settings. The use of the term client relates to the way clients access rehabilitation counseling services. Clients are generally referred to private rehabilitation by a third party payer, employer, or attorney as opposed to choosing to pursue services, which frequently occurs in state-federal rehabilitation. Nor did these rehabilitation counselors tend to use the insurance industry language of "claimant". Only two rehabilitation counselors used that term. The use of the term "client" may relate to the rehabilitation counselors

respect for the person with the injury or illness.

Private rehabilitation counselors are often said to serve many "masters." Serving many masters relates to the idea that rehabilitation counselors are hired by a payer to assist a person with a disability to return to work. They may be under increased pressure from the customer to perform activities that would compromise client welfare and the rehabilitation counselor's professional integrity (Matkin, 1987). In that interaction the rehabilitation counselor will also work with a variety of other professionals and agencies to facilitate medical stability and return to work for his or her client. All of these people have their own priorities which can cause potential conflicts of interest. The rehabilitation counselor must work hard to avoid compromising the client and his or her own professional integrity (Matkin & May, 1981).

Even private rehabilitation counselors are aware of this conflict. One rehabilitation counselor commented, "You very seldom have the luxury of answering to one person" (Susan: 2365-66). Erin elaborated further on this and gave her thoughts on what a rehabilitation counselor's stand should be:

Erin: . . . when you're in the insurance rehab practice you serve, you can feel like you're serving a lot of masters=
[
I: Uhuh.
Erin: =But the most important thing, and the bottom line, is you serve one master, and that's yourself=
[
I: Okay.
Erin: =And you've got to hold onto what you think is right, and there's a lot of, there's a lot of ways of doing that, and still be successful in this field. You don't have to sell your soul to the devil=
[

10 I: Uhuh.
11 Erin: =And you don't also have to go out of business because you can't meet
12 the=
[
13 I: Uhuh.
14 Erin: =Expectations of the insurance industry either=
[
15 I: Uhuh.
16 Erin: = There is a way to do this, as long as you stay true to yourself, and
17 {NEVER, NEVER} waiver from that, it, it can be done, it's, it's not
18 necessarily the easy road, but it's the longer road=
[
19 I: Uhuh.
20 Erin: =You'll stay in the field, and you'll be in it for as long as you want if
21 you do it that way=
[
22 I: Uhuh.
23 Erin: =And you'll be respected for it= (Erin: 1090-1121)

Lines 4 and 5 show Erin addressing the issue of maintaining professional integrity, by suggesting private rehabilitation counselors should remain true to themselves. In line 7, Erin suggested the rehabilitation counselor must remain ethical and in lines 8 - 16 that ethical rehabilitation counselors with professional integrity can survive in this field and be successful,. She comments in lines 17 - 23 "It's not necessarily the easy road," meaning you have to work harder to find customers willing to support your strong ethical standards, but "it's the longer road" in that you'll remain in business longer and be respected for your beliefs and values.

To further elaborate on the professional maturity theme, I will discuss some additional evidence to support the concept of professional maturity. The exemplary rehabilitation counselors received nominations from peers, supervisors, and managers. According to Lewin and Zwany's (1976) review of the peer rating literature, peer ratings have high validity in predicting future performance criteria. Additionally,

other researchers (Boyatzis & Burruss, 1977; McClelland, Klemp, & Miron, 1977) have found this nomination approach useful to distinguish superior from average counselors.

Research suggests that clients gain with a skillful, wise, and stable therapist (Lambert & Bergin, 1994). The experience level of the exemplary rehabilitation counselors indicates stability and that these rehabilitation counselors are skillful enough in their work with clients to stay in business. It is, thus, reasonable to infer they have the knowledge and skills and likely have acquired the wisdom to help clients gain in their rehabilitation program.

As indicated in the beginning of Chapter 4, research has indicated that persons with a master's degree in rehabilitation counseling or a related counseling field have significantly better client outcomes in working with persons with severe disabilities than those with an unrelated master's and bachelor's degree. This greater length of experience positively moderates the relationship (Szymanski, 1991). Ninety percent of the exemplary rehabilitation counselors had achieved this level of education and further, their average years of experience exceeded those of state-federal rehabilitation counselors. Thus, it is anticipated that they would have better client outcomes.

Professional maturity was evidenced in this statement by Ned. Ned described private rehabilitation counseling as a perfect second occupation. As a second occupation, rehabilitation counselors are at a point in their lives where they want to provide a benefit to people and have the maturity to achieve this goal; however, they do not wear their heart on their sleeves. Many stated their own life experiences,

specifically working a variety of jobs before beginning a career in private rehabilitation counseling had helped facilitate their work with client.

This professional maturity is further evidenced by the ability of the exemplary rehabilitation counselors to work independently and to think on their feet. These rehabilitation counselors exhibit a spark or a passion when they talk about their work. They allow themselves not to be perfect and consider themselves more experienced than exemplary.

Treating clients fairly

One sub-theme under the theme professional maturity is that exemplary rehabilitation counselors have strong beliefs and values about what constitutes fair and equitable treatment of clients. Thirty-five percent of the rehabilitation counselors spoke of treating clients fairly. One rehabilitation counselor said "that we can treat people always fairly, . . . and really try and help even though we're dealing with systems" (Claude: 1519-20). The exemplary rehabilitation counselor's use of the term "client" as previously discussed represents respect for the person who is injured and an acknowledgment of the person for whom the services are being provided. I think this is of interest because of the adversarial nature of the job and the expectation that private rehabilitation counselors may be influenced by the profit motive and focus more on customer interest than client interest (Matkin & May, 1981). I found this supported by statements such as "[I] had the courage of my convictions and [went] against pretty much what [the facility] did not particularly feel [the client] should be

doing" (Harriet: 1321-1325). Another rehabilitation counselor indicated she will stand up for what is right regardless of the consequences including the loss of the case and/or customer.

The voices of many of the rehabilitation counselors sounded compassionate when they spoke of both successful and unsuccessful cases. There was a real sense that their clients matter to them: "Just having a true sense of compassion for that person and . . . just very basic things, like treating one with respect and dignity" (Ann: 2360-66).

The exemplary rehabilitation counselors feel they relate well with clients. Forty-five percent of these rehabilitation counselors said "I care," at some point in their interviews, about the clients they work with. Although others may not have used these words, there was a sense that most of them cared about their clients. Corey and Corey (1993) have described the portrait of an effective helper. One of the characteristics is genuinely caring for those whom you help. Caring is demonstrated by doing what is in the client's best interest. This was illustrated by Gayle in lines 1 - 7 of the upcoming transcript. She wants clients to be active participants in the rehabilitation process and to have the knowledge and ability to choose their own destiny, as illustrated in text lines 24 - 34. She would close a case if she felt the payer had expectations outside her value and belief system and the code of ethics under which she practices. This text from Gayle illustrates these points:

1 Gayle: Uh, (.3) I care=
2 I: [Okay.
3 Gayle: =I, I really care what happens to the people that I work with, and um,

I've had this argument with a lot of people, but I really do (.4) start out every file working for that person=
[
I: Okay.
Gayle: =Who has the disability. You know, if you want to say work for somebody=
[
I: Right.
Gayle: = {when}, I walk in, they say, oh, so, you're from the insurance company=
[
I: {Mmhm}.
Gayle: ={No}, No, I'm {not}, I have my business, and it's separate from the insurance company, and there is that you know, notion that yeah, they do pay me=
[
I: Right.
Gayle: =They pay me, so I should do what they want necessarily? And I don't buy that=
[
I: Okay.
Gayle: =You know, I don't just do what the insurance company wants. And there are adjustors who won't use me=
[
I: Okay.
Gayle: =You know, and I don't want to work for them=
[
I: Okay.
Gayle: =So, um, but I do start out every case and I think I keep that profile most of the time, in working for the person, for what would be the best interest for the person. Now, that person and I might disagree on what's in their best interest=
[
I: Okay.
Gayle: =You know, but um, I feel that if the person who has the disability um, {(.3)} gets where, {where} they (.3) can be=
[
I: Uhuh.

Gayle: =So, reaches the potential that they can reach, then {(.)} everybody wins.

I: Okay.

Gayle: So, I fight for resources to help them do that. (Gayle: 2432-2489)

Lines 24 - 35 support Gayle's strong beliefs and values about what is fair and equitable treatment of clients.

As previously discussed, a concern some people have with private rehabilitation is that rehabilitation counselors will do what they are told by the customer at the expense of the client. Gayle illustrated this is not the case for her in lines 16 - 22. As a result some customers will not refer cases to her. Gayle finds this arrangement satisfactory. She has sufficient business that she does not need to handle a case that would compromise her beliefs and values. This was true of other rehabilitation counselors. This is a sign of professional maturity and of confidence in one's abilities.

One rehabilitation counselor did admit she has been "put in the position where they [the insurance carrier] want you to more or less harass the person" (Ann: 2098-2100), which is "really stressful" (Ann: 2103). She has only a few of these cases. Here is another example where further questioning of the rehabilitation counselor may have clarified the circumstances of these cases. These two comments suggest that conflicts of interest exist and are handled differently by different counselors.

Understanding the limits of their roles and responsibilities

Another component of the professional maturity theme among the exemplary rehabilitation counselors was their understanding of the limits of their roles and responsibilities. They recognized that there are rules and regulations in the benefit system from which their clients are receiving services. Half discussed this issue

directly, others comments were more indirect. They also know that creativity, rational explanations, and justifications of recommendations can help their clients receive nontraditional services, which help to make the clients successful according to industry standards.

I think this concept can be developed further in the interpretations these exemplary rehabilitation counselors give to their roles. The rehabilitation counselor needs knowledge about the key players in a client's rehabilitation program. The client is at the center of his or her rehabilitation. Surrounding the client are the other key players in the client's rehabilitation, the employer, insurance carrier and the respective attorneys. The rehabilitation counselor, physician, therapist and other ancillary service providers give support to the client's rehabilitation program, but are more distantly removed from the client (Doug Langham, Personal Communication, 1979). It is critical for rehabilitation counselors to understand the roles of these players and their perspective in the rehabilitation process to be effective in their work with clients, "because someone is going to be offended if you step on their turf" (Larry: 2917-2922). Larry further stated:

> "the SUCCESSFUL REHAB consultant will not be unemployed. Because you BETTER UNDERSTAND how the insurance industry operates, what the role of the claim[s]person, what THEIR objectives are on the file, {not that} you take sides, but you better APPRECIATE and UNDERSTAND what's really going on. I HAVE FOUND adjusters to be, by and large, good to {work with}. . . .Some of them become crusty and cynical, but I've, I've YET to have one refuse, if I go

to them and say 'This is what I want to do, and this why I want to do it', invariably, that's fine" (Larry: 2927-2958).

Larry illustrated the importance of understanding the role of the payer. Additionally, he stated the importance of communicating openly with the adjustor regarding the needs of the client and the rationale for recommending these needs be met.

This is supported by a series of statements from several different rehabilitation counselors, which tell both the story about the role of rehabilitation counselors and their limitations in controlling clients' lives. Fifty-five percent of the rehabilitation counselors discussed clients needing to be responsible for their lives, and 75% discussed their job was to provide clients with choices or options. One rehabilitation counselor commented, that their job is to open doors and opportunities for clients and to eliminate barriers. The client must then decide what to do with these opportunities. Another said, that they need to understand some clients are motivated differently from the goals of the workers' compensation system. Another suggested they can't be responsible for what others do with their lives, and they should not attempt to control their clients.

One rehabilitation counselor said clients made choices in their lives before involvement with rehabilitation and can continue to make choices in their lives unless an injury or illness diminishes this capacity. Sometimes client choice means not accepting a job or deciding not to pursue training. Although these choices may be counter to what the rehabilitation counselor feels is in the client's best interest, the

rehabilitation counselors commented that at least the client had made a decision. Clients are allowed to make the choices that fit within their lives, even if it is not the choice the rehabilitation counselor would have made for the client.

Ann's comments could be interpreted as a counter-assertion to being supportive of a client's decision. She discussed allowing clients to make their own decisions, but described the client's decision not to follow her recommendations as non-cooperation, a term with a negative connotation in the insurance industry. Ann was one of two rehabilitation counselors who discussed a client not cooperating with rehabilitation. Rehabilitation counselors generally described the client's action as choosing not to accept a job, as opposed to using the term non-cooperation.

Ann: . . . if you explain to them that, you know, you're in a system, there are compromises, this is what the insurance company expects, this is my role in it.

I: Okay.

Ann: You know, these are OPTIONS. I'm not judging you for your actions, but these are options that we have to look at, and what you decide, ultimately, is your decision. (Ann: 4587-4595)

.
.
.

Ann: =. . . you're hired to give your recommendations as you go along in time,=

I: [Right.

Ann: =And if that's something they're [the client] not AGREEING with, sometimes, I mean, SOMETIMES I feel like, "No, I'm NOT going to back off the"=

I: [Right.

Ann: ="This is it, and this is what I truly BELIEVE"=

I: [Um, hm.

18 Ann: ="If YOU decide not to cooperate, and this is{n't} the path YOU want to
19 take, then SAY IT NOW, and talk to the insurance company".

(Ann: 4611-4625)

In lines 1 - 7, Ann described the sentiment of other rehabilitation counselors. The client has the right to make his or her own decision. However, in lines 12 - 19 Ann seemed to assert that she knows what is right for the client. When a client chooses not to follow her recommendations, the client's choice is perceived negatively. Ann does, however, remove herself from the interaction by directing the client to the insurance carrier to discuss his or her decision. I should have asked Ann additional questions to clarify her feelings and with what type of client and rehabilitation counselor interactions this may occur.

Peter had a different interpretation of a client not following his suggestions at the time services were rendered. Here the client chose to use the knowledge and skills provided by the rehabilitation counselor after case closure:

> Cause, I think I've never had a client that I was unwilling to assist. Unwilling to provide the appropriate tools to achieve their objective. There is no way in the world that I am that powerful that I can make them use those tools to achieve that goal. . . . I don't believe in changing anybody, cause I don't believe change is the issue, . . . you take the product [client] you have and you assist that product [client] in seeing the options they have, and if they fail to exercise that option, you shake hands, and give them credit for their decision making. . . . . Many times I've bumped into clients later on, and believe it or not, they chose to use those options much later after they met me and they're doing just fine. (Peter:

286-335)

Peter credits the client for making a decision. He sees the information provided to the client as useful information that the client can choose to use when it meets the client's needs.

Additionally, the rehabilitation counselor must also understand the business environment in which private rehabilitation operates. It is a for-profit business, as described by Ingrid when she discussed hiring a new rehabilitation counselor. "It's nice to find people who have an interest in business, who don't have a problem with business and with making a profit, that's important" (Ingrid: 2815-2825).

Tim talked about the intrinsic rewards he receives from his clients, in addition to the financial rewards of the work:

> I was willing to take a risk with them and they believed in me . . . I kind of like that. I mean to me that's what I went into this business for. I mean its a business, don't get me wrong, I mean this is all about money . . . but I . . . take on a number of cases . . . free of charge (Tim: 711-729).

So how do exemplary rehabilitation counselors assist clients in making decisions that will direct them toward their own destiny? They try to get the client to develop his or her own rehabilitation plan:

> My philosophy for all cases is to attempt to ah assist a client in developing their own plan and simply be a support system for the plan that they've chosen. With that sort of approach, {ah} I think there is a greater chance of success because in fact, they own the plan, and the agenda (Rene: 361-74).

They also provide the client with knowledge. They attempt to provide clients with the maximum information available to make good medical and career decisions. This requires taking information about medical, vocational, and insurance issues that is complicated to the client and making it understandable. They teach clients problem-solving and decision-making skills. This gives the client knowledge and thus the power to choose their own destiny. Additionally, these rehabilitation counselors described providing clients with options within the limits of the law, to achieve their short term goals while planning and preparing for the long term goals. Their service was not always effective. They commented that they are dealing with people who are choosing their own destiny. Their choice is not always that of the rehabilitation counselors, but the information they are given may help them to move forward in their decision-making process and may be used at another point in their lives. Here's how Fran feels about her clients' choices:

1 Fran: I'm really proud of my client who through determination has made
2 something of herself=
[
4 I: Okay.
5 Fran: I {feel badly} for my client who decided that um {(.5)}, he'd rather sit at
6 home and let the problems overwhelm him, as opposed to addressing
7 them=
[
8 I: Okay.
9 Fran: =And making something of himself. When someone has potential, I really
10 {(.4)} urge them on {in} every means, {and} with every possible technique
11 {(.3)} so when someone has {the} potential and {the} capability and {let} it
12 to go?=
[
13 I: Uhuh.
14 Fran: =Um, I think they're doing such a {disservice}= (Fran: 390-410)

Lines 5 - 14 show that Fran feels sad about her client's choice not to do

something with his or her life, but it is the client's choice.

Exemplary rehabilitation counselors do not always have positive attitudes about their clients, as illustrated in this text by Ken. When Ken was asked to discuss a case of his choice, his response was, "I don't like to talk about any of them" (Ken: 934):

> I like to work more on the cases where the clients are friendly, {and} more cooperative, and where I think the chance of outcome is better. I just don't enjoy dealing with people {that} are nasty and negative and want to uh argue with me all the time. . . . It's just me. I don't enjoy those so {that's} probably hard core . . . I tend to work more for the people that I think are ah, you know, on board (Ken: 1551-58).

When Ken was asked why he was exemplary, this was his response:

1 Ken: I'm not sure that I am.

2 I: Okay.

3 Ken: Um, {(.2)} I think in some ways, you know, I'm not the most cerebral guy
4 out there=
[
5 I: Okay.
6 Ken: =I'm probably not the best counselor=
[
7 I: Okay.
8 Ken: =um, (.5) I do think though, that I, {I} like to stay objective, I think I like,
9 {my, uh, {(.2)}I generally like my clients=
[
10 I: Okay
11 Ken: =I like them to like me. Um, {(.3)} I think I just work very, very hard at
12 (.2) knowing the labor market, and finding job leads for people=
[
13 I: Okay.
14 Ken: =I work very hard on resumes, {um (.) I think} I know what it takes, what
15 employers are looking for . . . .

.
.

16 Ken: I'm probably exemplary because I, I've stuck it out so many years in
17 this field=
[
18 I: Okay (paper shuffle).

20 Ken: {maybe (.2)}, I think I'm ethical=
[
21 I: Okay.
22 Ken: ={(.2)} and {hhhh...(.2) ah} I just ah, hopefully (.3) much more
conservative now than I used to be in terms of my view on the, on the
23 field, and the clients. I value character in people a great deal.

24 I: Okay.

25 Ken: {(.6) Not} that that makes me exemplary, {but (.)}, I just {come} to
26 appreciate that both {from} the people I work for, and work with, and my
27 clients.

(Ken: 1948-2008)

Ken's earlier comment about wanting to work with clients who are "on board" ties into line 23 where he commented that he values character in people. It appears he has doubts about the character of clients who have negative attitudes and are not on board with regard to participating in their rehabilitation program. He sees his strength as his objectivity, ethics, and placement skills.

Qualities of Exemplary Rehabilitation Counselors

During the interview, the exemplary rehabilitation counselors were asked, "What makes you exemplary?" The rehabilitation counselors were modest about having been selected as an exemplary rehabilitation counselor. Eight said, "I don't know that I am!", two stated, "You chose me!, and three commented, "Other people said I was." The remaining respondents did not directly say that they were exemplary, but

responded in terms of what qualities they possess that may make people think of them as exemplary. Some respondents described themselves as different, unique, nonconformist, or a risk-taker, but not exemplary. One respondent stated that he hoped he was selected for his creativity rather than the fact that he has been around a long time. He further indicated the reason he had not called me back after my initial calls indicating he was nominated as an exemplary rehabilitation counselor was because he did not think he was exemplary. He just does the right thing for his clients, what he thinks he should do.

So why was their interpretation different from others? Was it modesty as previously suggested, does it relate to limited interactions with other rehabilitation counselors in the field as suggested during the nominee selection process, or are other factors involved? Interaction with other competitors in the field is limited as stated by some of the potential nominators. Competition is one factor that decreases interaction with other private rehabilitation providers for fear of learning trade secrets. This was the reason some rehabilitation counselors refused to participate in the research and refused to nominate rehabilitation counselors. A second factor is that a rehabilitation counselor's opportunity for interaction with other professionals is limited primarily to professional association meetings or conferences. There are two private rehabilitation associations in Michigan. A rehabilitation counselor would need to be a member of the association board of directors to meet frequently with other rehabilitation counselors throughout the year. Otherwise, rehabilitation counselors may only meet at conferences held once or twice a year. Sole practitioners and others stated they

had limited interaction with other private rehabilitation professionals in the field, thus, they had no one to nominate.

Although the rehabilitation counselors nominated as exemplary did not describe themselves as exemplary, they could describe why they were successful. They felt they were successful because they were good at establishing client-counselor relationships. Fifty-four percent of the comments focused on this relationship. They included comments that they relate well with clients, have good communication skills and allow clients to make their own decisions. Nineteen percent of the responses related to the skills used in the case management process. The remaining responses focused on personal qualities and characteristics, such as believing in what they do and confidence.

So what are the qualities of these exemplary rehabilitation counselors? The most frequently mentioned qualities focused on the previously discussed development of an effective client-counselor relationship, including being honest and assisting the client to regain control of his or her life. Many of the rehabilitation counselors spoke with compassion when they discussed their clients. Twenty percent described caseload management techniques like good organizational skills. The desire to continue learning was also mentioned by twenty percent. Additionally, individuals described qualities such as being resilient, knowledgeable, and goal-oriented. Other rehabilitation counselors mentioned being proactive and ethical.

Besides describing their own qualities, exemplary rehabilitation counselors were asked to describe what qualities they would look for in rehabilitation counselors they

would hire. Thirty percent would look for people who had a variety of work experience. Twenty-five percent would look for someone with counseling experience. This same percentage desired honesty and someone who was not afraid to ask questions. Being organized was mentioned by twenty percent of the rehabilitation counselors. Fifteen percent mentioned such characteristics as being ethical, caring, committed, having good communication skills, liking people, being independent, and good time management skills. Some of these qualities are similar to those mentioned earlier as qualities of effective helpers (Corey & Corey, 1993).

Defining Success

The focus of these rehabilitation counselors is on making a difference in their clients' lives as opposed to just returning the injured worker to work. They see success in cases that would be unsuccessful by industry standards, if they can "touch" the client's life. This seemed to have evolved from the complexity of the cases these rehabilitation counselors handle. Several said that their caseload is filled with difficult cases or that insurance companies call them when they have a challenging case to refer. Because the challenging cases were not always successful, these rehabilitation counselors may have redefined success to find satisfaction in their work.

Before success is defined, let's review how the rehabilitation counselors defined unsuccessful cases. Half described unsuccessful cases as those in which you give a lot to a client's case, but the client does not return to work. However, one rehabilitation counselor commented, these are not unsuccessful because the client

made a choice in his or her rehabilitation program. Thirty percent described unsuccessful cases as cases in which the client has another agenda. Fifteen percent indicated unsuccessful cases are when a client returns to work in a job that is not in his or her best interest (i.e. the client is not working to his or her potential).

Now let's look at how these exemplary rehabilitation counselors define success. From the insurance companies' perspective, success is returning to work and/or reducing exposure to claims through such things as settlement of a claim or maximum medical improvement for clients who are not physically capable of returning to work. Although this view existed, the exemplary rehabilitation counselor tended to have a client-focused definition of success. Again, I will let the rehabilitation counselors words tell their own story. Success is when the "claimant is happy with his choice or her choice whether that be to work or not go to work" (Dawn: 1634-37). Success is also:

> when you're making your last follow-up call and the client says he's happy to hear from you, but he hasn't got time to talk, because he's either going to work or has planned a vacation {for} his family from work, and is too busy to discuss any issues that you might have. Theoretically the client has fired you at that point and that's a successful outcome (Peter: 108-21). Or, if you asked the person two years after I'd start working with them that they would say I've benefited them (Ned: 152-57).

Generally, the rehabilitation counselors consider clients successful when they have become self-actualized, have regained control of their life and have dignity. One

rehabilitation counselor stated he feels successful when he knows he has been ethical, followed the rules, and provided the best quality rehabilitation services possible.

Their experience demonstrates their commitment to the profession of rehabilitation counseling. They love what they do and would quit if they stopped having fun in their jobs, as illustrated by Tim:

Tim: I think the thing that makes me the most successful, is that I love what I do

. . .

Tim: Because I just love, I love that kind of stuff, I love problem-solving=
[
I: Uhuh.
Tim: =And this business allows me to be in, do so many different things with so many different people, and be challenged by so many different people. The litigation system, where you're, you're always challenged as to your opinions, the rehab system, the clinical system where the clients are challenging you, um, you know just trying to figure a way through a maze for a client, you know, like the [indicated a successful aspect of a client's rehabilitation plan] (Tim: 3226-3320)

. . .

Tim: Um, so, that's what turns me on, is the creativity. The minute that ends is the minute I'm gone=
[
I: Yeah.

Tim: I'm history. I'm history, I, I don't want any part of, ah, you know, this is the way it's got to be kind of routine. I'm, I'm not a part of the main stream, never have been, and never will be. Ah, I don't believe that I was put on this earth to just do routine stuff. I, I believe that I, I have an affinity to being creative, and I want to be creative, and I'm not musically creative, I'm not artistically creative, I can't write well.

I: Uhuh

Tim: I mean, but I can think fairly good, and I, and I think that's been a very very helpful thing for me, in terms of the kind of clients I've dealt with,

24 and the kinds of problems I've tried to solve for people.
(Tim: 3348-3368)

In lines 1 - 2 Tim attributed his success to the pleasure he receives from being creative in his work. Specifically, he likes solving challenging problems, as indicated in lines 3 and 22 - 24. Tim also enjoys the creativity and variety required on the job as illustrated in lines 5 - 19. If he could no longer be creative on the job, he would leave the field, per lines 12 - 16.

Erin's comments seem most effectively to summarize the professional maturity of these exemplary rehabilitation counselors:

1 Erin: =Uh, that I feel that I, I more than just meet the standards of my practice
2 in my industry=
[
3 I: Uhuh.
4 Erin: =Um, but I try to set the standards in some ways to move the industry
5 forward, um, and always there's more work to do with that, but to try new
6 and different things,=
[
7 I: Uhuh.
8 Erin: =I think um, to sit back and just you know, just do things that everybody
9 else always does, that's the easy road,=
[
10 I: Okay.
11 Erin: =I think taking the harder road may be um, (.10) OH .hhhh , I, I
12 suppose there's a certain amount of recognition, um, that comes from
13 people in the industry, (moving papers) and people outside the industry,
14 um, (.3) our outcomes definitely I think that's a big piece right there, you
15 know, how many people do we successfully, (I: throat clear) I mean, how
16 many people do we actually help?= . . . (Erin: 947-967)

Erin believes that her role as an exemplary rehabilitation counselor is to help set the standards for the industry (lines 4 and 5), in addition to helping the client. Recognition from the industry is good, but not what is key for this exemplary

rehabilitation counselor.

Best Practice

One goal of this research was to be able to interpret best practice. The research questions developed from a hunch that there is something in the case process of exemplary rehabilitation counselors that is different from representative rehabilitation counselors and could be defined as best practice. What I found were fairly consistent beliefs and values about clients and how these rehabilitation counselors view their job. The interview questions were initially analyzed in relation to the case process; however, in the 20 exemplary rehabilitation counselors' interviews completed, I did not find a consistent approach as to how they handled each aspect of the case management process. When I began this study, I expected to see more similarities between the case management approaches of the exemplary rehabilitation counselors, and that was how I planned to define best practice. Instead what I saw as I interviewed rehabilitation counselors was the specialized nature of their approach to clients. They used creativity, critical thinking and analysis skills, and problem-solving skills to make decisions regarding the approach they used with clients. They have a knowledge of resources and how they should be used most effectively with clients. They have a proactive, interventionist nature. Additionally, I noted their compassion for their clients, a love of their work, and a desire to facilitate change, by allowing clients to choose their own destiny. The interviews also revealed the rehabilitation counselors desire to establish the client-counselor relationship. The

exemplary rehabilitation counselors perception of success is broader than the payer standard of return to work.

So when I reflected on best practice after reviewing the interview transcripts, I realized I needed to take a different approach. I went back through the transcripts and looked for the practices these exemplary rehabilitation counselors discussed that seem to make a difference in their work and in their results. I reviewed the analysis and reflected back over the interviews, in doing so there were five aspects of their casework which have been discussed throughout Chapters 4 and 5. They are as follows:

1. An effective client-counselor relationship is important for success.
2. Open lines of communication among all parties - the client, employer, physician, attorney, and insurance carrier - improves the case process.
3. Educate clients about the systems from which they are receiving benefits, as well as regarding their medical status and vocational rehabilitation.
4. Provide clients with the information needed to make choices about their lives. Then allowing clients to make their own choices.
5. Redefine success to focus on impacting or touching their clients lives no matter what the case outcome.

These exemplary rehabilitation counselors see themselves as providing a needed service to persons with disabilities. They are mature, responsible professionals. They are considered exemplary by their colleagues. They have learned coping behaviors that allow them to redefine success so they can feel comfortable in their

work, no matter what the case outcome. They have achieved professional maturity.

According to Combs (1986) (as cited in Corey & Corey, 1993), there are five beliefs that discriminate effective and ineffective helpers. These beliefs include (a) a focus on the personal world of the client and being people oriented; (b) positive beliefs about people; (c) a positive self-concept and feeling confident about one's abilities; (d) a sense of purpose about their role and seeing a societal value to their service; and (e) the value effective helpers place on characteristics that influence methods. The latter characteristics include empathy, warmth, compassion, genuineness, and unconditional positive regard. These beliefs of effective helpers are the beliefs I have presented for the exemplary rehabilitation counselors. The clients they work with are important to them. The clients and the challenges of the case work are a big part of why these people are exemplary rehabilitation counselors.

In conclusion, Chapter 4 emphasized the importance of the client-counselor relationship in the lives of the exemplary rehabilitation counselors. The importance of this relationship has consistently been proven to be effective for client gain. It was reiterated in the responses of the exemplary rehabilitation counselors that it is important to treat clients fairly and equitably. Rehabilitation counselors also help their clients understand their role and limitations in insurance rehabilitation. Thus, they must be cognizant of their role and that of the payer. These are all requirements of the counseling profession. These are included in Feingold's (1977) (as cited in Wright, 1980) tenets that are basic to the counseling profession. Although Feingold does not speak directly to insurance rehabilitation, he indicates counselors are

responsible not only to clients, but also to their work settings. Additionally, he discusses clients right to choose, even if it may be a wrong choice.

According to Wright (1980), professionals value the provision of a needed service without consideration of power, prestige, and income. These rehabilitation counselors are modest about having been selected as exemplary. They perform their job because they enjoy the job, not for power and prestige. Financial gain does not seem to be the sole motivator as demonstrated by their statements about closing cases if requested to perform unethical acts. Additionally, these rehabilitation counselors have the education and credentials that represent an acceptable standard of quality (Leahy & Holt, 1993). These exemplary rehabilitation counselors meet the requirements to be considered professional.

If maturity can be evaluated by knowledge gained through experience, then these rehabilitation counselors have reached maturity. Using Super's (1974) definition of maturity, we must look at outcome expectations as defined by peers in private rehabilitation as return to work. If we look at how exemplary rehabilitation counselors have developed coping behaviors leading to outcomes as finding satisfaction in their work through client choice, then these rehabilitation counselors have achieved maturity and can be considered to have attained professional maturity. Maybe this is the quality that makes these rehabilitation counselors exemplary - how they approach their clients as opposed to how they handle their job.

Perspectives of the Nominators

Up to this point I have not shared why these rehabilitation counselors were nominated as exemplary. I have given my perceptions of why the rehabilitation counselors are exemplary based on their ability to develop client-counselor relationships and their professional maturity, their professional qualifications, their education, work experience, their views about clients, and how they perceive their roles and responsibilities. Now let's take a look at why they were nominated.

As previously indicated, the reasons the rehabilitation counselors were nominated as exemplary were not reviewed until the analysis had been completed and written. The only exceptions were the six nomination forms which were taken over the phone. Thirty nomination forms were received for the 20 exemplary rehabilitation counselors that were interviewed, as some rehabilitation counselors received multiple nominations. The nomination forms were reviewed and the reasons for nomination tallied. All the rehabilitation counselors studied received multiple reasons for being nominated. The three primary reasons they were nominated as exemplary were their knowledge (40%), their excellent job placement skills (37%), and their experience (33%).

Twenty-five percent were nominated because they are excellent counselors, are honest, and/or they have trained new rehabilitation counselors and other professionals. Twenty percent were nominated because they "go the extra mile," are committed to clients, are ethical, and/or have supervisory skills.

Because 12 rehabilitation counselors received multiple nominations and all

rehabilitation counselors received multiple reasons for nominations, all reasons for nominating rehabilitation counselors as exemplary were reviewed and tallied. This allowed for a content analysis of all responses received. In reviewing this information, four categories of responses evolved based on the nomination rationale. The categories include reasons for nomination related to a) the client-counselor relationship, b) case management skills, c) professionalism, and d) business skills. There were 36 (52%) reasons for nominating rehabilitation counselors as exemplary which related to the client-counselor relationship. These responses represented a total of 68 (46%) reasons rehabilitation counselors were nominated as exemplary. Twenty-seven (39%) of the reasons for nominating these rehabilitation counselors as exemplary focused on case management skills. This represented a total of 63 (43%) reasons these rehabilitation counselors were nominated. The remaining six reasons for nominating rehabilitation counselors as exemplary were categorized as professionalism and business skills. This represented 16 (11%) of all the reasons these rehabilitation counselors were nominated as exemplary.

This information could be interpreted in one of two ways. If one looks only at the number of individual reasons the rehabilitation counselors were nominated as exemplary, this data would tend to support my thoughts that the client-counselor relationship is the primary reason for their nomination. However, when you look at the percent of total responses per category, the percent of responses for the client-counselor relationship (46%) and case management skills (43%) are close. This would seem to indicate that the nominators gave equal weight to these two categories

as reasons for nominating rehabilitation counselors as exemplary.

As I reflected on these findings, I realized they complement what I have previously discussed and provide supporting documentation for data I did not collect regarding job placement. This information also provided a different perspective on why these rehabilitation counselors are exemplary. The importance of the client-counselor relationship was emphasized in this study both in the perspectives of the rehabilitation counselors and in the thematic analysis. The case management process was presented as described by the rehabilitation counselors. I did not note any specific aspects of the case management process as significant other than the introspection and retrospection that they use with cases. Having practiced in private rehabilitation, I see their case management behaviors as similar to my own or others I have supervised.

One primary reason the rehabilitation counselors were nominated as exemplary was their knowledge base. As I reflect on this, I wonder if I emphasized it enough in this work. In Chapter 4, I had the exemplary rehabilitation counselors share their knowledge by providing their perspectives on the case management process. I also considered them knowledgeable based on their education, credentials, and work experience. I think the nominators' emphasis on knowledge is an interesting insight, since with my interview questions I hoped to identify what exemplary rehabilitation counselors do differently in the case management process. The nominators focus on knowledge, experience, the client-counselor relationship, and case management skills seems to support the concept of professional maturity as it was described in this

chapter.

The dimension that was added was knowledge of the rehabilitation counselors excellent placement skills. Placement outcomes were not obtained directly from the research. The nomination letter did, however, state that I was looking for "private rehabilitation counselors who are extremely successful in their work" (see Appendix B). In this thesis, I focused on how they defined success, which was not generally in terms of successful placements. I suspected the exemplary rehabilitation counselors were successful at placement, as I indicated in Chapter 4 when I stated that their education level matches that of state-federal rehabilitation counselors and their experience level exceeds state-federal rehabilitation counselors who have higher placement rates with persons with severe disabilities (Cook & Bolton, 1992; Szymanski, 1991; Szymanski & Danek, 1992; Szymanski & Parker, 1989). The information provided by the nominators supports this assumption for exemplary rehabilitation counselors.

Limitations of Findings

Before proceeding any further a number of potential limitations regarding the findings from this study need to be emphasized. The pilot interviews conducted for this study were completed after the initial mailing requesting nominations of exemplary rehabilitation counselors. Had the pilot interviews been completed before the initial mailing, I would have known the interviews with rehabilitation counselors only took one to two hours, rather than one to two interviews lasting one to three

hours as was indicated in the letter of request. Even though the response rate was good, this more accurate assessment of the time involved for participants might have resulted in an increased number of nominees. Although, only one person commented on the nominee form about the time commitment of the research, there is no way of knowing how many others had this same view.

Partially as a result of my years of experience as a private rehabilitation counselor, I was able to gain access to the exemplary rehabilitation counselors. However, this knowledge and background about the field of private rehabilitation may have influenced what the rehabilitation counselors said and precluded the rehabilitation counselors from providing me with the depth of a response that they may have given an outsider with no prior knowledge about private rehabilitation. This is supported by comments such as "as you know from your own experience" (Tim: 811-12) or "you{'re} familiar with that" (Claude: 906). This observer effect (Bogdan & Biklen, 1992) may also have decreased the natural manner of the interactions and made them more hesitant to be self-critical.

In reviewing the transcripts, I realized broad questions were deleted in some of the interviews. I also did not always probe enough when I received a closed ended response to one of the broad questions. Thus, not all questions were fully explored. Probes also could have helped those rehabilitation counselors elaborate on comments to clarify their ideas. I became too focused on being systematic and covering the questions developed, as opposed to achieving thorough responses to the questions asked. Had additional probes been used, additional insights might have been gained.

I now realize that my underlying thoughts were that exemplary rehabilitation counselors are exemplary because of something they do in the case management process, versus their interactions with clients and that this assumption influenced the types of broad questions initially asked. There may have been other more powerful questions that would have given additional insights, had I not had this preconception in question development.

Ideally, in qualitative research, transcripts are reviewed as the interviewing continues and further interview questions evolve. Due to transcription delays this did not occur to the desired level. More questions may have evolved than the few added based on a review of the field notes alone.

In reviewing the transcripts, I felt I occasionally cut off the rehabilitation counselors thoughts by prompters such as okay, right, and yes. There are some transcripts where this resulted in the rehabilitation counselor discontinuing his or her train of thoughts and other instances were there appeared to be no effect. Once I observed this during review of the transcripts, I attempted to use more nonverbal prompters such as shaking my head up and down. This was not, however, consistent in subsequent interviews. It is difficult to say whether the verbal versus nonverbal prompters facilitated or hampered conversation. It may have occasionally resulted in the rehabilitation counselor pursuing a line of thought that may not have been addressed otherwise. In other instances it may have prevented them from completing their thoughts.

Additionally, I noted that a rehabilitation counselor would be describing a case

scenario that would touch on a subsequent interview question. I occasionally redirected the response toward the subsequent interview question. This may have precluded response depth on the case scenario. Had I continued with the original case scenario, I may have gained additional insights that did not occur with refocusing the question.

The interviews may have benefited from longer pauses between responses to questions or statements such as "anything else." This would have allowed the rehabilitation counselors to complete all their thoughts and may have added depth to the interviews. I gained a lot of additional insight from one rehabilitation counselor when I used this technique.

Implications

Research

Hill and Corbett (1993) suggested that timing, quality, and competence in therapy need to be studied. The results of this study of exemplary rehabilitation counselors would suggest that another counselor variable - professional maturity - should also be studied further. Professional maturity may move us closer to linking process with outcomes. Professional maturity goes beyond education, credentials, and knowledge. It includes qualities such as risk-taking, creativity, critical thinking and analysis skills, professional judgment, treating clients as respected and autonomous individuals and providing appropriate, ethical services within the parameters of the clients' benefit system. These are some of the qualities of the exemplary rehabilitation counselor that

have made them both effective and successful and are qualities that could be investigated further in subsequent research.

In role and function (Emener & Rubin, 1980; Fraser & Clowers, 1978; Harrison & Lee, 1979; Jaques, 1959; Muthard & Salomone, 1969; Rubin, et al., 1984) and competency research (Leahy, et al., 1987a & 1987b) we have done an effective job of defining skills and tasks of rehabilitation counselors. These studies also recognize the importance of individual counseling skills. My research lends support to that aspect of this prior research. This is not surprising, given that 90% of the exemplary rehabilitation counselors are CRC's. Additionally, current validation research indicates the importance of knowledge domains in the areas of vocational and employer consultation services, case management services and coordination, workers' compensation, and assessment (Leahy, et al., 1993). These areas were also addressed and defined as important by the exemplary rehabilitation counselors. This research will provide another dimension to the knowledge, skills, and abilities necessary to practice as a private rehabilitation counselor.

Further research could support and enhance this research. This could include interviewing representative private rehabilitation counselors and comparing their responses to exemplary private rehabilitation counselors to lend further support to the themes of professional maturity, fair and equitable treatment of clients, and understanding the limitations to their roles and responsibilities. A study that included a comparison of client and private rehabilitation counselor reactions to rehabilitation would provide additional insight into the client-counselor relationship and similarities

and differences in perceptions about the effectiveness of rehabilitation. Additionally, research defining successful case outcomes such as return to work, length of time in rehabilitation, quality of services, and quality of closures including wages and type of job obtained has not been thoroughly conducted.

If this study were done again, I would begin by selecting a specific qualitative tradition for the research design. One suggestion might be the use of grounded theory. Grounded theory generates theory from data. Theory evolves through the interplay between analysis and data collection. Additionally, there may be existing theory that could be elaborated or modified during data collection (Strauss & Corbin, 1994). The theory of interest would relate to the approach the exemplary rehabilitation counselors used with their clients that results in a vocational outcome considering their knowledge, skills, abilities and professional maturity.

I would also want to include methods to triangulate the study such as the use of multiple researchers and observation. Working with a researcher with less personal involvement with private rehabilitation might assist in providing additional insights into the analysis. Observations within the client-counselor relationship would also provide additional insights. Triangulation would remove potential bias and enhance reliability of the study (Denzin, 1978).

Further research should improve the construction of the interview questions to focus more on case descriptions and attempting to understand the thoughts, feelings, and actions of the rehabilitation counselor as opposed to focusing on the case management process. Other questions of interest would include defining success and

qualities required of rehabilitation counselors. The interviewer should be sufficiently skillful and the interview sufficiently developed to recognize and probe significant responses as well as covering the broad questions. I would like a quicker turnaround on transcription, so the information gathered during the interviews can be used to develop questions for subsequent interviews. These suggestions would both enhance and expand the current research.

Education

From the exemplary rehabilitation counselors' retrospective review of cases, I recognized a number of qualities that rehabilitation counselors need to learn to enhance their effectiveness as rehabilitation counselors in the private sector. In addition to the counseling and technical skills currently included in preservice education, we need to help masters' level rehabilitation counseling students to explicitly develop the components and characteristics of professionalism, critical thinking/analysis skills, creativity, and risk-taking. Professionalism should include professional identity, using professional judgment, thinking independently, and how to work for the best interests of clients within the bounds of their benefit system. Some of these qualities can be incorporated in preservice education through the development of active learning strategies used with students. Others may not be easily taught in preservice education. For those qualities that can be taught interactions within class and coursework would benefit from the inclusion of tasks requiring inductive and deductive reasoning skills and the use of problem-solving and decision-making skills.

Specifically, this could be accomplished by using teaching strategies such as experiential learning, role-playing, and case studies. Students could be presented with case scenarios and asked to consider both traditional and nontraditional methods for resolving the problem. They can then be requested to present evidence to support their plan of action (Davis, 1993).

Additionally, in individual counseling classes, strategies can be developed to engage students in examining their beliefs and values and assumptions about what makes a good helper. In a practicum class, opportunities can be structured to explore their feelings about clients with whom they are currently working. The goal of these activities is to assist students in developing their own personal belief system about clients which will help them function effectively in their work environment (Combs, 1986). In addition, these activities would allow students to acquire greater insight, skills in processing biased and ineffective reactions to certain clients, and coping strategies to use with clients.

If we look at the insights provided by the exemplary rehabilitation counselors, we can infer what beginning rehabilitation counselors need to pursue in order to become successful in this job. In reviewing the list of qualities, I noted some of the qualities could be taught in school, but other qualities were innate. Honesty, integrity and compassion can be offered to new rehabilitation counselors as qualities of exemplary rehabilitation counselors to emulate. However, being self-directed would be more difficult to modify. New rehabilitation counselors again could be informed this is a quality of exemplary rehabilitation counselors and is strongly recommended to

succeed in this rehabilitation setting.

Skills that can be taught in a training program can be divided into two major areas: counseling skills and management skills. The counseling skills include being an effective communicator, respecting the client, learning the skills to help clients regain control of their lives, being introspective and retrospective about their case work, and having an interest in continually learning to enhance their skills and knowledge base as the industry changes.

The management skills that should also be learned include being an independent and critical thinker and learning how to research the unknown. With regard to moving client cases forward in the rehabilitation process, rehabilitation counselors need to be proactive, not reactive, as well as being goal/task oriented. They need to know how to teach clients problem solving/decision-making skills, then to help clients use these skills to set short and long term goals. They also should be taught to achieve quality outcomes and to construct and negotiate a win-win situation for all parties. This list of qualities and skills demonstrates the multi-faceted nature of the job of rehabilitation counselor.

This knowledge can also be incorporated in the curriculum to assist students completing their master's in rehabilitation counseling to understand the role of the private rehabilitation counselor from the perspective of the practitioner. This will help them understand the challenges and rewards of the job. Additionally, it can be used by rehabilitation counseling students and their advisors to assess the strengths and limitations of the rehabilitation counseling student for placement in the private

sector.

This study provides insight into the adversarial nature of the job, as well as providing a prospective on how exemplary rehabilitation counselors find value and satisfaction within this adversarial environment. Educators can use these exemplary rehabilitation counselors experiences to demonstrate how some rehabilitation counselors have managed to remain both professional and objective, when faced with competing demands. It is important to help students understand that success has many definitions. In private rehabilitation the payer's desire is return to work. This may not always happen in a case. The student needs to be able to achieve and acknowledge the value of alternative outcomes even if a return to work does not occur, such as looking at improving quality of life and having specific positive impacts on people's lives.

We are unable to provide new graduates with the work experience of these exemplary rehabilitation counselors, but we can provide them with the wisdom of their knowledge and expertise regarding how they view this work environment. This will allow new rehabilitation counselors to better judge if this is the right work environment for them at this point in their career. Private rehabilitation may be a work environment where experienced rehabilitation counselors can more easily adjust to its demands. This knowledge allows students to make more informed choices about their career and destiny.

Practice

This research provided an overview of private rehabilitation from the perspective of exemplary rehabilitation counselors. Many would not have anticipated this client focused perspective, since private rehabilitation is a for profit business. The exemplary rehabilitation counselors interviewed focused on their client's needs. Their responses shed yet another light on practice that is desired based on counselor training and ethical standards, but is not generally expected in the adversarial environment of private rehabilitation. These insights can be used by rehabilitation counselors when interviewing for employment, to insure that the private rehabilitation firm holds similar views about the client and the rehabilitation counselor's role in this work.

The exemplary rehabilitation counselors' perspectives may or may not reflect the beliefs and expectations of representative private rehabilitation counselors; however, it provides possibilities for effective practice in private rehabilitation. It demonstrates that rehabilitation counselors can practice ethically, adequately meet both client and customer needs, and obtain personal and professional satisfaction from their work.

This study lends support to the complexity of the field of rehabilitation counseling in the private sector. A rehabilitation counselor can have the education, credentials, and knowledge to perform the job but may experience challenges in his or her success with clients. These challenges may be due to an inability to take risks or be creative, to think critically and analytically, or to sustain professionalism within oneself. The insights gained from the exemplary rehabilitation counselors I studied may be beneficial for training practitioners who are new to private rehabilitation. It may help

the practitioners decide if this is an appropriate career choice. Additionally, the exemplary rehabilitation counselors' views of success may be useful to review if a rehabilitation counselor is experiencing burnout from cases closed as unsuccessful.

Some of the interview questions can be used by supervisors hiring rehabilitation counselors to learn how they would handle casework and how their behaviors and qualities match those of the organization to which they have applied. These questions may also help to assess practitioners strengths and weaknesses for work in the field.

Perspective of the Researcher

Although I felt successful as a practitioner, I always wanted to assist more clients in returning to work. Throughout my graduate work, I continued in this pursuit by researching client, counselor, and employer variables that impact success. I began this research with the hope of finding a magic formula that would help increase the number of clients who return to work. I thought it would be related to the use of a specific case management technique by these exemplary rehabilitation counselors. What I learned instead is that they have had to develop their depth of analytical and clinical skills as well as their approach to how they work with clients. This is both a difficult and challenging task. Because of this challenge they have expanded their definition of success to include having a positive impact on a client's life whether or not return to work occurs. When I reflect back on my own casework, I can now say I touched people's lives. I provided them with skills and abilities that they could use later in their life when their medical condition stabilized or when circumstances

changed so that they could now choose to return to work. On a personal and professional level, the perspectives of the exemplary rehabilitation counselors provided a valuable lesson and contributed to my own development. I have found the magic formula I sought in how exemplary rehabilitation counselors approach their clients, as opposed to the specific case management techniques they use with clients.

As vocational rehabilitation continues to change, we do not want to lose sight of our clients, their needs, wants, desires and right to choose their own destiny. We also do not want to lose sight of an individualized approach to our work with clients. This in and of itself provides a service to those people we serve.

APPENDICES

APPENDIX A

APPENDIX A

SCRIPT TO REQUEST CONTACT NAMES

This is Martha Mirch. I'm a doctoral student at Michigan State University. I am interested in talking with exemplary private rehabilitation counselors in Michigan who work with workers compensation recipients. I would like to send correspondence to the supervisor, manager, and vocational/rehabilitation counselors in your firm to obtain recommendations for who I should interview. Could I have their names please?

When uncertain whether a firm worked with workers' compensation recipients, I would ask "Does your firm have rehabilitation/vocational counselors on staff who work with workers compensation recipients?"

APPENDIX B

APPENDIX B

LETTER TO REHABILITATION COUNSELORS, SUPERVISORS AND MANAGERS

Dear Colleague:

As you know, today's managed care environment focuses on cost effectiveness and outcomes. As a former private rehabilitation practitioner, I understand your desire to obtain successful results with your clients in an ethical and cost-effective manner. As a former supervisor, I also understand the challenge you experience in hiring qualified rehabilitation counselors and training them to perform the job effectively and efficiently. We all know private rehabilitation counselors who are extremely successful in their work with injured workers. Your help is needed in locating these exemplary rehabilitation counselors. I am interested in interviewing exemplary rehabilitation counselor to gather insights that may help us enhance the effective delivery and outcome of vocational rehabilitation services to injured workers. This will include identifying behaviors, approaches, and practices used by exemplary rehabilitation counselors to return injured workers to work. As a future rehabilitation counseling educator, I would like to use the knowledge gained to tie theory to practice and to improve and update master's level training and continuing education.

I am interested in interviewing these practitioners to learn more about what makes them exemplary. To begin the nomination process, I would appreciate your completing the attached Nomination Form for an Exemplary Rehabilitation Counselor. The exemplary rehabilitation counselor can be currently employed at your firm or be someone with whom you have previously worked. You can nominate up to three exemplary rehabilitation counselors. Upon receipt of all nominations, twenty exemplary rehabilitation counselors will be selected for interviews. The selected rehabilitation counselors will be contacted and asked to participate in this research. This will involve completing one to two interviews each lasting one to three hours.

The information you provide will remain confidential. It will be used to contact the exemplary rehabilitation counselor. If you are unable to recommend an exemplary rehabilitation counselor, please return the attached form indicating you have no nominations. The identification number on the Nomination Form is to facilitate the sending of follow-up correspondence.

Interviews will be audiotaped to help in analyzing the information obtained. Pseudonyms will be used in the final research report. There is a slight chance that someone who reviews the final research report might guess the identity of the

APPENDIX B

exemplary rehabilitation counselor based on the transcript text. The audiotapes will only be shared with the research team and may be used for educational training purposes only with the permission of the rehabilitation counselor.

The Nomination Form should be returned by December 15, 1996 to:

Martha Mirch
8030 Barnsbury
Commerce Twp., MI 48382

If you have any questions, please do not hesitate to contact me at (517) 355-1838. Thank you for your participation.

Sincerely,

Martha C. Mirch
Doctoral Candidate, Rehabilitation Counselor Education
Michigan State University

Enc: Nomination Form

APPENDIX C

APPENDIX C

NOMINATOR'S FORM FOR EXEMPLARY REHABILITATION COUNSELOR

Nominator's Name:_____
Employer:_____
Address:_____
_____
_____
Telephone #:_____

___ Please check if you do not wish to recommend an exemplary rehabilitation counselor.

If you are making a recommendation, please complete the remainder of the form. Thank you.

Nominee's Name:_____
Employer:_____
Address:_____
_____
_____
Telephone #:_____

Please answer the following question about your nomination for exemplary rehabilitation counselor: (If more space is needed, please use the back or a separate sheet of paper.)

1. Why do you consider this person to be an exemplary rehabilitation counselor?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you for your assistance.

Please return this form to:
Martha Mirch, 8030 Barnsbury, Commerce Twp., MI 48382

APPENDIX D

APPENDIX D

SECOND NOTICE

January 3, 1997

SECOND REMINDER: If you have already returned the nomination form(s), I would like to extend my sincere appreciation. If not, please do so within the next 14 days to save the expense of a future follow-up. Thank you!

Dear Colleague:

As you know, today's managed care environment focuses on cost effectiveness and outcomes. As a former private rehabilitation practitioner, I understand your desire to obtain successful results with your clients in an ethical and cost-effective manner. As a former supervisor, I also understand the challenge you experience in hiring qualified rehabilitation counselors and training them to perform the job effectively and efficiently. We all know private rehabilitation counselors who are extremely successful in their work with injured workers. Your help is needed in locating these exemplary rehabilitation counselors. I am interested in interviewing exemplary rehabilitation counselor to gather insights that may help us enhance the effective delivery and outcome of vocational rehabilitation services to injured workers. This will include identifying behaviors, approaches, and practices used by exemplary rehabilitation counselors to return injured workers to work. As a future rehabilitation counseling educator, I would like to use the knowledge gained to tie theory to practice and to improve and update master's level training and continuing education.

I am interested in interviewing these practitioners to learn more about what makes them exemplary. To begin the nomination process, I would appreciate your completing the attached Nomination Form for an Exemplary Rehabilitation Counselor. The exemplary rehabilitation counselor can be currently employed at your firm or be someone with whom you have previously worked. You can nominate up to three exemplary rehabilitation counselors. Upon receipt of all nominations, twenty exemplary rehabilitation counselors will be selected for interviews. The selected rehabilitation counselors will be contacted and asked to participate in this research. This will involve completing one to two interviews each lasting one to three hours.

The information you provide will remain confidential. It will be used to contact the exemplary rehabilitation counselor. If you are unable to recommend an exemplary

rehabilitation counselor, please return the attached form indicating you have no nominations. The identification number on the Nomination Form is to facilitate the sending of follow-up correspondence.

Interviews will be audiotaped to help in analyzing the information obtained. Pseudonyms will be used in the final research report. There is a slight chance that someone who reviews the final research report might guess the identity of the exemplary rehabilitation counselor based on the transcript text. The audiotapes will only be shared with the research team and may be used for educational training purposes only with the permission of the rehabilitation
Counselor.

The Nomination Form should be returned by January 17, 1997 to:

Martha Mirch
8030 Barnsbury
Commerce Twp., MI 48382

If you have any questions, please do not hesitate to contact me at the above number or (517) 355-1838. Thank you for your participation.

Sincerely,

Martha C. Mirch
Doctoral Candidate, Rehabilitation Counselor Education
Michigan State University

Enc: Nomination Form

APPENDIX E

APPENDIX E

RESPONSE RATE

FIRST MAILING

Total number of letters mailed: 201
  Number of individual letters sent: 165
  Number of packets of multiple letters: 36
Total number of companies to whom correspondence was mailed: 117

RESPONSES FIRST MAILING

Total responses received: 33
Total number of companies responding: 28
Total number of responses recommending nominees: 20
Total number of responses not recommending nominees: 11

Number of companies indicating they did not wish to participate: 2

SECOND MAILING

Total number of letters mailed: 167

RESPONSES SECOND MAILING

Total responses received: 60
Total number of companies responding: 37
Total number of responses recommending nominees: 15
Total number of responses not recommending nominees: 40

Number of companies indicating they did not wish to participate: 4
Number of companies indicating they have no rehabilitation counselors on staff: 1

TELEPHONE CALLS:

Total telephone contacts attempted/made: 104
Number of contacts made: 37
Number of incomplete calls: 7
Total responses received: 38
Total number of companies responding: 23
Total number of responses recommending nominees: 9
Total number of responses not recommending nominees: 24

APPENDIX E

Number of companies indicating they did not wish to participate: 2
Number of people who were unavailable due to medical leave: 2
Number of people inappropriate for the study: 1
Number of people who received multiple mailings: 1

OVERALL RESPONSES

Total responses received: 131

Total number of companies indicating they did not wish to participate: 8
Total number of companies who did not have rehabilitation counselors on staff: 1
Total number of people unavailable due to medical leave: 2
Total number of people inappropriate for the study: 1

Total number of companies responding: 88

Overall response rate all correspondence and telephone calls: 65%
Overall response rate by company: 75%

APPENDIX F

APPENDIX F

CONSENT FORM FOR PARTICIPATION

December 15, 1996

Dear Participant:

Per our discussion, you have been nominated as an Exemplary Rehabilitation Counselor by several private rehabilitation colleagues. Those who nominated you felt you represented one of the best private rehabilitation counselors in Michigan. Your nomination and willingness to be interviewed will help shape future rehabilitation practice, education, and research. The purpose of this research is to further explore best practices of exemplary rehabilitation counselors by gathering information on the behaviors, approaches and practices you use in returning injured workers to work.

We have scheduled to meet on (date and time). The focus of this interview will be to gather insight into your experiences as a private rehabilitation counselor. One interview will be required, lasting one to three hours. To obtain an accurate record of your responses, it would be beneficial to audiotape these interviews. While we cannot guarantee any specific benefits, we believe the knowledge gained from our conversations with you will be valuable to us, to the practice of rehabilitation counseling, and to future rehabilitation counseling students. This knowledge should help improve our work with persons recovering from work related injuries.

Your participation in this study is completely voluntary. You can choose not to participate in this study at all, or you can withdraw at any point throughout the study without penalty. If you choose to participate in this study, you have the right to refuse to answer any interview question.

For any audio recording, you have the right to request that we stop recording at any time or that the audiotapes not be used. If you do not grant your permission to be taped, we will not do so. Your identity on the audiotapes will be disguised. Your names will not be used in any reports or research papers produced as a result of this research. Identifying information will be deleted or disguised. There is a slight chance someone might guess your identity if they read the final research report. Specific details of our discussions will not be shared with anyone other than members of the research team. Select segments of the transcript may be used to emphasize points in the final research report.

APPENDIX F

Thank you very much for your willingness to participate in this research. If you have any questions, please feel free to contact me at (810) 360-1976 or (517) 355-1838.

Sincerely,

Martha C. Mirch
Doctoral Candidate, Rehabilitation Counselor Education
Michigan State University

Consent for Participation

I have read the above description and understand the nature of my involvement in this research. I understand that the data from this study will be maintained indefinitely, to be used for training future rehabilitation counselors, for conference presentations and in published articles. I have been assured that in any such uses, my identity will not be revealed. I do understand that in audiotapes, my voice might be recognizable to those familiar with me. I may choose to have any segment of audiotape not used in the study or presentations. The researcher will also change client characteristics to ensure confidentiality.

I have also been assured that I can deny permission for my participation in any or all of the interviews. I can also withdraw my participation at any time, without penalty. I understand there is a slight chance someone could guess my identity if they review the final research report.

Name (Please Print):

_____

Signature: _____
Date: _____

APPENDIX G

APPENDIX G

DEMOGRAPHIC SURVEY

Name:_____
Employer:_____
Address:_____
_____
_____
Telephone #:_____

Age:_____

Gender: Male Female (Please circle the appropriate number.)

Education: (Please indicate the highest degree earned)

___ PhD Rehabilitation Counseling
___ PhD Related Area (Couns., Special Ed., Psyc., Soc. Work)
___ PhD Other (Please specify)_____
___ MA/MS Rehabilitation Counseling
___ MA/MS Related field
___ MA/MS Other (Please specify)_____
___ BA/BS Rehabilitation Counseling
___ BA/BS Related field
___ BA/BS Other (Please specify)_____

Please specify all credentials:

___ CRC ___ CVE
___ CDMS/CIRS ___ CSW
___ CCM ___ NCC

Are you a Licensed Professional Counselor?

___ Yes
___ No

How many years have you worked with your current employer? _____

APPENDIX G

How many years have you worked in private sector rehabilitation? _____

How many years have you worked in the field of rehabilitation, in all settings? _____

APPENDIX H

APPENDIX H

INTERVIEW QUESTIONS

(Adapted from Boyatzis, 1982)

Exemplary rehabilitation counselors will be asked to consider these questions for both a successful and an unsuccessful case file.

. Think of an initial interview you conducted. Describe the approach you used in introducing yourself to the client, in describing your services, and the goals of rehabilitation. Describe why you think this style was appropriate and/or effective or inappropriate and/or ineffective?

. When working with an injured client, how did you decide what was a reasonable grieving time for the loss of the injury vs. moving the client forward toward vocational rehabilitation and return to work.

. Think of a client interview you conducted. Describe the style you used in conducting the meeting. Describe why you felt that this style was appropriate and/or effective or inappropriate and/or ineffective. How would you describe your intervention style? (Supportive counseling, social counseling - personal and social, other)

. Think of the last time you referred someone to a vocational evaluation facility. Describe why you felt this referral was necessary. Describe how the person referred differed from clients who were not referred. Describe the client's characteristics. Describe how you discussed the referral with the client and the subsequent results.

. Think of the last time you referred someone for testing. Describe why you felt this referral was necessary. Describe how the person referred differed from clients who were not referred. Describe the client's characteristics. Describe how you discussed the referral with the client and the subsequent results.

. Think of the last time you assisted a client in returning to work with their former employer. Describe the interaction you had with the employer, the client. Describe the steps you took in facilitating the return to work. Describe the characteristics of the employer and client that you think facilitated the return to work. How did this interaction differ from clients who do not return to work with their former employer.

. Think of the last time you placed a client. Describe how the person placed differed from clients you have been unable to place. Describe the person in terms of his/her characteristics which you valued. If the client was placed based on prior experience, describe the characteristics you think the person had based on their past experiences.

. Think of your successful clients, describe the behavior and accomplishments of the persons who returned to work, how did these clients differ from clients who did not

APPENDIX H

return to work.

. Think of the last time you, or someone you know in rehabilitation, effectively, resolved a conflict among individuals involved in the rehabilitation process. Describe the style that the person used. Describe the steps taken to resolve the conflict.

. Think of the last time you reassigned priorities to objectives or activities in which you were engaged. Describe the reasons for these changes in priorities." (p. 6)

. If you are a supervisor/manager, think of the last time you hired a case manager. Describe how the person selected differed from candidates whom you did not select. Describe the person in terms of his or her characteristics which you valued. If you made the decision to hire based on the experience of the person in the prior job, describe the characteristics you think the person had based on his or her past experiences.

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return to work.

. Think of the last time you, or someone you know in rehabilitation, effectively, resolved a conflict among individuals involved in the rehabilitation process. Describe the style that the person used. Describe the steps taken to resolve the conflict.

. Think of the last time you reassigned priorities to objectives or activities in which you were engaged. Describe the reasons for these changes in priorities." (p. 6)

. If you are a supervisor/manager, think of the last time you hired a case manager. Describe how the person selected differed from candidates whom you did not select. Describe the person in terms of his or her characteristics which you valued. If you made the decision to hire based on the experience of the person in the prior job, describe the characteristics you think the person had based on his or her past experiences.

APPENDIX I

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INTERVIEW QUESTIONS - REVISION

How did you get into private rehabilitation?

Could you walk me through a typical day for you at the office, for example yesterday.

How did your day begin?
What happened next?
How did you feel about the client, employer, physician you contacted today?

Think about a successful client, walk me through that case from receipt of the file to the present or case closure?

Think about an unsuccessful client, walk me through that case from receipt of the file to the present or case closure?

Think about a client of your choice, walk me through that case from receipt of the file to the present or case closure?

What happened when you received the referral?
How did you make the initial client contact?
Thoughts, feelings, behaviors?
Were there points in the case, where you made decisions that facilitated (un)successful case resolution?
Were there decisions made that could have resulted in this case being (un)successful?

Upon receipt of a referral, how do you introduce yourself to a client? Describe the initial interview? Your services? Goals of rehabilitation? Why style appropriate and effective?

When do you refer clients for testing?

When do you refer clients for vocational evaluations?

Information used in making this decision?
Why technique appropriate or effective?
When techniques inappropriate or ineffective?

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Describe coordinating a RTW with a former employer? A new employer?
- Information used in coordinating the RTW?
- Interactions with employer, client, and physician?
- How interactions differ from clients who do not RTW?
- Client and employer characteristics?
- Behavior and accomplishments of client?

How do you prioritize your casework?

How do you handle conflicts in cases?
- Steps used to resolve the conflict?

How do you work with clients who are grieving the loss of their injury?

What makes you successful?

What makes you exemplary?

If you were hiring a rehabilitation counselor to do this job, what characteristics would you look for in the counselor? What kind of work experience?

Which of these characteristics/qualifications do you have?

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TRANSCRIPTION SYMBOLS AND CONVENTIONS

This appendix will explain the transcription symbols and conventions used to transcribe the audio cassette tapes of the interviews. These symbols are also found in the transcripts throughout this thesis.

In the transcript, "I" refers to the interviewer, and the respondent is identified by a pseudonym to insure confidentiality. Text has been renumbered to make reading the transcripts easier. At the conclusion of the transcript text the respondents name and the location of the text in NUD*IST is indicated to allow reference back to the original transcript and text (for example, Barry: 2345-2399). This occurred because some transcripts had over 4000 lines of text, due to the smaller margins required in NUD*IST.

Some segments of transcript are laid out as follows:

Transcript line number	Speaker	Transcribe-able utterances
1	Gayle:	I care.
2	I:	Okay.
3 4	Gayle:	I, I really care what happens to the people that I work with.

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These transcriptions and symbols were adapted from Gail Jefferson (1973) (as cited in Campbell, 1980) by Jim Schenkein (1978), and Douglas Campbell (1980). The presentation format for this thesis was adopted from Douglas Campbell (1980).

They include:

Symbol	Example	Explanation
GO	many TIMES we	Capital letters are used to indicate emphasis or increased volume when speaking a word.
{ }	{pointing}	Cursive type brackets indicate discrepancies between the transcriptionist and I. The text within the brackets is that of this researcher, added following review of the tape and typist transcript.
=	Jo: quantum leap= [I: No Jo: =overtly, unless	Equal signs are used to indicate utterances that are so precisely timed that there appears to be no pause between them. This is known as "latching" and can occur within and between speaker turns. Latched lines are lined up within the transcript when possible by a single bracket ([) followed on the next line by the equal sign.
. . .	lost time . . . you're	Horizontal eclipses indicate words trailing off or missing words in the dialogue.
[ ]	Jo: [and all that]	Parallel brackets indicate overlapping talk, when two speakers are talking simultaneously. The left bracket begins when the overlapping talk begins. The right bracket is placed at the end of the overlapping talk.
[ ]	I: [we've all done] that	
( )	(Telephone rings)	Parentheses enclose non-verbal activity that occurred during the interview. When a number is within the parentheses, it indicates the length of the pause between words during the conversation.
	(.4)	

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(?)	you're in (?) if you (explain?)	Question mark within parentheses indicates the transcriptionist could not understand the word to be transcribed. If a question mark follows a word, the transcribed words accuracy is in question.
[ ]	them [the client]	Single brackets indicate words inserted for clarity of content.
. . .	1 Jo: believe it or 2 not. . . . 3 Jo: they're doing just fine.	Vertical eclipses separate missing segments of text.

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